



forum
Knowledge. Power. Access.

thursday, **JUNE 25, 2009**
vancouver

SUMMARY REPORT





Table of Contents

Table of Figures	3
Acknowledgements	5
Background.....	7
About the Immigrant Older Women – Care Accessibility Research Empowerment (ICARE) team....	7
Why look at older visible minority immigrant women’s health?	7
Research Focus.....	7
Context.....	7
The ICARE Forum: Knowledge. Power. Access.....	9
Purpose of the Forum.....	9
Overview of Forum Structure.....	9
Participants.....	10
Laying the Foundation.....	11
Intersectionality Framework.....	11
Immigration in Relation to Women’s Health and Health Care Access	12
Approach to Studying Health Care Access	12
Personal and Peer-Based Perspectives of Immigrant Women’s Health & Health Care Access.....	13
Concurrent Roundtables	15
Immigrant Women-Centred Chronic Disease Care Model	15
Roundtable Participants.....	15
Problems with the Conventional Chronic Disease Self-Management (CDSM) Model.....	15
Chronic Disease Risk Factors for Older Visible Minority Immigrant Women	16
Health Promoting Practices being used by Older Visible Minority Immigrant Women.....	17
Towards an Immigrant Women-Centred Chronic Disease Care Model.....	18
Developing a Research Framework	19
Older Visible Minority Immigrant Grandmothers as Caregivers	20
Roundtable Participants.....	20
Issues affecting Older Visible Minority Immigrant Grandmothers as Caregivers	21
Supporting Grandmothers as Caregivers: What Models are Working?.....	24



Developing a Research Framework 24

Community Resources for Older Immigrant Women’s Mental Health..... 27

Roundtable Participants..... 27

Risk Factors for Poor Mental Health..... 27

Barriers to Mental Health Services..... 28

Supporting Positive Mental Health: What Models are Working in the Community? 29

Ideas: What’s needed?..... 30

Developing a Research Framework 30

Next Steps..... 32

References Cited 33

Appendices 37

Appendix A: A Framework for Women-Centred Health 37

Appendix B: Forum Program 38

Appendix C: Presenter Biographies 40

Table of Figures

Figure 1: Total ICARE Forum Participants..... 10

Figure 2: ICARE Team Composition..... 10

Figure 3: Immigrant Women-Centred Chronic Disease Care Model Roundtable Participants 15

Figure 4: Older Visible Minority Immigrant Grandmothers as Caregivers Roundtable Participants 20

Figure 5: Community Resources for Older Immigrant Women’s Mental Health Roundtable Participants. 27



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BACKGROUND

About the Immigrant Older Women – Care Accessibility Research Empowerment (ICARE) team

Why look at older visible minority immigrant women's health?

The number of older immigrant women in British Columbia is growing, but research is not keeping pace. The largest proportion of women in this group comes from China and India. Most are sponsored by their families, which renders them financially dependent for ten years. Many are widows. Often they provide much-needed childcare services for their grandchildren. These factors alone can make access to health care very challenging. Such challenges need to be understood in the context of the considerable discrimination that many of these women have faced throughout their lives. Limited access to education, paid work opportunities, and freedom outside of the home has left many without the skills to overcome such barriers. Furthermore, as older visible minorities in an unfamiliar cultural environment they are also susceptible to discrimination based on their age, gender and skin colour.

Research Focus:

The purpose of the ICARE team is to develop a research program that explores the myriad ways in which intersecting oppressions, experienced before and after immigration, influence access to health care by older visible minority immigrant women.

Context:

Ethnocultural minority older adults are neglected in both research and social and health policy because their numbers are thought to be too insignificant to constitute a 'problem'. Gendered analyses of this age group are likewise extremely rare. But health inequities are often experienced far more dramatically and at great cost to individuals, families and health care systems by such minorities, indicating the need to direct research efforts to addressing those with the highest unmet needs. Moreover, the numbers are no longer insignificant. Older adults represent the fastest growing segment of the Canadian population and average more than two times the number of physician contacts per year than do persons under the age of 65.¹ Although the aging process can be positive, it also presents challenges related to both physical and social losses over the life course. The experience of such losses differs considerably according to variables such as ethnicity, gender, and immigration status.

In the Greater Vancouver region in 2006, one-third (31%) of the population aged 65+ were visible minorities, 80% of whom were Chinese (56%) and South Asian (24%).² Between 2002 and 2006, 65% of foreign-born older adults arrived in B.C. without official language ability.³ Refugees accounted for only a small proportion (4%) of immigrant older adults during this period; the majority (88%) arrived as Family Class immigrants; usually as parents and grandparents sponsored by children and grandchildren. Both classes of immigrant older adults have poorer health than long-term immigrants and the Canadian-born population.⁴⁻⁷

In BC, almost one-third of Family Class immigrants are aged 50+ and 60% are female.⁸ Compared to immigrants to Canada overall, arrivals in this class have lower levels of education and English language



ability. India has consistently accounted for the largest proportion of Family Class immigrants to BC (30% from 2000-04), with China being second. Overall, however, the Chinese have constituted the largest proportion (28%) of all immigrant older adults to BC from 2002-2006; those from India were the second largest group (18%).³

The ICARE Forum: Knowledge. Power. Access.

Purpose of the Forum:

The ICARE forum **Knowledge. Power. Access.** was held on June 25, 2009 from 10:00 a.m. to 4:00 p.m. at Langara College in Vancouver, British Columbia.

The forum provided an opportunity for the ICARE team to introduce and communicate our purpose to a diverse group of stakeholders from the multicultural settlement, community, health service provider and academic sectors. Participants worked collectively to develop research questions in each of the three prioritized theme areas:

1. Immigrant Women-Centred Chronic Disease Care Model.
2. Older Visible Minority Immigrant Grandmothers as Caregivers.
3. Community Resources for Older Immigrant Women's Mental Health.

THE STATED FORUM OBJECTIVES WERE:

- To clarify how gender, age and immigration can interact to create barriers to health care access for older visible minority immigrant women.
- To identify and develop research questions in each of the three prioritized topic areas.
- To collectively identify and prioritize next steps for action.
- To create opportunities for participants to stay involved with the project.

Overview of Forum Structure:

An introductory panel provided the context for the forum. Two older women from the South Asian and Chinese communities presented personal and peer-based perspectives on health and health care access issues for older visible minority immigrant women.

In the latter part of the morning participants were led through an interactive exercise to explore how constructions of gender, age, immigration and visible minority status may interact to influence individual health care experiences.

For the remainder of the day, three concurrent roundtables explored each of the three prioritized theme areas. Roundtables began with panel discussions led by members of the ICARE team. Throughout the day facilitators for each group led participants through a series of exercises intended to articulate research priorities and begin to develop research questions.

Participants:

There were 60 participants in attendance. Participants reflected a diversity of sectors and positions, including health professionals, multicultural settlement workers, older adults, policy makers and researchers. Most participants came from BC’s Lower Mainland; however there was also representation from the Fraser Valley, the Interior of BC, and Vancouver Island.

The following diagram illustrates the participant breakdown by sector for the total number of ICARE forum participants.

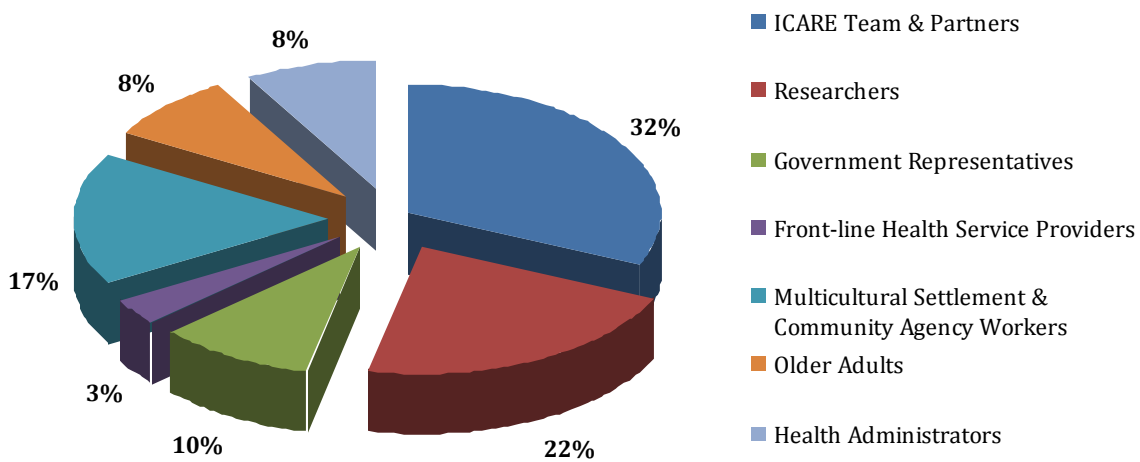


Figure 1: Total ICARE Forum Participants (n = 60)

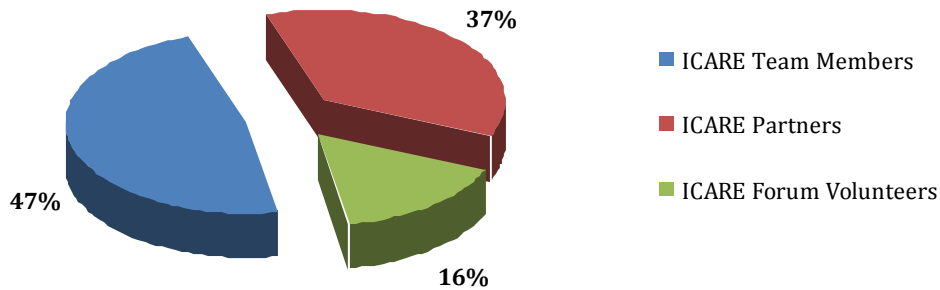


Figure 2: ICARE Team Composition (n = 19)

Laying the Foundation

The following conceptual frameworks reflect the ICARE team's approach to health care access for older visible minority immigrant women, and serve as a theoretical grounding for each of the three roundtable topics.

Intersectionality Framework:

The social losses often associated with aging are more frequently and acutely experienced when they intersect with gender, visible minority and immigrant status. Access to health services, employment, childcare and other key resources necessary for promoting and sustaining health are determined by the dynamic intersection of sociodemographic categories such as gender, age and immigration status. Intersectionality considers the simultaneous interactions between multiple dimensions of social identity (for example, sex, gender, age, visible minority and immigration status) that are contextualized within broader systems of power, domination and oppression (for example, sexism, ageism and racism).⁹

For the ICARE team, an intersectional approach behooves us to ask how gender, age, ethnicity, visible minority and immigration status interact to create barriers to health and social care access for older visible minority immigrant women.

Although older women are underrepresented in health research,¹⁰ considerable evidence exists to link health inequities with the social determinants of health, among which gender and cultural factors have cross-cutting influences. Biological differences intersect with socio-political constructions of gender to produce health inequities that become, for example, "violence against women, lack of access to resources and opportunities, and lack of decision-making power over one's own health."¹¹

For older Chinese and South Asian immigrant women, the process of racialization greatly impacts health and quality of life. The social category of race and the corresponding social production of racial identities interact with other fundamental determinants of health such as ethnicity, age, gender, and immigrant status to impact an individual's ability to access the key social resources necessary for health promotion and maintenance.¹⁰ In practical terms, racism affects health through systemic and individual-level occurrences of discrimination, marginalization, and susceptibility to poverty, to name a few.¹⁰

Ethnicity is defined by the Women's Health Research Network as: "...a group's shared cultural heritage based on common ancestry, language, music, food and religion."¹⁰ Like race, ethnicity is a fundamental determinant of health. Cultural practices on their own do not necessarily determine health; rather it is the treatment of cultural/ethnic differences within, for example, our health care system that (re)produces health inequalities for ethnocultural minorities.

Applying Intersectionality to Research Design:

In practical terms, an intersectional perspective informs how research is designed, from the types of questions we ask to processes of knowledge translation and exchange.

When developing a research question, an intersectionality framework implicates what is often referred to as a "bottom-up" or inductive approach that recognizes and validates an individual's knowledge and authority over their own unique set of experiences.⁹ Research questions should furthermore aim to bring historically marginalized perspectives and experiences to the forefront.⁹



The question of how knowledge is translated into action is critical within an intersectional approach to research. Intersectionality encourages the involvement of multiple and diverse stakeholders; as such, plans for knowledge translation and exchange should be developed collaboratively between these groups.⁹

Immigration in Relation to Women's Health and Health Care Access:

The impact of the process of immigration on older visible minority women's health is difficult to disentangle from other fundamental determinants of health.¹⁰ It is clear, however, that oppressions experienced earlier in life by this cohort of older immigrant women often leave them with low levels of social capital (e.g. lack of education, experience outside of the domestic sphere, and illiteracy)^{12, 13} that in turn interact with ethnicity and other determinants of health to influence the resettlement experience.

The immigration experience itself critically influences health. The "resettlement stress, new pathogens, poverty, inter-racial and inter-generational conflict and family separation" common to the experience of many immigrants can exert a heavy toll on the physical and, most especially, the mental health of immigrants.¹⁴ The intersection of gender and the immigration experience renders women especially vulnerable to psychological distress.¹⁵

As immigrants, women encounter new forms of oppression based on their immigrant status, racialization and status within the family which can render them vulnerable to social isolation and loneliness,^{16, 17} family conflict (possibly even abuse and neglect),¹⁶⁻¹⁹ and economic insecurity.^{20, 21} These factors in turn have been found to negatively influence health.^{22, 23}

Approach to Studying Health Care Access:

The health inequities of older immigrant women highlight the need to better understand their unique health care access experiences. However, the concept of health care access is extremely complex and has been fraught with inaccurate assumptions. Studies have shown, for example, that long-held beliefs by providers that certain visible minority populations "take care of their own", resulting in lower formal service needs, is flawed, and that this belief itself can effectively limit access by shifting the burden of responsibility to family caregivers.²⁴⁻²⁷ Like gender stereotyping, such racialized and culturalist explanations of need operate as a barrier to health care access for older visible minority immigrant women.

The ICARE team has adopted a recently-developed model on access to health care by vulnerable populations that identifies multiple intersecting points along the continuum of care at which health care access is negotiated and can be compromised.²⁷⁻²⁹ The seven dimensions of the model include the person's self-identification of the need for care, their ability to identify, locate and get to the care they need, the interactions between patient and providers, involving both the patient's presentation of their claim for care and the provider's assessment of that claim that may or may not result in appropriate treatment or follow-up, the patient's decision to accept or reject the treatment or referral, the extent to which particular services are accessible relative to the resources (such as time, money, and knowledge) available to patients, and specific local (for example, geographic) and policy level factors influencing care options. It is our belief that this model holds great value for facilitating a comprehensive and systematic understanding of health care access for ethnocultural minority older women.



Personal and Peer-Based Perspectives of Immigrant Women's Health & Health Care Access:

As part of "laying the foundation" for the ICARE forum two speakers, Mohinder Sidhu and Maggie Ip, provided personal and peer-based perspectives on South Asian and Chinese older immigrant women's health and health care access issues, respectively. Their presentations are summarized in the article below published by the Georgia Straight newspaper on July 9th, 2009.³⁰

Isolated older women at risk without English

Maggie Ip will never forget her conversation with an elderly Chinese woman who had recently immigrated to Canada. Ip, the founding chair of the multicultural agency S.U.C.C.E.S.S., was volunteering at a free tax clinic, and she could tell something was wrong with the woman sitting across from her. When Ip asked if she was okay, she started to cry. The woman—a widow who didn't speak any English and had no formal education—told Ip that her son had kicked her out of the family home. He had arranged for her to live in a tiny, windowless room underneath the staircase in a stranger's home, where she could only access her meagre space whenever the owner was home to let her in. The woman had no support and no knowledge of the services that were available to her and other women like her in similar dire straits.

"This lady cried her heart out," Ip said at a recent forum hosted by Sharon Koehn, a researcher at the Centre for Healthy Aging at Providence, as well as members of iCARE (Immigrant Older Women—Care, Accessibility, Research and Empowerment), a group of researchers, health professionals, and community workers. "It reminded me that there is a large number of this kind of woman out there, living in a basement somewhere... in a helpless situation."

Ip—a former Vancouver city councillor who was born in Shanghai in 1943 and came to Canada in 1966—was one of several speakers at the June 25 event, which aimed to shed light on the plight of visible-minority older immigrant women, with a focus on accessing health and social services.

According to the 2006 census, 51 percent of Vancouver residents are visible minorities. The largest group, those of Chinese descent, represents 29.4 percent of Vancouver's population. According to a 2005 Statistics Canada report, non-European immigrants are more likely than the Canadian-born population to report having low social support.

Mohinder Sidhu, who works for various local seniors advocacy organizations, explained at

the forum that there are many barriers to care for older immigrant women. The lack of knowledge of English is just one, albeit a big one.

"Most seniors [who come from South Asia] don't understand what other people say; they can't read or write," said Sidhu, who was born in Punjab in 1935 and came to Canada in 1970. "Growing up in India, girls have less access to education than boys. In our culture, girls are [expected] to make families and stay at home, knitting, sewing, cooking, and doing housework. Some are even illiterate in their mother tongue. There are no schools in some villages."

Once in Canada, many of these women feel lost, quite literally: it's hard for them to decipher the public-transportation system, never mind navigating the health-care system.

"Life without English means they can't even take the bus," Sidhu said. "They only remember the numbers of the bus. They rely on their children to get them to doctor's appointments, but they hesitate to ask [their working children] to get spare time for them."

The communication problem doesn't end there. When they do seek medical care, older visible-minority women may not understand what the doctor is saying to them.

"They may say yes even when they don't understand when the doctor is explaining something," Sidhu said. "The problem of language can be invisible to doctors. They will say yes because they're tired of saying, 'I don't understand.'"

The lack of comprehension can drastically affect their well-being, Sidhu explained. Many in the local South Asian community have diabetes, a condition that requires regular monitoring of blood-glucose levels and, in some cases, insulin injections. Learning how to read glucose meters and take care of themselves can be a challenge for many older immigrant women.

Immigration status itself imposes a barrier. Many seniors are subject to a 10-year dependency period associated with sponsorship and don't have full access to government financial assistance or health services.

Sidhu added that it's common for Indian

Health
Gail Johnson



S.U.C.C.E.S.S.'s Maggie Ip (left) and seniors' advocate Mohinder Sidhu are working to improve support for elderly immigrant women who don't get proper care due to language barriers. Pieta Woolley photo.

families to bring older women to Canada strictly so that they can cook, clean, and take care of children.

"They view older women only as caregivers," said Sidhu, who heads a walking club for Indian women, has taught cooking classes in Punjabi for people with diabetes, and would like to start a community kitchen. "As women age and they become unable to cook, clean, and care for the children, the families may become angry with them. This can cause unhappiness or abuse."

The families of some seniors expect them to work on farms or in factories if they're not taking care of children.

"It's hard labour," Sidhu said. "They work 12 hours a day, and that makes their health worse."

Many also experience depression.

"They are depressed over the loss of family and friends in India; a loss of income; they have hard work, neglect, and elder abuse," Sidhu noted. "There is isolation. There are not enough places to sit and talk... They don't have money for community programs."

They also don't know what they're legally entitled to in Canada, such as services like home support and low-income housing.

Sidhu said it would help if immigrants had better access to interpreters as well as health workshops in their own language. Furthermore, having shuttle buses run from community centres to places of worship would enable seniors to meet and talk with their peers. Training in practical skills like reading bus schedules, shopping for household items, and talking to doctors.

The aim of the forum, Koehn said, was to build on research that will lead to new policies directly benefiting the day-to-day lives of older visible-minority immigrant women. The ultimate goal, of course, is an improvement of their physical, emotional, and spiritual well-being. ♦

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CONCURRENT ROUNDTABLES

Immigrant Women-Centred Chronic Disease Care Model

Roundtable Participants:

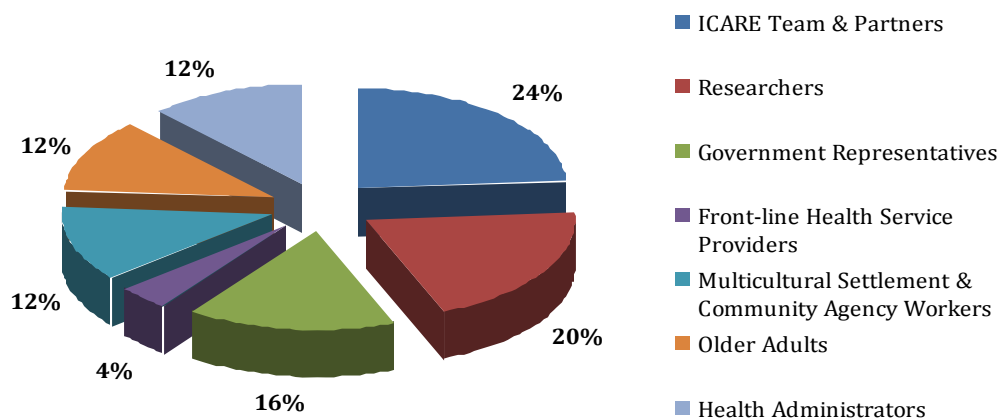


Figure 3: Immigrant Women-Centred Chronic Disease Care Model Roundtable Participants (n = 25)

Problems with the Conventional Chronic Disease Self-Management (CDSM) Model:

The Chronic Disease Self-Management Program in British Columbia (CDSMP) teaches patients the practical skills needed to cope with and manage their chronic diseases.³¹ Courses are led by trained “lay leaders” who meet with groups of 10 to 12 people with chronic conditions for two and a half hours each week for a six-week period.³¹ Individuals are given lessons on performing activities of daily living such as healthy eating, exercising and communication skills.³¹ The CDSM model is intended to support traditional patient education provided by health professionals in primary care settings.

Participants in this roundtable expressed concern that the conventional CDSM model fails to consider the unique needs of ethnocultural minority women with chronic diseases, specifically South Asian and Chinese older women. Panelists Joan Bottorff and Suki Grewal presented a schematic framework for discussing the contextual, interrelated dimensions of women’s health (see Appendix A). In addition to the key determinants of health such as education, income and biology/genetics, a women-centred health framework includes considerations of women’s involvement and participation in service design and delivery, preferences in obtaining care and empowerment.³²

The overarching questions that emerged from this roundtable were: (1) Is the framework for women-centred health truly practical? (2) What would it look like to implement all of these options in practice?

When considered in conjunction with an intersectionality approach, the women-centred health framework provides a starting point for guiding policymakers as to how the health care system might best respond to the unique chronic disease management needs of older visible minority immigrant women. The first step is to find out what those needs are, understanding that they will be shaped by the many ways in which culture, ethnicity, age, immigration status, visible minority status, and gender can converge to determine an individual woman's unique health experiences. Appropriate health system responses to older South Asian and Chinese women's chronic care needs will involve: (1) gender-inclusive methods of research; (2) gender-inclusive curricula in medical schools; (3) knowledge of how systemic inequalities impact women's health; and (4) recognition of service delivery processes that engage and empower women.³²

Chronic Disease Risk Factors for Older Visible Minority Immigrant Women:

Chronic disease risk factors for older visible minority women were discussed within the context of the entire immigration experience, from pre- to post-immigration. The majority of data brought into the roundtable discussion was from work done by the panelists within the South Asian community. Future working group discussions should strive to additionally include information from the Chinese community.

Pre-Immigration Health Status:

As previously discussed, oppressions experienced by older visible minority immigrant women pre-immigration often leave them with low levels of social capital that in turn influence health outcomes through the resettlement experience.

Immigrant women are at greater risk than men for developing certain chronic diseases. For example, South Asian women are at a higher risk than men for developing heart disease.^{33,34} The Heart and Stroke Foundation recognizes this trend and is currently looking to collaborate on research to examine this issue.

In India, 53% of deaths are related to chronic diseases.³⁵ India has the highest rate of Type II Diabetes in the world,³⁴ and diabetes-related visual loss is commonly seen in South Asian women.³⁶

Post-Immigration Risk Factors:

There are many barriers operating on individual, community and organizational levels within the post-immigration context that predispose older visible minority immigrant women to developing chronic diseases, and moreover create difficulty in controlling the progression of chronic diseases.

Language barriers often prevent older immigrant women from understanding how to navigate the health system and access appropriate health services, such as medical specialists. In the doctor's office, language barriers require interpretation, a task most often performed by family members although this is far from ideal. The disclosure of intimate health concerns to family members in the doctor's office is problematic for some older immigrant women depending on the age, gender and nature of their relationship with the family member who is interpreting. Older women may also be dependent on family members for transportation to and from the doctor's office.

Older South Asian and Chinese immigrant women may furthermore be unaware of existing health services. For example, many of these women are not aware of the availability of cancer screening tests. Additional barriers may present even when there is an awareness of these services; for example, the gender of the care provider may be significant for some women who are uncomfortable speaking about their health concerns to a male physician, particularly a younger one.³⁷

Many older immigrant women may not have the time or resources to seek out the health services they need, particularly if they are sponsored by their families to look after grandchildren and perform household chores. These responsibilities often make it difficult for older women to find the time to access not only health services, but broader social support services such as community groups that support the development of good health.

For the South Asian community in BC, changing food/nutrition habits can leave women at risk for developing diabetes, heart disease and other chronic diseases. Rich foods are easily available and affordable in Canada, in contrast to the simpler foods that mainly comprise people's diets in India. In Canada rich foods become associated with status, and people's intake of these foods increases.

The self-care model presents many assumptions about an individual's ability to navigate the health system that may not be true for many older visible minority immigrant women. For those who have limited means of transportation, money and English language skills, systemic barriers to health care access exist. Traditional health care models are literacy-centred, and there is a lack of resources for women to know where to go for health promotion and disease management. Questions as to who to contact for disease management and what services are available are prevalent. Difficulties navigating and accessing health services means that for some women chronic disease may go undiagnosed and/or unmanaged.

Health Promoting Practices being used by Older Visible Minority Immigrant Women:

Religious centres provide an important space for health promotion among older immigrant women. For South Asian women, weekly visits to the temple provide an opportunity to socialize with peers while also addressing spiritual health needs, combating the social isolation experienced by many as a result of their household and family responsibilities.

Some older immigrant women also choose to practice traditional forms of health maintenance.³⁸ Tai chi is one example of a traditional form of exercise that a growing number of older Chinese women practice.

Community centres and neighbourhood houses are other places where older women may socialize and find support among peers. Various women's groups help address women's physical, social and psychological health needs. For example, women's 'walking groups' help them to get out of the house and exercise while socializing at the same time. Many women are accessing health services through such 'informal' means by approaching family and friends to get the appropriate information.¹⁹

For all of these health promoting practices undertaken by older immigrant women there are also barriers – many of them structural. For example, while community centres may offer support groups, older women are often unable to find the time, transportation and money needed to participate in community programming.

Towards an Immigrant Women-Centred Chronic Disease Care Model:

Throughout the course of the day the group began to discuss the necessary elements of a chronic disease care model tailored to suit the needs of older Chinese and South Asian immigrant women.

What Models are Working?

Disease management clinics are popular with South Asian and Chinese communities but funding is limited. Pap test/breast exam clinics initiated in the South Asian community were very successful: women tended to bring up many other health problems when being examined by female physicians who spoke their language. The biggest drawback of these clinics was that there was no capacity or mandate for health providers to deal with women’s broader health concerns.³⁹

Funded services and programs that are offered through trusted community organizations have been successful in recruiting older immigrant women. For example, a pilot screening program in Calgary tested for cardiovascular disease among South Asian individuals in four different languages.⁴⁰ The individuals performing the screening tests were specifically-trained lay volunteers from the Indo-Canadian community.^{40, 41} Of those screened, 81% of high risk women and 82% of high risk men followed up with their family physicians within a year; however, only 45.5% of high risk women and 30% of high risk men were actually referred to a specialist.⁴¹ Of those referred, 87% of women and 100% of men attended the appointment.⁴¹ Tests were offered at the temple during evenings; interestingly similar tests offered at community centres were not as effective in recruiting people to the program.

Self-care options such as yoga can work if provided in an environment familiar to women (such as the temple).

Requirements for an Immigrant Women-Centred Chronic Disease Care Model:

The group developed a set of questions to assess the appropriateness of any potential chronic disease management program for older visible minority immigrant women.

IS THE MODEL...
Women-centred?
Ethnoculturally-centred?
Family-focused?
Life-course-focused?
Located within the community?
Reciprocity-based?

Developing a Research Framework:

The group aimed to produce a series of initial research questions and accompanying research strategies to develop an immigrant women-centred model of chronic disease management. These questions will serve as the starting point for a more in-depth discussion leading to the development of a research proposal(s) in this area.

Research Objectives:

- To create services and provide improved access to wanted services (promotion, prevention and treatment) that will help to improve the health and well-being of older South Asian and Chinese immigrant women in British Columbia.
- To determine what services are needed, how to create and sustain access to these services, and how to achieve and evaluate successful (desired) outcomes.

RESEARCH QUESTIONS:

1. What are the health care needs of older immigrant women living with chronic disease and how might they be addressed?
2. What is the most appropriate model to increase access to chronic disease management health services for older visible minority immigrant women?
3. What kind of community-based/community-owned services would be most effective in improving access to chronic disease management services for older visible minority immigrant women?

Preliminary Discussion of Research Methods:

Preferred research methods cited by the group included various collaborative research strategies, such as Participatory Action Research (PAR). Models of service provision must be evaluated and/or developed in partnership with immigrant women, their families and communities in order to ensure their relevancy. Processes of knowledge translation and exchange are likewise enhanced through a collaborative approach to research.

A comparative study to measure the effectiveness of existing programs holds potential for this topic. For example, the CDSMP has launched peer training sessions for members of the Punjabi community in Vancouver. These individuals will facilitate workshops specifically designed for the Punjabi community. This model could be compared with, for example, a community program in Richmond where patients diagnosed with chronic diseases are immediately connected to community networks (for example volunteers and specialists) for assistance in managing their chronic disease(s).

Older Visible Minority Immigrant Grandmothers as Caregivers

Roundtable Participants:

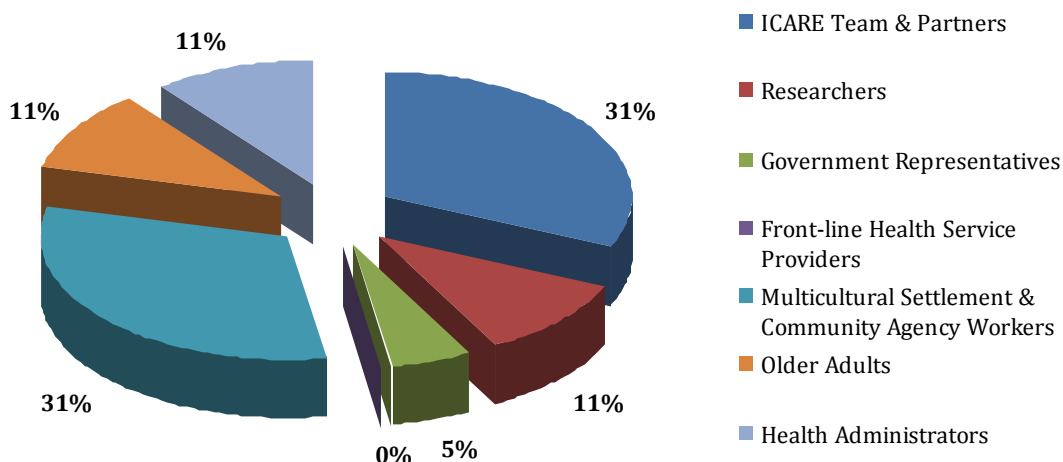


Figure 4: Older Visible Minority Immigrant Grandmothers as Caregivers Roundtable Participants (n = 19)

Reuniting immigrant families is an important goal in Canadian policy.⁴² Older adults comprised almost one-half of all family class immigrants to Canada in 2006.⁴³ In BC, 88% of older immigrants arrived under the Family Class category between 2002 and 2006.⁴⁴

When an older relative is sponsored under the Family Class immigration category, the sponsor makes an unconditional undertaking of financial support for a period of ten years to the Minister of Citizenship and Immigration. This is a longer period than for any other Family Class group.

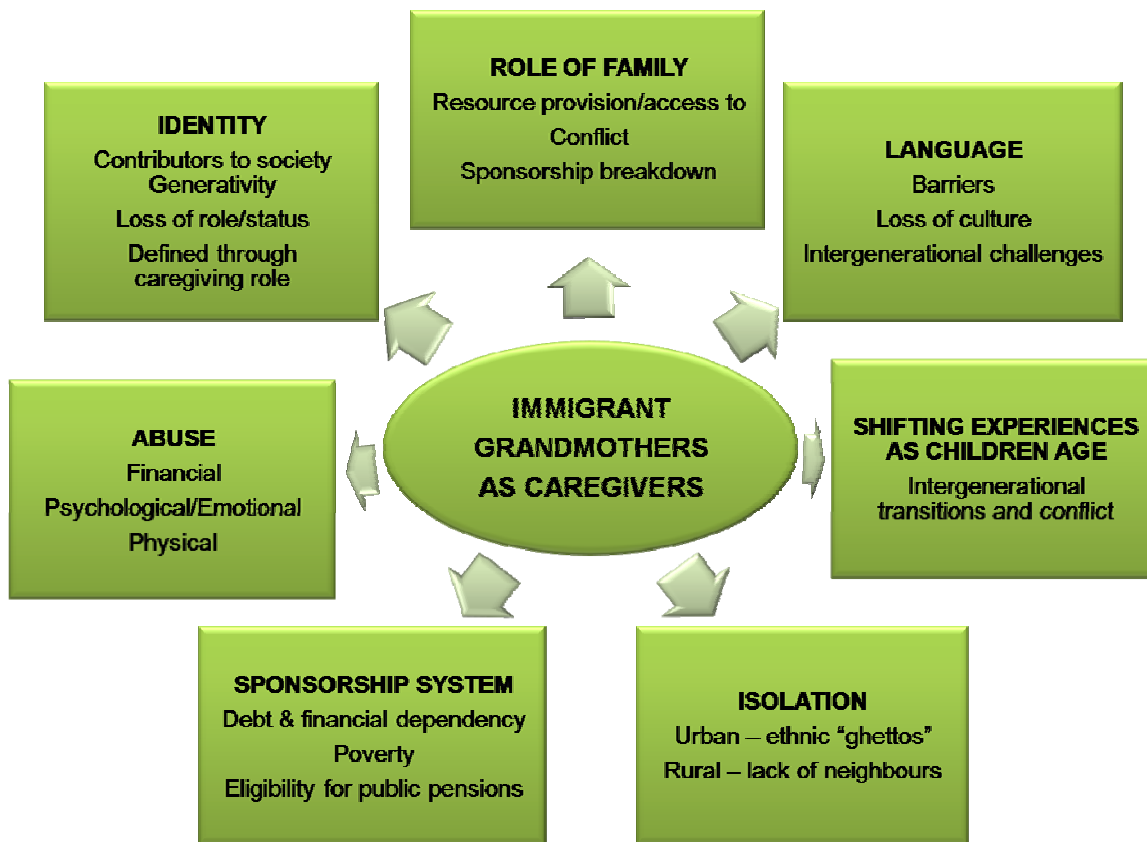
The financial dependency of older relatives on their family sponsors often leaves them under a great sense of obligation. Sponsored grandparents – and in particular grandmothers – are often expected to provide unpaid childcare services for grandchildren. As grandmothers age and become unable to cook, clean and take care of their grandchildren, they are increasingly vulnerable to depression, isolation and abuse.

There are numerous issues to address for older South Asian and Chinese immigrant women as caregivers to grandchildren. Language barriers are significant, and require services and resources. Although services are provided in multiple languages, transportation, cost and other barriers still exist for some families. Elder abuse has been documented in both communities, and requires action to reduce the vulnerability that underpins abuse. When grandmothers need help, whether for abuse or any kind of assistance, they often do not know where to begin to ask, and what types of services are available.

There is currently a lack of research to understand how caregiving roles affect visible minority immigrant grandmother's health and quality of life. Future research should investigate how social isolation, financial barriers, family dynamics, and the sponsorship system interact to impact the health of grandmothers as caregivers.

Issues affecting Older Visible Minority Immigrant Grandmothers as Caregivers:

The diagram below summarizes the multiple issues affecting the health of older visible minority immigrant grandmothers. These issues are understood by the group to be intersecting, dynamic and non-hierarchical.



Sponsorship System:

Sponsorship policies and practices create difficult conditions for families. Older relatives are rendered financially dependent on their family sponsors for an obligatory ten-year period. During the initial dependency period, older adults may not be eligible for public pensions such as the Allowance, Old Age Security or the Guaranteed Income Supplement, subsidized housing or housing subsidies, or other local benefits such as reduced fare bus passes.

Many older immigrants remain economically disadvantaged even after sponsorship ends because of the way the residency criterion for Old Age Security is calculated. Immigrants from South Asia, for example,

are at a greater disadvantage than immigrants from countries such as Australia, New Zealand and the United Kingdom since Canada has reciprocal agreements on social security with these countries.⁴⁵ These agreements can have a beneficial effect on residency credits, which determine the eventual amount of Old Age Security the person will receive.

Dependent on their sponsors in every respect, sponsored older adults seldom have accurate information about their rights. They are often fearful that their sponsorship can be withdrawn, and they do not know where to turn for help if problems do occur.¹³

Access to health care is also affected by the older adults' extreme dependency on their sponsors for translation of written information, and for rides and interpreting at medical appointments. The policy also renders sponsored older adults ineligible for many services, such as rehabilitation and long-term care, during their ten-year dependency period.²⁷

Abuse:

Older adults are at great risk of abuse by someone known to them.⁴⁶ Adult children are responsible for more than 35% of abuse perpetrated against older parents.⁴⁶ There are two components of the legal obligation to provide for all of the sponsored older adult's needs that significantly increases their susceptibility to abuse or neglect.¹⁶

The first of these components is the length of time of the sponsorship obligation during which the financial status of the sponsor and the health status of either the sponsored older adult or the sponsor may decline through no fault of their own. The result may be extreme financial hardship and sometimes emotional or physical abuse, or passive or active neglect. Once a sponsored grandmother qualifies for her public pension, she may experience abuse in the form of pressure to sign over her pension cheque to her family.

The second component of sponsorship-related policies that may increase the potential of abuse is the intensification of dependency and resultant power imbalance between family members that the policies invoke. The dependency of grandmothers on their family sponsors leaves them susceptible to many forms of abuse. While abusive acts are often thought of as physical, many grandmothers may also suffer specific types of psychological/emotional abuse such as being left out of family functions.^{46, 47}

Identity:

The very real situation of dependency results in the loss of status within the family structure for some older immigrant women whose familial role becomes defined through caregiving tasks.¹³ On a broader social scale the loss of status is also experienced by older visible minority immigrant women through the combined effects of racism, sexism and ageism.

The identity of grandparents is often constructed through their role in the intergenerational transmission of knowledge, culture and values – a concept referred to as “generativity.” Recent research has proposed that the various challenges (for example, acculturation) that emerge through the process of immigration may impact this particular expression of grandparent identity.⁴⁸

Language:

A lack of English skills creates challenges for older immigrant women. As caregivers to grandchildren, immigrant grandmothers experience additional pressure to achieve competency in English. The pressure to learn English as one aspect of acculturation may produce feelings of loss of culture and its transmission to grandchildren. As a means to work through this, the role and identity of South Asian and Chinese grandmothers may be to encourage grandchildren to speak both languages.

Role of Family:

Family is an invaluable resource for older immigrants to Canada. Beyond legal obligations, families are able to provide access to community – both formally and informally – and help grandparents to navigate health and social services.

Unfortunately, family may also be a source of conflict for grandparents. The sponsorship relationship creates difficult terms for the relationship between older relatives and their family sponsors. The situation of dependency for grandparents creates power differentials that are difficult to navigate.

Different parenting styles between grandparents and their adult children is a source of family conflict. Grandparents have different ideas of how to parent and prepare young children for school based on their own experiences of child-rearing in their country of origin; however in a new family and community context many feel lost and parents become frustrated. Grandchildren observe the conflicting authority between their parents and grandparents and react accordingly.

In some cases, the sponsorship relationship breaks down. Declaration of sponsorship breakdown is an infraction of the sponsor's legal undertaking. Unless sponsored older adults have income or other relatives willing to support them, they must apply for social assistance, a process that varies considerably across Canada and which is by no means guaranteed.¹⁶

South Asian women participants noted in a 2005 study by Grewal *et al.*¹⁹ that they experienced unexpected roles changes within their families post-immigration. For example, older women noted that in their post-immigration Canadian family context, they felt obligated to provide childcare and other household services, even at the expense of their own health.

Shifting Experiences as Children Age:

In much of the work done on immigrant grandmothers as caregivers, the focus is typically on the experiences of grandmothers to young grandchildren. How do caregiving experiences shift as grandchildren grow older? Intergenerational transitions may produce conflict. Are there any new services required to provide for these shifting needs?

Isolation:

Many conditions of isolation exist for grandmothers as caregivers. Caregiving responsibilities in part determine a grandmother's ability to establish a social existence, whether through the creation of informal support networks or through accessing available programs and services.

In large urban centres such as Vancouver, the existence of 'ethnic enclaves' means that when they are able to move around, older women are often relegated to one particular area of the city. In rural settings,

a lack of neighbours creates substantial isolation – both geographic and social – for older immigrant women.

Caregivers of Children with Health Challenges:

Empirical evidence from Dr. Noreen Simmons of the BC Family Hearing Resource Society reveals that grandparents to children with hearing loss experience multiple caregiving challenges. Grandparents have difficulty learning sign language in addition to trying to learn English as a second language. These challenges are exacerbated when grandchildren do not speak or use their native language. A loss of dexterity and vision creates difficulties for grandparents attempting to learn how to use small auditory devices for their grandchildren such as hearing aids or cochlear implants. Grandparents also have difficulty adjusting when new hearing technologies are developed.

Further evidence suggests that while grandparents often provide care for grandchildren during the day, parents are often the ones to accompany their children to the hearing clinic, and they do not always effectively communicate caregiving instructions to grandparent caregivers. Grandparents also report not feeling respected by their children because of different parenting styles.

Supporting Grandmothers as Caregivers: What Models are Working?

The First Steps project managed by DIVERSEcity Community Resources Society in partnership with Options: Services to Communities Society provides newly arrived refugee children under five and their caregivers with a range of programming to support early childhood development. The project aims to equip caregivers with, “information on parenting in the Canadian context.”⁴⁹

A South Asian Task Group began performing outreach and awareness-raising strategies for South Asian parents with young children but discovered that grandparents are actually providing much of the care for grandchildren.⁵⁰ At this realization the task force shifted their outreach strategies to include live radio and television shows as a means of targeting grandparent caregivers.⁵⁰ Additionally, with funding from the United Way of the Lower Mainland, DIVERSEcity produced a calendar in Punjabi with caregiving tips targeted at grandparents.

Developing a Research Framework:

Research Objectives:

- To determine those factors that support the physical, emotional and spiritual health and well being of South Asian and Chinese immigrant grandmothers as caregivers.
- To further investigate how the immigration process and Canadian immigration policies affect the health and social status of grandmothers as caregivers.

Research Questions:	
<ul style="list-style-type: none"> ▪ What influences quality of life (positive and negative) for immigrant grandmothers as caregivers? 	<ul style="list-style-type: none"> ▪ This question encompasses, but is not limited to, the following considerations: ▪ Grandmothers in rural areas; ▪ Grandmothers to teenagers; ▪ Grandmothers to grown children; ▪ Grandmothers to children with health issues; ▪ The financial and social dependency of immigrant grandmothers.
• Sub-questions:	
<ol style="list-style-type: none"> 1. How do different social determinants of health influence quality of life for immigrant grandmothers as caregivers? 2. In what ways does immigrant grandmothers' financial and emotional dependency impact/influence their health? 3. How are these impacts similar or different for diverse groups of grandmothers (ages and stages, location, etc.)? 	
<p>Who should be involved in this research?</p>	<ul style="list-style-type: none"> ▪ Immigrant grandmother caregivers from China and India; ▪ Settlement/social service agencies to grandparents and children; ▪ Health agencies; ▪ Schools; ▪ Researchers.
<p>Where should this research take place?</p>	<ul style="list-style-type: none"> ▪ Rural and urban locations across BC; ▪ Places of worship; ▪ Community centres, specifically older adults' programs.



Preliminary Discussion of Research Methods:

The group discussed different possible research methods including focus groups (of three to four people) and one-to-one interviews to use within a Participatory Action Research (PAR) methodological context.

Interviews and focus groups should be conducted in participants' first language/language of choice and later translated by the interviewer/group facilitator. Research questions should be refined in consultation with older women and service providers.

Community Resources for Older Immigrant Women’s Mental Health

Roundtable Participants:

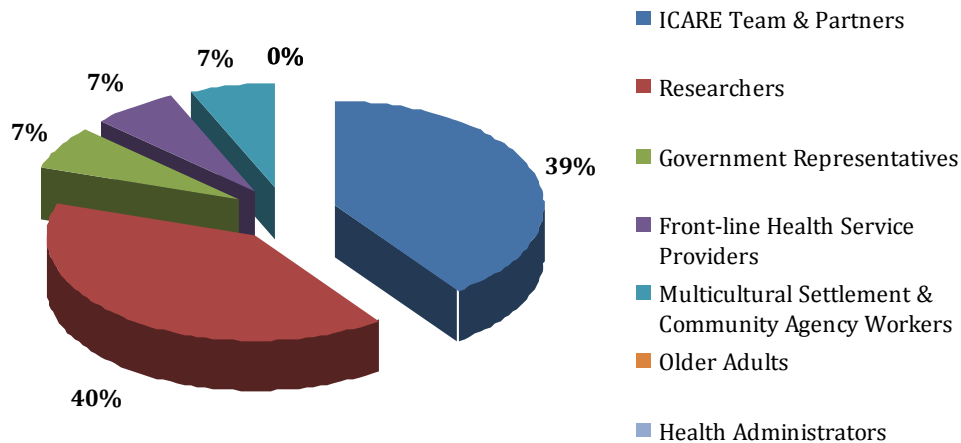


Figure 5: Community Resources for Older Immigrant Women’s Mental Health Roundtable Participants

The mental health needs of older visible minority immigrant women have received little attention within health research; however, a wealth of empirical evidence suggests that this group of women have significant needs that are not being met within the health care system. These needs are determined by many factors that result from the intersection of gender, age, ethnicity, visible minority status and the immigration experience. In particular, for many women, mental health issues emerge as a result of the stresses associated with the immigration process.

Risk Factors for Poor Mental Health:

Social Isolation/Exclusion

Social isolation in the Canadian context has emerged as a key issue affecting the mental health of older immigrant women. Social isolation is exacerbated by: (1) a lack of knowledge of community resources, and (2) difficulties accessing social activities outside the home due to cost, transportation, inclement weather and household/childcare responsibilities. Without the establishment of new and enhanced culturally appropriate and relevant social networks in Canada, isolation and depression are likely to continue to occur for this population.

The experience of ethnic and cultural difference for minority populations creates stigma when the differences are accentuated; consequently, older adults feel pressured to suppress language and other identifying aspects of their cultural practices. This practice of suppression leads to unhappiness. In

contrast, social support within cultural groups promotes a feeling of cultural/ethnic identity that supports good mental health.⁴⁶

Anecdotal evidence suggests that for older South Asian women, there are not enough places to, 'sit and talk'. In addition, many women live in the basement of their family's house and are sometimes excluded from family events and excursions.

Loss of Support Networks:

The loss of broad-based family and friend support networks in their country of origin contributes to depression among older immigrant women, especially when they are largely confined within the home.⁴⁶ Many women feel that, in Canada, they're expected to take care of themselves, even though they often do not have the resources to do so. The loss of 'informal' sources of social support post-immigration is a stress-inducing and isolating factor for older immigrant women.⁴⁶

Abuse:

Conflict within families is common. Older women are susceptible to many forms of violence, abuse and neglect. Elder abuse is defined as:

...any intentional, unintentional or negligent act that causes harm or serious risk of harm to an older person. Abusive acts can be physical, sexual, psychological, emotional, financial or involve neglect and abandonment.⁴⁶

Within the context of family sponsorship, abuse may sometimes take the more nuanced form of social exclusion from family activities. Family shame of the 'inappropriate' dress or accent of older female relatives sometimes results in exclusion from social gatherings.⁴⁶ Moreover, a gap is created if older women believe, 'my children will look after me,' but children expect older parents to take care of not only themselves, but their grandchildren as well.

Poverty:

The current configuration of the sponsorship system places many older South Asian and Chinese immigrant women in a position of poverty. A lack of economic stability causes stress, and leads to mental health issues for these women. After the initial ten-year sponsorship dependency period is over, many women experience additional pressure from their families to sign over their pension cheques, and some are coerced into doing so.

Barriers to Mental Health Services:

Immigrant populations are underserved by the mental health system. This is primarily due to structural inequalities within the delivery and organization of mental health services that limit, prohibit, omit and exclude certain populations from gaining access. There is moreover a false assumption that the nature and type of services provided are accessible to all.

In fact, group participants expressed that many community mental health services are not culturally appropriate, relevant or significant for older South Asian and Chinese immigrant women. For one, cultural notions of 'counseling' and 'depression' are new to many immigrant populations. In some instances sharing such personal information with strangers is considered shameful and unacceptable.

The stigma associated with being seen as ‘crazy’ may furthermore prevent older women from accessing these services. Although touted as an answer to the problem of cross-cultural difference, the idea of peer counseling is unsafe for many older immigrant women because of the fear of a confidentiality breach within the community. The same might also apply for ethnically-matched mental health professionals.

In addition to considerations of culture, language barriers prevent access to community mental health services. Many older women without English language skills are dependent on family members for assistance with service access, and they might not feel comfortable approaching family members to help them access mental health services, especially if family members are implicated in abuse. Many women are also reliant on family members for transportation to and from community group meetings. If family members are busy, many older women are unable to go on their own.

Further empirical evidence suggests that a lack of awareness of existing community mental health services continues to be a critical barrier to service access for this population of older women. In part this is due to the lack of similar programs in women’s home countries and unfamiliarity with the concepts of advocacy and demand for outreach services.

Supporting Positive Mental Health: What Models are Working in the Community?

Support for Community-Based Outreach Services:

Outreach support groups located in the community help keep women connected to one another and prevent social isolation and depression. For many older South Asian and Chinese immigrant women, community support groups may be their only opportunity to come out of the house and socialize with peers. Support groups in the community allow older adults the opportunity to open up about feelings of shame and experiences of abuse and neglect. Doctors specializing in mental health often refer ethnocultural minority older adults to community groups because formal services may not be available, relevant or appropriate.

In 2008 DIVERSEcity started a South Asian older adults’ outreach support group in Surrey with the aim of raising awareness of community resources and providing mental health information within the community. The project began by reaching out to immigrant older adults in religious gathering spaces with translated brochures, and talking to older adults one-on-one in places such as parks and community centres. In this way, the mental health needs of this particular population emerged, and women’s unique needs became a central focus. 80% of the clients are now women, many of whom actively seek out further information, activities and resources to promote their mental health and well being. This project demonstrates that lack of information and awareness of available services are significant barriers and can be overcome with the right programming and outreach strategies.

Settlement agencies located in the community provide a place for new immigrants to feel at home. For example, the multi-service agency S.U.C.C.E.S.S. helps to socially embed older adult immigrants within the greater Vancouver area by involving them in program design and implementation. Older adults in multiple locations meet to get involved in the community, discuss their needs, and plan social activities. Community empowerment is a central goal of groups that are initially run through the organization but ideally grow to be self-directed.

The success of community-based outreach programs suggests that when community organizations begin to advocate for older immigrant women’s mental health needs, women themselves begin to self-advocate.

Ideas: What’s needed?

The group created a list of “needs” for future community mental health service development that incorporates the identified needs of older South Asian and Chinese immigrant women. They include:

- The need to get older women to come out of their comfort zones and become more involved in their communities.
- The need to lobby for more outreach resources.
- The need for minority groups to self-advocate for their community mental health needs to government and policymakers.
- The need to offer transport and onsite daycare services for those women who have to take care of their grandchildren.
- The need for appropriate long-term planning
- The need for culturally-appropriate services.

Developing a Research Framework:

Research Objectives:

- To conduct evaluative research to support and demonstrate the efficacy of existing community mental ‘wellness’ programs.
- To showcase and demonstrate the value of successful community-based outreach services to key decision-makers.

Research Question:

- What are the promising practices within community mental health service provision that could support positive mental health outcomes for older South Asian and Chinese women?

• Sub-Questions:

- What are the experiences of people who need to get help?
- What are the needs of the isolated/hidden people?
- What does success look like?
- How do we know that programs are providing what's needed?

Preliminary Discussion of Research Methods:

Participatory Action Research (PAR) is a preferred methodological framework for this group. Ethical considerations of informed consent, what meaningful participation looks like cross-culturally, and avoiding the use of academic jargon that might stigmatize participants were discussed within such a framework.



Next Steps

The ICARE forum was the first step towards developing three research grant proposals for major funders. Operational research questions developed within the roundtable sessions will be discussed and further refined through conversations with older Chinese and South Asian immigrant women as well as with those that provide and regulate their care. Three working groups will meet regularly beginning in October 2009 to work towards the development and submission of three separate research funding proposals in 2010. We strongly believe that the involvement of pertinent stakeholders at this early stage of research planning and development will improve both the relevance of the research and the likelihood of uptake of recommendations into policy and practice.

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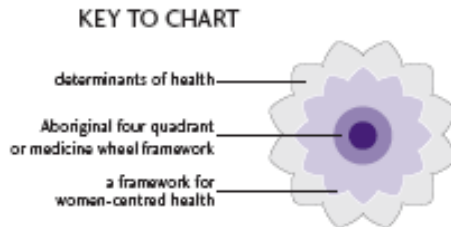
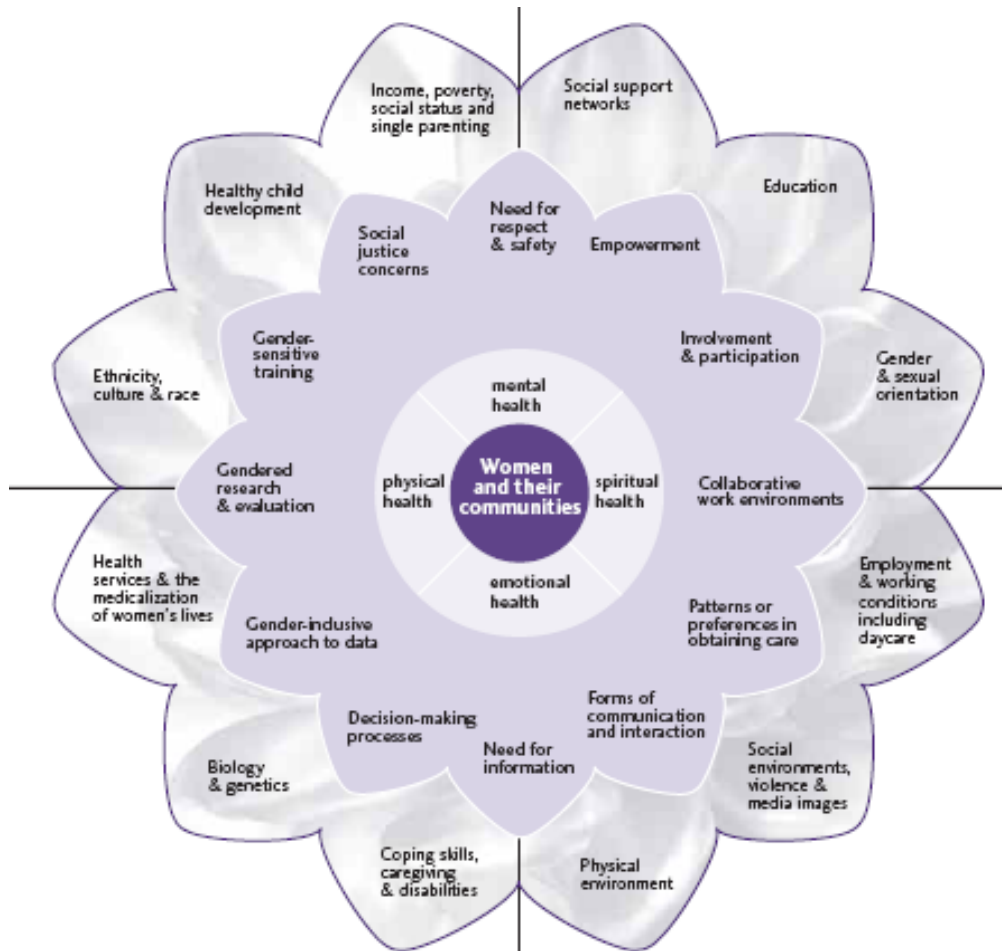
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Appendices

Appendix A: A Framework for Women-Centred Health³²



A framework for women-centred health



Appendix B: Forum Program

Thursday, June 25, 2009, 10:00 to 16:00

Langara College, Vancouver

ICARE (Immigrant Older Women – Care Accessibility Research Empowerment) forum: **Knowledge. Power. Access.**

Welcome:

We are pleased to welcome you to the ICARE forum: **Knowledge. Power. Access.**

We believe that in order to produce research that will have a positive influence on access to health care by older visible minority immigrant women, we need to build on the collective **knowledge** of a diverse and caring group of stakeholders.

We begin with the recognition that for many older immigrant women, gender-based experiences of inequity throughout their lives can combine with their experiences as older immigrants, creating barriers to care. Working with you, we hope to identify ways in which research may help to facilitate greater **power** and equity in health care **access** for this growing subpopulation of older adults in British Columbia.

Thank you for joining us for the first stage of this important collaborative journey.

Forum Objectives:

To clarify how gender, age and immigration can interact to create barriers to health care access for older visible minority immigrant women.

To identify and develop research questions in each of the three prioritized topic areas.

To collectively identify and prioritize next steps for action.

To create opportunities for participants to stay involved with the project.

Program

09:30 **Welcome & Check-in** – *moderator for the day:* Colleen Reid

10:00 **Laying the Foundation** – *speakers:* Karen Kobayashi, Mohinder Sidhu, Maggie Ip

10:45 **Intersectionality Exercise**

11:15 **Question Period/Transition**

11:30 **Concurrent Roundtables | Brainstorming**

I: Grandparents as Caregivers – *facilitator:* Colleen Reid; *panelists:* Daljit Badesha, Noreen Simmons, Sharon Koehn

II: Immigrant Women-Centred Chronic Disease Care Model – *facilitator:* Karen Kobayashi; *panelists:* Joan Bottorff, Suki Grewal,



III: Community Resources for Mental Health – *facilitator:* Elana Brief; *panelists:* Satwinder Bains, Eric Lau, Saleem Spindari, Lokayata Kular

- 12:30 **Lunch**
- 13:15 **Concurrent Roundtables | Priorities, Purpose, Problem**
- 14:15 **Break & Exercise | “The Grammar of the Research Question”**
- 14:30 **Concurrent Roundtables | Getting to the Question**
- 15:30 **The Gallery Walk & Wrap-up**

Acknowledgements

This forum would not have been possible without the generous funding and support in kind from our sponsors:



Thanks are also due to **Las Chicas** for providing a delicious lunch for our participants.

ICARE Team

- Principal Investigators:** Karen Kobayashi PhD | Sharon Koehn PhD
- Research Assistant:** Melanie Spence Hon. BA
- ICARE Team Members:** Reva Adler MD, MPH, FRCPC | Satwinder Bains MEd, PhD (C) | Joan Bottorff PhD, RN, FCAHS | Daljit Gill-Badesha MA | Sukhdev Grewal RN, MSN | Lokayata Kular | Janet Kushner-Kow BSc, MD, MEd, FRCPC | Eric Lau | Noreen Simmons PhD, SLP | Saleem Spindari BA

ICARE Team Partners/Forum planning:

Elana Brief PhD (*WHRN*) | Andrea Cosentino (*BCNAR*) | Amy Johal (*BCNAR*) | Colen Reid PhD (*WHRN*)

Appendix C: Presenter Biographies

Satwinder Bains, MEd, PhD (candidate, Simon Fraser University) is the Director of the Centre for Indo Canadian Studies at the University of the Fraser Valley. Her research interests include the Indo Canadian Diaspora's cultural, social and historical settlement and adaptation as it affects their well-being. Satwinder is also involved in community development by building leadership capacity within cultural minority communities.

Joan Bottorff, PhD, RN, FCAHS is a Professor and Director of the Institute for Healthy Living and Chronic Disease Prevention at the University of British Columbia Okanagan, Kelowna. Her research interests include health promotion and health behaviour change with a focus on gender and cancer control. Her research has included studies in the South Asian community focusing on women and men's health – these projects have been conducted in collaboration with Ms. Suki Grewal.

Elana Brief, PhD is a Research Director for the Women's Health Research Network where she inspires BC health researchers to ask how sex and gender may influence the conditions they study. She holds a PhD in Physics from the University of British Columbia where she developed methods for using MRI (Magnetic Resonance Imaging) to non-invasively measure concentrations of chemicals in the human brain. Elana currently serves as President of the Society for Canadian Women in Science and Technology (SCWIST) to encourage and promote women and girls to engage in science.

Daljit Gill-Badesha, MA is Co-Manager of the Family Services Department at DIVERSEcity, and oversees the education, prevention and outreach programs of the department. Through her role as the South Asian ECD Task Group Coordinator for the Surrey/White Rock area she has worked extensively in the South Asian community to raise awareness on parenting in the early years. She has worked in the social services sector for 14 years as a family support worker, educator, counsellor, group facilitator and manager.

Sukhdev Grewal, RN, MSN is a nursing instructor with Langara College. She has extensive experience working with multicultural populations as a community health nurse. Her research focuses on South Asian women's health beliefs and the family's influence on women's decision making as it relates to health.

Maggie Ip came to Canada in 1966 for her postgraduate study at the University of Ottawa and received her MEd degree in 1967. Upon graduation she worked for the Department of National Health and Welfare in Ottawa before moving to BC in 1970 with her family. She is the founding Chair of S.U.C.C.E.S.S. – a non-profit organization serving new immigrants since 1974. Maggie was a Secondary School teacher with the Richmond School Board until her early retirement in 2003. She was elected to the Vancouver City Council from 1993 to 1996.

Karen M. Kobayashi, PhD is an Assistant Professor in the Department of Sociology and a Research Affiliate at the Centre on Aging at the University of Victoria. She is a co-leader for the National Initiative on the Care for the Elderly's (NICE) Ethnicity and Aging team. With funding from the Canadian Institutes of Health Research (CIHR) and the Social Sciences and Humanities Research Council (SSHRC), her current research programs focus on the relationship between social isolation and health care utilization among



older adults, the negotiation of social support and care in ethno-cultural minority and immigrant families, and the “healthy immigrant effect” in mid- to later life.

Sharon Koehn, PhD is a medical anthropologist who has been conducting qualitative action-oriented research with ethnocultural minority older adults since 1990. Her research has focused on constructions of health, illness and health care provision and on organizational barriers and solutions to health care access, primarily with Punjabi elders in BC and India. She has also conducted research with older adults from the Chinese, Vietnamese and Hispanic communities in Greater Vancouver. As a research associate with the Centre for Healthy Aging at Providence Health Care she now leads/participates in several interdisciplinary projects focusing on dementia, health and health care access, and quality of life of ethnocultural minority older adults.

Lokayata Kular was born and raised in India and moved to Canada in 1998 with her family. She works with the South Asian community as a Family Support Worker at DIVERSEcity. Her role as a Multicultural Outreach Worker is to reach out to families with children from 0-6 years and the 55 plus population – raising awareness and connecting them with the appropriate community resources and services. Lokayata has 20 years of experience as an educator, translator/interpreter, administrator and family support worker.

Eric Lau was born and raised in Hong Kong before immigrating to Vancouver with his family in 1996. He is currently the program coordinator of the S.U.C.C.E.S.S. Seniors Quality of Life Outreach Project. The project offers drop-in social activities for over 200 Chinese-speaking immigrant seniors, mostly women, at the Killarney, Victoria-Fraserview and Marpole-Oakridge neighbourhoods in Vancouver.

Colleen Reid, PhD is a Research Director for the Women's Health Research Network. In 2002 she earned an interdisciplinary PhD from the University of British Columbia (UBC) in the areas of health promotion research, women's studies and education. In 2007 she completed a postdoctoral fellowship at Simon Fraser University. Colleen has devoted her research career to studying the social determinants of women's health, gender and health, and community-based research methodologies.

Mohinder Sidhu, MA came to Vancouver in 1970 where she taught Punjabi to children at the Khalsa Diwan Society for 20 years, including 12 years as director of the program. Mohinder continues to serve the Indo Canadian community through her work with seniors' organizations and advocacy programs. In 2006 under the auspices of the 411 Seniors Centre Society, Mohinder conducted a series of workshops for Punjabi-speaking seniors that focused on seniors' rights and access to government pensions and other services.

Noreen Simmons, PhD, SLP works as a researcher and Speech-Language Pathologist at the BC Family Hearing Resource Centre. Her past and current research investigates cultural and linguistic issues that impact clinical interactions for ethnically diverse families.

Saleem Spindari, BA is the coordinator of the Community Outreach Program at MOSAIC. He coordinates the Afghan Women's Group, Kurdish Women's Group, the Drop in Centre for Temporary Foreign Workers, and Multilingolegal.ca. Saleem has previously worked as an interpreter, settlement counselor, community development worker and a legal advocate. He is also a board director with the Vancouver Cross-Cultural Seniors Network Society.