

Introduction

“In Canada, two interesting demographic trends have been silently progressing: an aging population and a population growth based upon immigration. These patterns combine to form a new group of aging immigrants that seems to have evaded notice. For the most part, gerontological research has failed to recognize ethnicity or culture as a relevant variable and research on ethnicity has failed to recognize aging as a relevant variable.”

(David Durst, 2005, p. 2)

In recognition of the importance of immigrant and refugee seniors in Edmonton who enrich us with their diverse ethnicity, this review intends to summarize the current research literature, statistics, consultations, good practices, cultural and special issues relevant to immigrant and refugee seniors in the Edmonton area.

Demographics (World, Canada, Alberta and Edmonton)

Seniors are changing and shaping global demographics.

“Population ageing and urbanization are two global trends that together comprise major forces shaping the 21st century. At the same time as cities are growing, their share of residents aged 60 years and more is increasing.”

([World Health Organization](#), 2007, p. 1)

“Today, immigration in Canada has a far-reaching impact on the country's population growth. It was responsible for two-thirds of our population growth in the intercensal period of 2001 and 2006. Due to the settlement pattern of the foreign-born in the recent decades, the effect of immigration is mostly felt in Canada's largest urban centres and their surrounding municipalities.”

([Statistics Canada](#), 2007b, p. 1)

Immigrants are a significant group of people among seniors in Canada. More than 20 per cent of all foreign-born are seniors, and this percentage is higher than the national average (14 per cent), according to a study based on Statistics Canada data (Durst, 2008). In 2001, some 29 per cent of individuals aged 65-74 and 28 per cent of those aged 75 to 84 were immigrants, which means they were not born in Canada and/or did not have Canadian citizenship at birth (Turcotte and Schellenberg, 2006). In this same year, almost one-quarter of immigrant seniors (23 per cent) belonged to a visible minority group, compared to only 0.8 per cent of Canadian-born seniors which represents a significant increase since 1981.

In Alberta, there has been a steady increase of the population aged 65 years and over, from 9.9 per cent of the general provincial population in 1996 to 10.7 per cent in 2006 ([Statistics Canada](#), 2007). Immigrant seniors in the province have followed the trend. According to Statistics Canada figures a relatively large share of immigrant seniors from Alberta (25.5 per cent) belong to a visible minority group, which is five times the percentage noted in 1981 (Turcotte and Schellenberg, 2006).

More recent immigrants are much more likely to be visible minorities. Among immigrant seniors who landed in Canada in 1991 or later, 75.6 per cent belonged to a visible minority group. This was the case for only three per cent of immigrant seniors who came to Canada before 1961. The top 10 source countries of newcomers in 2007 are China, India, Philippines, United States, Pakistan, United Kingdom, Iran, Korea, France and Colombia (Citizenship and Immigration Canada (CIC), 2007).

Newly arrived seniors usually come under the family class category of immigration since they would most likely be sponsored by their children. In 2007 alone, a total of 236,758 newcomers made Canada their new homeland. By age, 15.6 per cent or 21,033 immigrants were aged 45 years and older and 6.7 per cent or 6,836 immigrants were parents and grandparents of permanent residents or Canadian citizens (CIC, 2007).

The recent Federal Census of Canada indicates that the Edmonton Census Metropolitan Area (CMA) has the 6th largest share of immigrants in Canada. In 2006, 189,800 foreign-born were living in the Edmonton CMA. This represented 36 per cent of all Albertans born outside of Canada.

The foreign born population in Edmonton grew by 14.9 per cent between 2001 and 2006, outpacing the total growth of the CMA (10.6 per cent) and the national growth rate of the foreign-born population (13.6 per cent). The majority of recent immigrants (92.6 per cent) resided in the city of Edmonton in 2006.

Immigrants come to Edmonton for many reasons-work, family and refuge. Of the 6,045 immigrants who landed in the city of Edmonton in 2006, four out of 10 entered the city through the economic class. Another 32 per cent of immigrants were sponsored by close family members and the remaining 14.4 per cent (874) were admitted for humanitarian reasons.

Language ability is also cited as one of the most important aspects in immigrant settlement, affecting both social and labor market integration. Of concern is the number of seniors 56+ years who do not speak the official language. For seniors, lack of English may impact opportunities for social and recreational participation as well as creative intergenerational communication difficulties in their own families. In 2001, 4.5 per cent of Edmonton seniors age 75-84 (or 1179 people) and 6.1 per cent of seniors aged 85 and over (or 507 people) were recently arrived immigrants who could speak neither English nor French.

Immigration from Asia and Pacific continues to dominate immigration patterns in Edmonton, accounting for 60 per cent of all immigrants in Edmonton from 2002 to 2006.

In 2001, Edmonton had the fifth highest proportion of visible minorities among census metropolitan areas, behind Vancouver, Toronto, Abbotsford and Calgary. Statistics Canada projections during 2001 and 2017, indicate that the number of visible minorities is projected to grow by 74 per cent.

Edmonton's visible minority population remains younger than the general population. Although the population is aging, in 2001, the median age of the visible minority population is approximately six years younger than the median age of the rest of the population.

Sources: Statistics Canada (2006), City of Edmonton Corporate Environmental Scan (March, 2008) and *Aging in Place-A Neighbourhood Strategy*-City of Edmonton (2007).

Marginalization of Immigrant Seniors

A Government of Canada study shows that

“a number of factors contribute to the marginalization of ethnic minority seniors. Barriers to health care and other services such as those stemming from language and cultural differences, discrimination and racism, or a lack of access to income sources, can lead to situations of isolation, dependency and poverty. Other factors such as being born in or outside Canada, the age at immigration and the number of years worked since immigration can also play significant roles in the degrees to which barriers exist.”

(Government of Canada, NACA, 2005, p. 4)

One important problem is that, according to Stewart, Spitzer, Orti, Khalema and Nsaliwa (2008), 18 per cent of immigrants are seniors, and they are more likely than other immigrants to suffer from chronic health conditions. Furthermore, these authors argue that additional challenges experienced by immigrant seniors have not been fully investigated.

Immigrant seniors spoke out

The results of participatory research on immigrant seniors by Edmonton agencies, supported by the Multicultural Health Brokers and the Edmonton Seniors Coordinating Council, were revealing, and a large number of agency partners got together to assess and address the findings. Discussions included more than 45 participants from community-based immigrant and senior-serving organizations who developed strategies “to improve immigrant seniors’ access to programs and services” (Action for Healthy Communities, Multicultural Health Brokers Co-operative, Edmonton Seniors Coordinating Council and Seniors Association of Greater Edmonton, 2006, p. 1).

Participants

“learned about the needs and circumstances of immigrant and refugee seniors, mapped immigrant and senior serving organizations to the respective communities, and discussed strategies to address core issues facing those communities. Core issues identified through this study included: 1) language barriers, 2) complex health issues, 3) poverty and income insecurity, 4) social isolation, 5) lack of housing/homelessness, and 6) transportation issues. The language barrier was the most discussed issue at this meeting, as it was perceived to be a causal factor for many other concerns identified in the study.” (Ibid, p. 1)

What changes should service providers consider?

The question is whether support for immigrant seniors’ needs could be obtained for specific communities. The study by Stewart, et al (2008) found that some important practical support needs

were not fulfilled for the Afro-Caribbean, Chinese, Kurdish, Spanish, and Yugoslavian seniors interviewed. Moreover, the better life expected by these seniors did not materialise. When it came to employment opportunities, either employers felt that the immigrant seniors were too old to work or the immigrant seniors found that their credentials were not accepted. On health needs, the “immigrant seniors face additional impediments in accessing health facilities compared to mainstream seniors” (Khalema, presentation of research results at the May 15, 2008 Roundtable, *Mobilizing for Action: Culturally Responsive Pathways for Isolated Immigrant Seniors*, Edmonton, Alberta).

Furthermore, Stewart, et al’s (2008) research shows that some of the immigrant seniors studied in Edmonton are homeless and depend on community organizations for basic human needs such as food and clothing. Similar to the findings of a number of other studies on immigrants, immigrant seniors identified the English language as the major barrier to communicating, seeking and accessing social support services. This finding coincides with one reported by the Multicultural Health Brokers (Edmonton Seniors Coordinating Council and Multicultural Health Brokers Co-op, 2005) and discussed during the subsequent roundtable with immigrant seniors and their serving agencies (Edmonton Seniors Coordinating Council, 2008).

To add to their isolation, a number of immigrant seniors have restricted mobility and rarely meet people outside their family to socialize (Stewart, et al, 2008). Most of these seniors’ challenges are aggravated by a lack of information about services and what some feel is an inequitable distribution of services amongst people of different cultural backgrounds.

The Stewart et al study identifies additional challenges for immigrant seniors, including:

- Social isolation and depleted social networks
- Dealing with family ties or differences (e.g., abuse by children)
- Lack of acceptance by people from other races (specifically in nursing homes)

To these challenges, the study adds “personal barriers” (language barriers and cultural restrictions on the movement of women), “inaccessibility of programs” (poor information and language barriers), “hesitancy/fear to ask for services” due to language difficulties; reluctance to disclose family secrets (e.g. abuse); experiences of being victimized by the government in their country of origin; and systemic barriers such as government policies that prevent them from seeking gainful employment (Khalema and Makumbe, presentation of research results at the May 15, 2008 Roundtable).

In summary, the Stewart, et al study on Chinese (Mandarin-speaking), Afro-Caribbean, Kurdish, former Yugoslavian and Latino (Spanish-speaking) seniors in Edmonton recommended:

- social and cultural opportunities for immigrant seniors to meet one another
- delivery of services in different languages
- coordinated approaches [among serving agencies]
- partnerships among organizations

- employing immigrants to deal with immigrant seniors' issues
- increasing financial help to alleviate poverty, and
- improving government policies on immigrant seniors

Issues for Seniors

In a study done by the Seniors Advisory Council for Alberta (SACA, 2007), mainstream members of seniors centres in selected areas of the province pointed to positive as well as negative experiences with specific seniors services. Particular to housing, seniors discussed the challenges and barriers they face: critical staffing shortages, the need to restructure lodges to meet seniors' needs, the growing shortage of appropriate housing for seniors with mental health issues, the need to upgrade lodges to meet the expectations of future residents, "the poor job government does of keeping seniors informed about available services", the shortage of funding to enable caregivers to meet seniors' many needs, and others ([SACA](#), 2007, p. 2). Transportation related to seniors' housing facilities was also identified as a concern (ibid, pp. 12-14).

When SACA researchers compiled information related to challenges facing mainstream seniors, the concerns most often mentioned were, "Access to appropriate health care (shortage of some specific medical services); shortage of appropriate housing options; lack of accessible, affordable transportation; inadequate support services (programs are sometimes kept alive with funding from foundations and service clubs); and shortage of volunteers" (pp. 12-14).

City of Edmonton's commitment to seniors

The City of Edmonton Forecast Committee (May 2007), in its *Edmonton Socio-Economic Outlook, 2007-2012*, found that

"while Alberta has the youngest population of the provinces, 10.4 per cent of Albertans were 65 years of age or over in 2001. This compares to 13 per cent for Canada as a whole. Around 11.7 per cent of Edmontonians (11.5 per cent in 2005), slightly higher than the rate for the province, were over the age of 65 in 2001. However, their numbers are growing rapidly. In the ten year period 1991 to 2001, the number of seniors in Edmonton increased by 51 per cent while the total population increased by only 8 per cent. By 2012, the Edmonton CMA is expected to have 138,000 people aged 65 and over, or 12 per cent of the total population. By 2046 it is expected that one out of four Canadians will be over the age of 65 years."

([The City of Edmonton Forecast Committee](#), May 2007, p. 35-36)

Edmonton's Special Seniors Issues Initiative has committed to enhance services and opportunities for the growing seniors' population. City plans to improve "its knowledge base and continue liaison and partnerships with relevant agencies" include:

- Implement Senior Friendly™ training for city staff;
- Conduct forums for the city to ready itself for the growing seniors

- population;
- Help ensure equitable services for seniors;
- Develop a blueprint for action for seniors services;
- Support the Edmonton Seniors Coordinating Council and other agencies; and
- Expand city-operated senior centres.

The City of Edmonton has also been working to ensure that Edmonton City Hall is Senior Friendly™.

Adequate retirement income is a major factor in the well-being of older people. Canadians with incomes below \$20,000 are much more likely to state that they had no plans to retire than persons with an income \$40,000 or greater. Retirement plans are also greatly influenced by whether or not the individual has a private (or employment) pension plan. Recent immigrants (arriving since 1980) are much more likely (47 per cent) to have no fixed retirement plans and are also more concerned (45 per cent) about the adequacy of their financial preparations for retirement.

“The Government of Alberta appointed MLA Task Force to gather input on proposed health service and accommodation standards for continuing care, mostly for Alberta seniors, has made a number of recommendations to improve the level and standard of care as well as improve the quality of life of residents of long term care facilities.”
([The City of Edmonton Forecast Committee](#), May 2007, p. 37)

What puts a senior at risk?

The City of Edmonton Seniors at Risk Subcommittee (2004) defined seniors at risk as

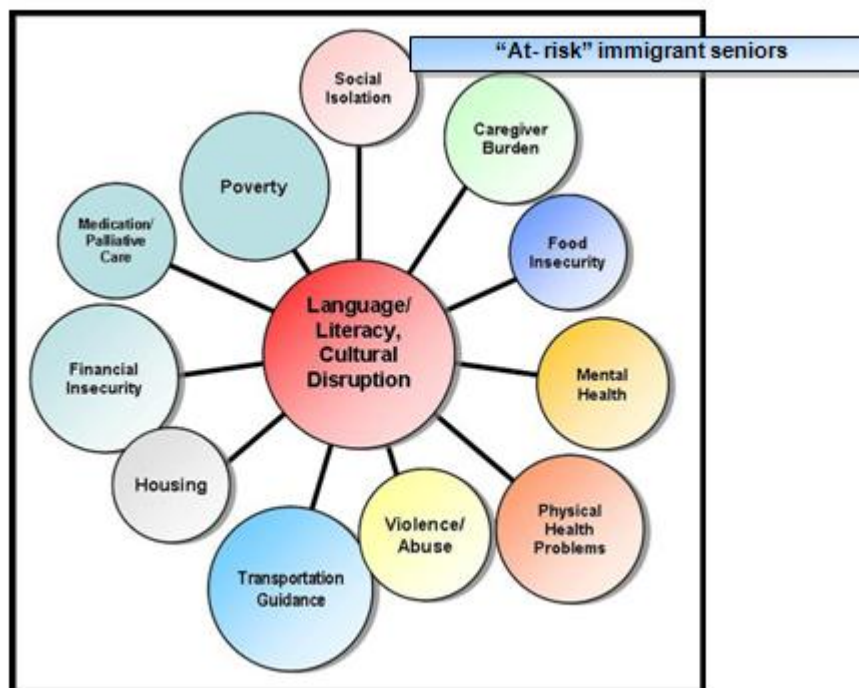
“generally adults aged 60 years and over, living in Edmonton who face economic, social, physical or cultural barriers that affect their independence, personal well-being and overall quality of life. Risk factors include: social isolation, lack of family support, advanced age (80+ years), poverty/low income, illness/disability/chronic health concerns, unhealthy lifestyles, language barriers/ethnicity, abuse, being in a caregiver role, mental health problems, unsafe environment, bereavement, limited or lack of community supports and/or limited access to resources, and addictions.”
(City of Edmonton, Seniors at Risk Subcommittee, 2004, p. 4)

The subcommittee produced an inventory of department programs and services for seniors at risk, besides doing an environmental scan of services and research on seniors at risk in Edmonton and in selected other municipalities, and compiled a “demographic profile of current and future seniors in Edmonton”.

“One conclusion is already becoming obvious from the forecast data: agencies providing social, recreational and other programs and services need to consider shifting more resources to address the growing needs of this substantial portion of our population.”

Why do immigrant seniors face added risks?

Early in 2005, Multicultural Health Brokers started to collect information about isolated immigrant seniors within four immigrant and refugee communities in Edmonton: Former Yugoslavia, Kurdish, Spanish-speaking, and Korean (Edmonton Seniors Coordinating Council and Multicultural Health Brokers Co-op, 2005). Some of the front line workers by then had identified a series of issues affecting those seniors and had depicted them in the following diagram.



Reproduced with permission. Author: Multicultural Health Brokers Co-op and the Edmonton Seniors Coordinating Council and (2008)

“At the core of immigrant and refugee seniors’ experiences are problems rooted in language and literacy barriers. Most of the seniors participating in this study do not speak English and some of them are even illiterate in their mother tongue. Immediately linked to language barriers are issues of cultural disruption. Immigrant and refugee seniors face huge problems related to cultural differences. All the issues depicted in this diagram are interrelated and lead to extreme social isolation, poor health and reduced quality of life.”
(Ibid, p. 3)

The issues noted in the outer circle (*in diagram above*) may well affect many mainstream seniors, but because of the added complication associated with the language/literacy barriers and cultural disruption, immigrant seniors face magnified obstacles in some or all of these areas.

In a follow-up to that participatory research, a number of agencies came together to strategize around building relationships with senior serving organizations and responding to such needs by determining long-term cultural and linguistic support schemes (Action for Healthy Communities, Multicultural Health Brokers Co-operative, Edmonton Seniors Coordinating Council and Seniors Association of Greater Edmonton, 2006).

There appears to be no reason to believe that many of the barriers and challenges experienced by mainstream seniors in housing and in other programs and services will not also be experienced by immigrant seniors, if not to a higher degree. This is due to what David Durst calls “multiple jeopardy” (Durst, 2008): the recognition that immigrant seniors have to deal with a combination of barriers and difficulties in adapting to the new society, besides having to face the challenges associated with their age.

Edmonton City Council asked the city’s Community Services Department in 2007 to undertake a study of residents over the age of 85. An important conclusion of the consultation refers to isolated seniors and certainly also applies to immigrant seniors.

“The rationale behind the strategy [of the City of Edmonton’s Aging in Place, where “place” is neighbourhood] is that human contact and aging are healthy features of life; and the more seniors are engaged and visible in their neighbourhood, the more likely they will receive help before a problem escalates to a crisis. Engagement not only prevents social isolation, it creates opportunities for a senior to seek help or for others to observe changes in the senior’s ability to manage. Outreach is therefore a key component of the strategy.”

(The City of Edmonton Community Services, 2007, p. 33)

Provincial and Municipal Plans Impact Seniors

Alberta Seniors and Community Supports published a *Findings Report* from their Demographic Planning Commission (December 2008) and the issues facing immigrant seniors were acknowledged.

“Significant in-migration and immigration to Alberta is creating a more diverse population, and many new Albertans face language barriers or under-employment. Many Albertans face barriers to greater participation in the labour force and mainstream society, including those with disabilities and Aboriginal Albertans. These additional demographic factors will influence the characteristics of Alberta’s future seniors population.”

(Alberta Seniors and Community Supports, December 2008, pg. 2)

At the time of writing this report, the Alberta government was planning, and had already started, to re-examine its benefits for seniors.

The City of Edmonton Community Services *Aging in Place: A Neighbourhood Strategy (Dec. 2007)* acknowledged the need to address language and cultural barriers in many theme areas such as health and well-being, daily living and transportation. Another important factor that

was noted was “As an immigrant, having to rely on sponsors’ willingness or ability to meet their financial obligations, and (the immigrant senior then) worrying about what will happen if the relationship breaks down.” (pg. 22)

How Cultural Knowledge Can Help Service Providers

Respecting and protecting the dignity of individuals and families is an important ethical principle of providers and workers in the human services sector. Integral to this ethical principle is to treat each person in a caring and respectful way and to be mindful of individual differences and cultural and ethnic diversity. Service providers working with immigrant seniors have a responsibility to develop cultural competence in their professional practice.

Cultural competence is an ability to interact effectively with people of different cultures. According to Martin and Vaughn (2007), cultural competence comprises four components:

- Awareness of one's own cultural worldview
- Attitude towards cultural differences
- Knowledge of different cultural practices and worldviews, and
- Cross-cultural skills

(Martin & Vaughn, 2007, pp. 1-2)

A culturally competent person can be defined as one who “demonstrates cultural awareness, knowledge and skill, and applies these components as he/she interacts with patients, co-workers, and customers” (Seright, 2007).

Further, the culturally competent individual “operates from a platform of respect for others. He/she continuously *self-assesses and adjusts to the dynamic and challenging opportunities* in remaining culturally aware and effective” (Ibid, italics added).

Competency requires changing what providers know, think, and most importantly, how they deliver services that support and serve people from all cultural backgrounds (Martin & Vaughn, 2007).

Cultural competency includes components such as “cultural awareness, cultural sensitivity, cultural knowledge and the building of cross-cultural relationships. It requires listening, flexibility, respect for different points of view, and a willingness to understand cultural influences in behaviour. It implies much more than mere tolerance of difference” (p. 5).

Age discrimination and the importance of culture

Ageism (discrimination against people because they are old) is a universal issue, according to a City of Calgary study (City of Calgary Community and Neighbourhoods Services, SSDCC, 2006).

But the way ethnic seniors lose privilege as a result of aging is linked to ethnicity as well as class, gender, ability and sexual orientation (p. 6).

Research has shown that as people age, the role of culture assumes a greater importance in healthy aging and in seniors' perception of their well-being and quality of life (SSDCC, 2006).

According to the City of Calgary study, a lack of cultural understanding and sensitivity have, on occasion, caused more problems and brought more harm to immigrant seniors than language barriers, which on their own represent a significant challenge. Considering that "culture becomes more important in the lives of people as they age" (SSDCC, 2006, p. 5), the understanding of cultural cues becomes more important as well. "Culture affects notions of health and nutrition; spirituality; receptiveness to medical treatment and lifestyle preferences" (Ibid).

With age, adaptation to new situations becomes more difficult. This may be even more challenging for older immigrants who are attempting to adjust to new cultural practices, "while simultaneously grieving the loss of familiar customs and both family and peer support networks" (p. 5).

Understanding immigrant categories

A recent report by the Capital Health Authority and the Multicultural Health Brokers Co-op (2008), states:

"Immigrants coming to Canada are broadly categorized into three major groups: 1) those who are admitted as *independent or voluntary immigrants* through a selection criteria based on economic skills, i.e. education and work experience, and good health status; 2) *family class* [comprising] those who are family members or close relatives of Canadian citizens or permanent residents; and 3) those who are admitted as *refugees* based on protocols under the 1951 Geneva Convention.

"These categories also reflect variations in immigration history that influence the newcomers' health status upon arrival, eligibility and access to health and social services, and subsequent exposure to risk factors associated with settlement and adaptation (Gagnon, 2002).

"The process of migration itself can induce a range of physical and mental health problems as well as health needs that may include conditions that result from their pre-migration experience, the difficulties of adjusting to a new culture and the socio-economic conditions in the new homeland."

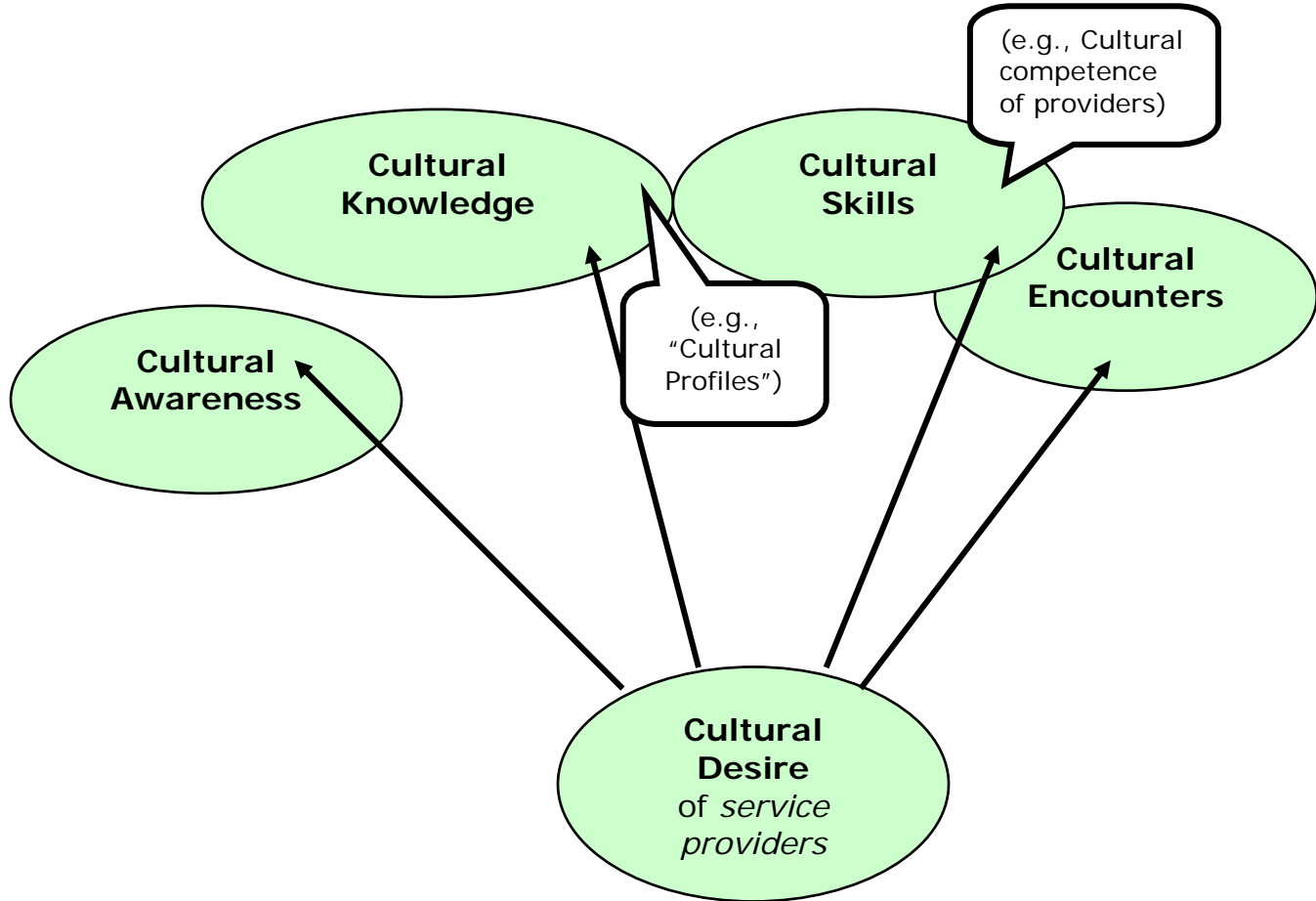
(Capital Health Authority and Multicultural Health Brokers Co-op, 2008)

Do service providers have a desire to be culturally competent?

Respecting and protecting the dignity of individuals and families is an important ethical principle of providers and workers in the human services sector. Integral to this ethical principle

is to treat each person in a caring and respectful way and to be mindful of individual differences and cultural and ethnic diversity. Service providers working with immigrant seniors have a responsibility to develop cultural competence in the professional practice.

What follows is a presentation of some models and guiding principles important for service providers working with ethnic seniors. The Campinha-Bacote model is familiar to cultural workers and service providers working specifically in the health care field. Other schemes are for general use and also applicable to services for ethnic seniors. The chart below shows the five key dimensions of cultural competence in the Campinha-Bacote model. (Graphic interpretation of model-Source: Campinha-Bacote, J. (2003). *The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care* (4th ed). Cincinnati, OH: Transcultural C.A.R.E. Associates).



According to Dr. Campinha-Bacote, the process of becoming culturally competent starts with *Cultural Desire* which is the motivation of the service provider to “want to” engage in the process of becoming culturally competent and not “to have to”. The assumption is that one must be open and willing to learn about different cultures. *Cultural awareness* is one’s willingness to examine one’s own biases towards other cultures and the in-depth exploration of one’s cultural and professional background, including the humility to challenge one’s own assumption and beliefs. *Cultural knowledge* is defined as the process in which the service provider seeks and obtains sound information regarding the worldviews and orientations of different cultural and ethnic groups and how these influence their behaviour. *Cultural skill* is the ability to use cultural information in caring and working with people from diverse cultural and ethnic backgrounds. These skills include conducting cultural assessment, practicing appropriate intercultural communication and accessing cultural resources and supports. *Cultural encounter* is the process which encourages the service providers to directly engage in face-to-face cultural interactions and other encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping (Campinha-Bacote, 1999).

A checklist for service providers--gauge your cultural competence

The following list was designed for health care workers but it can be customized for general use. It has been quoted, extracted, simplified and adapted from The Health Resources and Services Administration ([HRSA](#), 2001).

Cultural Competency Checklist

- I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.
- I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.
- I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviours that show cultural insensitivity or prejudice.
- Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.
- Mission/vision statements commit to the delivery of culturally and linguistically competent service.
- Conduct assessment of patient/parent beliefs using the following checklist:
 - identify beliefs that affect clinical care
 - suggest alternatives to harmful home remedies
 - explain aetiology and treatment rationale for given biomedical condition
- Use the following set of questions to assess folk illnesses and remedies:
 - indicate awareness of the existence of a folk illness that doctor may not know about
 - ask whether the patient has the illness now
 - ask what treatment the patient is receiving for the condition
- Conduct health beliefs inventory of patient to understand the patient's explanatory model for illness.

Source: [The Health Resources and Services Administration](#) (HRSA) - U.S. Department of Health and Human Services (September 2001). *Health Resources and Services Administration Study On Measuring Cultural Competence in Health Care Delivery Settings* (Report). The Lewin Group, Inc.:

VA. Retrieved on July10, 2008, from
<http://www.hrsa.gov/culturalcompetence/asures/attachment1.htm>.

Profiling a Culture

It is the practice of service providers working with ethnic clients to be guided by information on the particularities of the culture of the client, specifically the way that customs, beliefs, traditions, perceptions, access to service, and so on are shaped by the members of those communities living in Canada.

Cultural profiles, cultural cues, and cultural inventories are overlapping terms that define tools intended to help immigrant service providers become more culturally competent. Of course, as the literature and consultations indicated, no written cultural device can replace learning that service providers acquire in communication and consultation with experienced (cultural) providers or the learning acquired directly through interaction with the cultural communities.

Calgary published Cultural Cues

“Different cultures view their seniors in different ways. The Cultural Cues section describes the unique characteristics of each ethno cultural group as it relates to the elderly.”
([The City of Calgary](#), 2006, p. 8)

The following are categories the City of Calgary Community and Neighbourhood Services used for understanding cultural cues. (To download a copy visit:

http://www.calgary.ca/docgallery/bu/cns/cultural_cues.pdf)

- Immigration status and history
- Language and literacy
- Spiritual and religious beliefs
- Family values
- Cultural values and customs
- Communication variations
- Holidays and celebrations
- Food habits
- Aging and lifestyle-related issues
 - Economic security
 - Elder abuse
 - Use of time and participation in recreation and leisure activities
 - Other lifestyle related challenges
- Health Care and Medicine
- Mental and Emotional Health
- Death and Dying

Edmonton Cultural Profiles--first developed in 2004

The following are categories for the cultural profiles written by the Multicultural Health Brokers and Capital Health Authority in 2004:

- Historical background
- History of immigration to Canada
- Life in (country)/refugee camps
- Community concerns/hopes of ethnic organization in Canada
- Religion
- Demographic profile
- Hopes/issues for adults
- Community-generated solutions
- Health beliefs and practices
- Health issues in the community
- Suggestions for interacting with cultural patients/clients
- Women's/children's/seniors' health
- Health beliefs and practices/traditional healing practices
- Death and dying
- Communication styles
- Resources in the community
- Family values
- Cultural values and customs
- Communication variations
- Holidays and celebrations
- Food habits
- Aging and lifestyle-related issues:
 - Economic security in old age
 - Elder abuse
- Use of time and participation in recreation and leisure activities
- Health care and medicine
- Mental and emotional health
- Death and dying

Source: Capital Health Authority (Edmonton) and Multicultural Health Brokers Co-op (2004). *Cultural Profiles* (Unpublished Report). Edmonton.

New categories added for Edmonton 2008 cultural profiles

A revised version of Edmonton's cultural profiles has been developed based on the following *Template for Ethnic Communities Profiles Relevant to Ethnic Seniors*. Note: Not all categories are addressed in each community profile as community writers felt some of the categories were not applicable to their culture.

- Introductory notes

- Who is considered a senior? (Here the question is whether there are other considerations besides age; i.e., rearing of grandchildren, family position, and so on. For some cultures, there is even a need to consider the existence of inaccurate medical/immigration records)
- Historical background
 - Global context (including pre-migration situation)
 - Immigration history (including specific issues related to refugees)
 - Demographic profile
- Language(s) and communication
 - Languages spoken, written and alphabet used
 - Communication styles
 - Greetings
 - Meanings of different gestures
- Education
 - Literacy levels and seniors' education status
 - Seniors' attitudes towards education
 - Cultural attitudes towards "seniors in school"
 - How seniors view professionals
- Religion and faith groups
 - Religious practices and Holy Book or Scriptures
 - Influence of religion on culture
 - Influence of religion on health and healing
- Food and dietary guidelines
 - Religious or other guidelines
 - Eating protocols in home visits
 - Concept of "hot and cold" properties of food items
- Family structure
 - Familial roles, responsibilities, and relationships (power structures back home and in Canada, gender roles)
 - Family values and the role of a senior in the family
 - Parenting styles and seniors' role in raising a child
 - Intergenerational relationships
- Health beliefs, cultural perspectives on health and healing
 - Relationships and attitudes towards health care professionals and institutions

- How seniors perceive Western medicine
- Traditional medicine, herbal medicine and home remedies
- Mysticism, spirituality, supernatural beliefs, superstitions
- Chronic diseases, mental health, diabetes, and others
- Caring for a senior
- Rehabilitation for a senior
- Seniors' life in a nursing home

- Social and financial issues of seniors
 - Change of roles in family life
 - Social isolation
 - Elder abuse
 - Financial situation
 - Transportation
 - Access to recreation and enjoyment activities

- Socialization and hospitality
 - Appropriate clothing - national or cultural apparel and valuing modesty
 - Cultural celebrations and their significance
 - Cultural norms around hospitality

- Death and dying
 - Meaning of death
 - Rituals and rites at time of death and after death
 - Preparing the body and burial
 - Mourning period after death
 - Autopsy and organ donation

- Do's and don'ts in general
 - Examples particular to home visits include shaking hands or not in greetings, wearing appropriate (non-offensive) clothing, accepting food being offered, and not touching objects that are considered unclean

- Community resources and media resources (for cultural community announcements)

Source: ESCC et al, 2008, unpublished