Strengthening Social Capital through Residential Environment Development to Support Healthy Aging: A Mixed Methods Study of Chinese-Canadian Seniors in Winnipeg

By

Hai Luo

A thesis submitted to the Faculty of Graduate Studies of
The University of Manitoba
In partial fulfillment of the requirements of the degree of

DOCTOR OF PHILOSOPHY

Faculty of Social Work
University of Manitoba
Winnipeg

Abstract

This study attempts to understand the issues and challenges related to healthy aging faced by Chinese seniors who are living in a cultural and social context different from their home countries. Using an ecosystems perspective, the study focuses on exploring three major components in seniors' lives: health, social capital, and residential environment, and then analyzing the interactions among the components.

A convergent parallel mixed methods design was used in this study. A survey was conducted with seniors in Winnipeg Chinese communities to collect quantitative data on health (SF-36) and social capital (views of community, trust and reciprocity, civil participation, social networks and social support, and social participation), and focus group interviews were conducted to collect qualitative data on social capital and residential environment. One hundred and one respondents were interviewed in person to fill out the questionnaire and 43 seniors participated in focus group interviews. PASW 18 (SPSS) and NVivo 8 were applied to analyzed quantitative and qualitative data respectively. Descriptive and bi-variate statistics, a comparison of Winnipeg sample data and general Chinese-Canadian seniors data, and qualitative findings are presented to describe the research target group's demographics, health conditions, social capital, and residential environmental issues.

Overall, Winnipeg Chinese seniors enjoy moderate health; but many of them reported different levels and types of difficulties they had experienced with health care and health care support services. Both quantitative and qualitative data demonstrate the level of low social capital among Chinese Seniors in Winnipeg. The quantitative data reveal some correlations between social capital factors and Chinese seniors' health conditions, among which the most

significant is that social capital likely has effects on female Chinese seniors' mental health and male Chinese seniors' physical health. In particular, the level of *social networks and social support* was positively correlated with older Chinese women's mental health. The environments in which these seniors lived appeared to have hindered or triggered them in building or increasing their social capital. For example, those who had acquired less support from their immediate micro environment – family – tended to be more motivated to extend their social connections in a larger environment in order to obtain resources for problem-solving. Cultural influence and health care support services were critical factors in Chinese seniors' considerations and expectations of a residential environment. In contrast to traditional Chinese cultural norms of an inter-dependent living arrangement, the majority of Chinese seniors preferred to live in separate households from their adult children. Another important finding is that a cultural- and linguistic-homogeneous residential environment does not necessarily provide positive support to Chinese seniors for their acquisition of social capital.

Upon further analysis of social capital and its relationships with health and residential environments, the study offers implications from research findings to social work practice, integrating cross-cultural considerations. The study concludes with an analysis of limitations as well as suggestions for recommendations for future research.

Dedication

To those who inspire me to continuously explore the meaning of life and aging:

- My Advisory Committee members, Dr. Don Fuchs, Dr. Verena Menec, and Dr. Len Spearman for their consistent support and academic guidance

- Chinese seniors who generously shared their life experiences and thoughts with me

- Winnipeg Foundation, Winnipeg Chinese Cultural and Community Centre, and Faculty of Social Work, University of Manitoba for their generous financial and in-kind support to the study

- My son Silas and daughter Sophia who were a two-year-old and a newborn when I started my doctoral journey, and are now a grade-two and kindergartener

- All aging, maturing, and growing individuals (as we all are since birth)

- Life itself

with my deep gratitude.

Table of Contents

List of Figures & Tables

Chapter One

INTRODUCTION

Purpose of the Study

Population aging and cultural diversity are two major attributes of Canadian demographic change. Of the total senior population in Canada, more than 28% are first-generation immigrants (Durst, 2005; Special Senate Committee on Aging, 2007). This study explores the issues and challenges related to healthy aging faced by Chinese seniors who are living in a cultural and social context different from their home countries. This study, conducted through an ecosystems lens, examines the relationship between residential community environment and healthy aging for Chinese seniors, and how environment affects Chinese seniors' health and well-being in Winnipeg, Canada. By analyzing the role of social capital in building a supportive environment, the study contributes to the knowledge of the role that a residential community environment plays in promoting health and well-being for Chinese seniors, and how social work professionals can assist in creating positive interactions between retired immigrant seniors and the environments in which they live.

A convergent parallel mixed methods design was used in this study. This is a type of design in which qualitative and quantitative data are collected in parallel, analyzed separately, and then merged. In this study, quantitative data are used to measure the well-being and social capital of the target group and the relationships between them. Qualitative data, collected through focus group interviews with Chinese seniors, are used to explore the conditions and expectations of the community and housing environment for Chinese seniors, and how environment can influence both social capital and health. The reason for collecting both quantitative and qualitative data is to converge the two kinds of results to bring greater insight

into the phenomenon than would be obtained by either type of data separately (Creswell & Plano Clark, 2011).

Rationale for the Study

Past research has identified various issues in both social and health aspects of older immigrants' aging in a cross-cultural context. Both similarities and differences co-exist between older Chinese-Canadians and the general aging population in the areas of health conditions, mental health, health behaviours, living arrangements, care-giving, and other social and personal life aspects. Chinese seniors demonstrate significant cultural allegiance in their social and health behaviours which, in turn, greatly influence their lifestyle and the outcomes of healthy aging initiative of the federal government. For example, in the health aspect, Chinese seniors tend to combine traditional remedies (e.g., medicinal diet) with Western medicine for treating illnesses. However, the lack of recognition and regulation of traditional Chinese medicine practice has placed significant barriers for Chinese seniors to obtain quality health care services to their satisfaction (Lai & Chappell, 2006; Tjam & Hirdes, 2001). On the social perspective, Chinese seniors and their family members have adjusted their cultural beliefs and values to a certain degree in the host society due to societal, historical, and personal transitions (Li, 2009; Chappell & Kusch, 2007; Chappell, 2003, 2005). Some older Chinese prefer living in separate households from their adult children rather than the traditional lifestyle of multi-generational cohabitation (Lai & Leonenko, 2007). The long established impression of Asian families taking good care of their elderly in Western society is not entirely outdated (Chow, 2000; Gee, 2000; Chappell & Kusch, 2007), but social policies and services (e.g., living assistance programs, health care services, and housing) for seniors are challenged by the emergent population needs related to the phenomenon that more and more older Chinese adults choose to live independently in the community (Chappell, McDonald, & Stone, 2008; Gelfand, 2003; Durst, 2005, 2010b).

It is estimated that the current number of Chinese individuals aged 60 and over in Winnipeg is between 3,200 and 3,500 (refer to Chapter 2 for details). Although the literature has indicated strong evidence of the effectiveness of culturally appropriate community support and its benefits to ethnic minority seniors' lives (e.g., Health Canada, 2006; Franke, 2006; Veninga, 2006), the efforts of developing such supportive services within the seniors' environment have been insufficient to meet the needs of the growing aging population in Winnipeg, according to Winnipeg Chinese community leaders. These leaders are concerned about the service discrepancies, as there have been no consistent culturally competent services to facilitate Chinese seniors to age in place, despite the increasing demand for such services. Furthermore, in the last three decades, no systematic inquiry has been conducted to understand this particular group. The last community study of Chinese seniors was conducted in 1983, for the purpose of describing the community needs of residential buildings for retirees, according to the director of Winnipeg Chinese Cultural and Community Centre. During the last three decades, demographic characteristics and people's needs in the community have changed, so a new study is therefore necessary and timely.

Theoretical Framework

In the human service field, the emphasis on human agency and its relationships with and within the environment distinguishes social work's areas of expertise from those of psychology, psychiatry, law, religion, health care, and other professions. The Canadian Association of Social Workers' (CASW) statement that "(s)ocial work is a profession concerned with helping individuals, families, groups and communities to enhance their individual and collective well-being" (2013) indicates the holistic approach of social work. With the aim to understand immigrant seniors and their interactions with the environment in which they experience cross-

cultural aging, the study applies the ecosystems perspective as the overarching theoretical foundation.

Perspective differs from *theory* as the former serves as "a broad framework, based on ideology and knowledge, that guides social work practice. While a theory is a tight network of concepts, a perspective consists of a set of ideas, values, and knowledge that are loosely connected" (Heinonen & Spearman, 2001, p. 185). The ecosystems perspective combines key concepts from both general systems theory and ecology (Mattaini & Meyer, 2002). General systems theory in social work focuses on connections among social systems (as opposed to "parts" of human or social behaviour) (Payne, 2005; de Hoyos, 1989), whereas the ecological approach stresses the dynamic interactions between humans and their environments and how they adapt to one another (Miley, O'Melia, & DuBois, 2011). Because of relationships and connections, we make sense of parts of a system. "When fish begin to die off, we understand readily that certain birds will go hungry unless a functional ratio between these species is re-established" (Minuchin, Colapinto, & Minuchin, 2006, p. 15). This idea applies to human societies as well. For example, when we see a steadily growing number of seniors in the community, we know that we should expand our home care and other support services to meet the potential needs.

DuBois and Miley (1992) state that "human needs and problems are generated by transitions between persons and their environment, and through a process of continuous reciprocal adaptation, humans change and are changed by their physical and social environment" (in Heinonen & Spearman, 2001, p. 186). The goal of ecosystems practice is to achieve goodness of fit between the individual and the environment (de Hoyos, 1989). Individuals experience difficulties and challenges when this goodness of fit is lacking, and "(c)ausation is circular in that the environment and the person affect each other" (Heinonen & Spearman, 2001, p. 186). Based

on the ecosystems perspective, three concepts will construct the theoretical framework of the proposed study: healthy aging, social capital, and residential environment.

Older Canadians are living longer and healthier compared to previous generations. Healthy aging is a common goal for both the general public and governments at all levels because the health and well-being of older adults have tremendous and profound impacts on each individual's quality of life, family relationships, community cohesion, and economic and financial planning (Federal, Provincial and Territorial Committee of Officials - Seniors, 2006; National Advisory Council on Aging, 2006).

The Federal, Provincial and Territorial Committee of Officials (F/P/T) (Seniors) (2006) adopted the holistic concept of healthy aging from Health Canada (2002) and the United Nations (2002) to encourage individuals, practitioners, and researchers to strive for the physical, mental, and spiritual well-being of the aging population. A multi-dimensional view of healthy aging demands a multi-dimensional strategy to study presented issues and achieve better health of the aging population. Besides the direct epidemiological factors in healthy aging, social factors, such as social connectedness and isolation, have attracted many researchers' attention. The definition and interpretation of healthy aging by the Federal, Provincial and Territorial Committee of Officials (Seniors) (2006) will be applied as the foundational understanding of this term.

By placing the individual in the centre of the field of elements in which s/he is embedded, the ecosystems perspective encourages us to understand one in his or her context – the relationships and connections with other individuals, family, groups, community, and culture (Mattaini & Meyer, 2002). Research has found that seniors "who remain actively engaged in life and connected to those around them are generally happier, in better physical and mental health, and more empowered to cope effectively with change and life transitions" (F/P/T Committee of

Officials, 2006, p. 15). Lack of social connection, or isolation, can affect seniors' health behaviours as well. For instance, seniors without family or community support tend to eat insufficient amounts of food, have irregular meals, or consume food of little nutrition or poorly prepared (F/P/T Committee of Officials, 2006). They are also less likely to partake in physical and/or intellectual exercise if no one is available to accompany them. The idea of social capital, which embraces and integrates different but related concepts such as social connection, social connectedness, and social network, has become popular among scholars and policy-makers in the areas of public health and population aging, and has resulted in a federal government initiative of building social capital for the purpose of promoting healthy aging (Veninga, 2006). Promoting social capital is to encourage individuals and groups to expand their networks in order to access resources and support for enhancement of quality of life (Lai & Chau, 2010; Putnam & Goss, 2002). The study is based on the conceptualization of social capital developed by Health Canada and the Public Health Agency of Canada (Health Canada, 2006) that will be described in detail in the chapter of Literature Review.

The ecosystems perspective emphasizes person-in-environment (PIE), describing the way human beings and their environments — all physical, social, and cultural environments — accommodate and interact with each other. Residential environments of seniors (home and the community) are the context in which social capital can be either nurtured or restrained to generate a positive or negative effect on healthy aging. The theoretical understanding of housing in this study is based on a combination of the F/P/T Committee of Officials' (2006) model of social connectedness, analyses of various types of seniors' housing (e.g., Cannuscio, Block, & Kawachi, 2003), and interpretations of service needs and preferences of immigrant seniors, including older Chinese-Canadians (Makwarimba, Stewart, Jones, Makumbe, Shizha, & Spitzer,

2010). The guidelines of studying older immigrant housing needs will be presented in detail, along with other key concepts, in the next chapter.

Generally theories have assumptions, as do perspectives. The ecosystems perspective assumes (1) the value of the systems approach (i.e., interactions among elements of the whole) and (2) "that human systems seek to maximize pleasure and well-being while minimizing pain" (de Hoyos, 1989, p. 138). Furthermore, ecosystems is not a theory that carries explanatory power. However, it "spawns many useful ideas, concepts, and hypotheses that are testable and sometimes explanatory" (Heinonen & Spearman, 2001, p. 188). This study assumes that maximizing health outcomes is a common goal for any population in a society, including older immigrants who are spending their retirement years in an environment different from that in which they were raised. Through understanding how seniors' connections within the community – social capital – affects seniors' well-being, the research hopes to identify meaningful health-enabling factors in the physical, social, and cultural environments and their relationship with individuals' social capital development. Unlike most behavioural and psychological theories, the holistic thinking of the ecosystems perspective can provide a paradigm for understanding interrelational transactions between an individual and existing elements within a system; however, it does not provide clear theoretical guidance to explain the relationship between particular elements. For example, culture is an influencing factor for an individual's behaviour; but exactly how culture can impact Chinese seniors' lives in a Canadian context needs to be explored beyond ecosystems perspective, involving cross-cultural aging theories. Detailed articulation of the interactions between Chinese seniors and their environment can be found in a later chapter.

The literature review (Chapter Two) describes the social context in which the target population lives, and defines the major characteristics of members of this population; it then

expands to various issues and challenges that are commonly identified among immigrant seniors, particularly Chinese seniors, living in a social and cultural environment different from their original homes. The chapter also presents in-depth the key concepts of the theoretical foundations of the study: *healthy aging*, *social capital*, and *residential environment*, and the relationships between them. The review of relevant literature leads to a conceptual map illustrating the concepts and the connections among them, serving as a theoretical framework guiding the proposed study. The chapter on research design (Chapter Three) describes a detailed mixed method research plan, rationales, and ethical consideration, presenting various topics related to research with immigrant seniors. Chapter Three also reports on the data collection and analysis processes.

Chapter Four illustrates the key characteristics of older Chinese seniors who were involved in the study, by presenting their demographics and comparing the demographical factors of Chinese seniors in Winnipeg with those of Chinese seniors across Canada. Chapter Five demonstrates in detail the all-encompassing factors in Chinese seniors' lives, particularly their challenges related to language barriers in health care services, in building social networks and social support, and in English learning. Chapter Six describes the research participants' mental and physical health conditions, and compares Winnipeg Chinese seniors' health with that of the general Chinese senior population in Canada. Furthermore, this chapter reports on Winnipeg Chinese seniors' experiences of using health care services. Chapter Seven conveys different aspects of Chinese seniors' social capital: views of community, trust, civil participation, social networks and social support, and social participation. Chapter Eight focuses on the findings of the residential environment in which Chinese seniors lived. The chapter includes elaboration of cultural values and identity in seniors' lives, health support services, and seniors' expectations of a residential environment that consists of multiple services.

The last two chapters conclude the study. Through synthesizing the findings of Chinese seniors' health, social capital, and residential environment from previous chapters, Chapter Nine attempts to explain how an environment supports or restricts Chinese seniors in developing their social capital. The chapter also elaborates on the implications of the findings to social work practice and the consideration of social policies and cultural competence and sensitivity. Chapter Ten describes the strengths and limitations of the research, providing some thoughts for future studies.

Chapter Two

LITERATURE REVIEW

Demographics and Context

The understanding of the diversity of Canadian seniors is constantly growing due to the unique situation in Canada which embraces people of different races and cultures. Of the total senior population in Canada, more than 28% are first-generation immigrants, and approximately 19% of the immigrant population is now 65 years of age or over (Durst, 2005; Special Senate Committee on Aging, 2007). According to Statistics Canada (2010), Chinese immigrants, including those from China, Hong Kong, and Macao, have become the largest visible minority group in the country, with a population of 1.3 million, and account for more than a quarter of the visible minority population of Canada (Lai & Leonenko, 2007; Statistics Canada, 2006). Among the visible minority population 65 years of age or older, nearly four out of ten are Chinese, making Chinese the largest visible minority senior group in Canada (Lai & Leonenko, 2007; Lai & Surood, 2009; Chappell et al., 2008). Scholars estimate that by 2017 the combined population of Chinese and South Asian seniors will reach around four million, which was the total number of ethnic minority seniors in 2001(Chappell et al., 2008).

In 2006, in Manitoba, 161,885 individuals aged 65 and over represented 14.1% of the total population (Centre on Aging, 2010). Among them, about 5%, or slightly over 8,000, were visible minority group members. Chinese seniors comprised the third largest ethnic minority group (17.4%), following Filipino and south Asian senior populations. Taking into consideration the population distribution among different urban and rural areas, the number of Chinese seniors in Winnipeg was close to 3,172 in 2006 (Centre on Aging, 2010). As the growth rate of the senior population in Manitoba was 3.5% during the five years from 2001 to 2006, it is safe to estimate

that the current number of Chinese individuals aged 65 and over in Winnipeg is between 3,200 and 3,500, assuming a similar population growth rate after the 2006 census.

Who are the Seniors that are the Focus of the Study?

Seniors

The common understanding of aging seems both simple and vague, defined as "the process of growing old or maturing" in the most popular online dictionary - the Free Dictionary (2011); "growing old or older" in the online Oxford Dictionary (2011); or "becoming old and showing the effects or the characteristics of increasing age" in the online Merriam-Webster Dictionary (2011). These definitions of aging rely heavily on another construct, *old*, but there has been no common agreement on the exact age at which an individual can be called old. The use "of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous" (World Health Organization, 2011). In most developed countries, the chronological age of 60 to 65 years and above is the eligible age for receiving pensions, and, therefore, seen as the beginning of old age. The WHO and the United Nations also generally refer to an older population as those who are 60 years or older (WHO, 2011).

Biological change of the human body has a significant impact on the process of aging (WHO, 2002); however, historical and cultural constructions by each society help people make sense of old age. Fry (2003) argues that *age* itself is culturally constructed, in contrast to the concept *time* which is relatively more ascribed. In small-scale societies, people refer their age to generational kinship position and physical abilities (Fry, 2003). In some cultures, social age is more important than biological age for individuals as age norms to define people's roles and expectations at

certain ages (Settersten, 2003a, 2003b; Durst, 2010a). People attend schools at a particular age; one needs to reach a certain age to drink alcohol, marry, or work legally; only people within certain age ranges are eligible for recruitment to military services; and most people retire between 60 and 70 in modernized North American societies.

In the Canadian context, most censuses categorize people aged 60 years or above as the senior group (Centre on Aging, 2010). In understanding the socially and historically constructed nature of age, it is appropriate to consider individuals aged 60 years and above as seniors in both the Canadian and Chinese cultural context.

Older Chinese-Canadians

Defining and describing Chinese minority seniors in Canada is not an easy task. Comparing the two terms "Chinese-Canadians" and "Chinese in Canada", Li (2009) points out that the former term is commonly used in various government documents or publications, describing this group as "hyphenated" or "ethnic" Canadian citizens, whereas the latter indicates the marginalized status of this population coming from a foreign ethnicity. Both terms present the assumption that people of European heritage are natural Canadians, whereas non-European citizens are "different" groups of Canadians. Li (2009) considers the term "Chinese-Canadians" interchangeable with, but better than, "Chinese in Canada" because it "stress[es] the fact that they are not foreigners in Canada but Canadians with history that precedes Confederation, and to distinguish them from Chinese" (Li, 2009, p. 149) in other parts of the world. In this paper, both "older Chinese-Canadians" and "older Chinese (in Canada)" are used to refer to Chinese who are 60 years of age or older and who have obtained Canadian citizenship or landed immigrant status in Canada.

Issues Faced by Older Chinese-Canadians

Health

The common health determinants (WHO, 2002) for Chinese seniors are not much different from those of the general senior population in Canada, namely demographic factors, socio-economic status, interaction of mental and physical health, and service accessibility (Lai, 2004a, 2004b; Lai & Chappell, 2006; Tjam & Hirdes, 2001; Lai & Kalyniak, 2005). However, cultural-related indicators, such as cultural allegiance and language, are influential to Chinese seniors' health behaviours in seeking professional consultation and treatment, medication, preventive check-ups, oral health, mental health, and palliative care.

The majority of Chinese seniors (90%) have adopted the Canadian norm of obtaining a family physician; however, they are more inclined to visit Chinese physicians who share their language(s) and cultural beliefs (Lai & Chappell, 2006; Tjam & Hirdes, 2001). Seventy-six percent of older Chinese-Canadians acquired annual physical examinations covered by the Canadian health care system within the past year (Lai & Kalyniak, 2005). Secondary preventive health measures (e.g., screening for the early detection of chronic diseases) are foreign to older Chinese because this might not be a common practice, or might be costly, in the society from which they came (Lai & Kalyniak, 2005; WHO, 2002; Federal, Provincial and Territorial Committee of Officials, 2006). Less than half of the older Chinese population (48%) in Canada have used dental services in the past year (Lai & Hui, 2007). As dental health was a relatively understudied area in traditional Chinese medicine, Chinese seniors may not understand the benefits of dental care and its connection with old age well-being. Traditional Chinese medicine (TCM) is used by 50% to 65% of older Chinese in Canada, but most of them combine it with Western medicine (Lai & Chappell, 2006; Tjam & Hirdes, 2001). In particular, Chinese seniors

who have less financial limitations, stronger Chinese health beliefs, and more social support demonstrate a higher tendency of use of more TCM (Lai & Chappell, 2006; Tjam & Hirdes, 2001).

Older Chinese-Canadians report similar or better physical health but poorer mental health than the general population of the same age group in Canada (Lai, 2004a, 2004b). Nevertheless, Chinese-Canadians are less than half as likely as non-Chinese to use mental health services, even those with mild to high levels of depression (Chen, Kazanjian, & Wong, 2009). Mental health services are used more by those who have a weaker Chinese cultural orientation, such as those not speaking Chinese (Chen et al., 2009). Mental health problems may not be recognized as a health issue, but rather as excessive reaction to life hardships, unbalanced or uncontrolled emotions, divine retribution for misconduct, or spirit procession. Therefore, traditional treatment or non-medical remedies, such as meditation, herbal medicine, or traditional rituals, may be applied to restore mental balance, instead of Western pharmacological intervention or psychiatric counselling (Chen et al., 2009; Liu, Hinton, Tran, Hinton, & Barker, 2008). But other Chinese traditional practices have been documented as a positive force in seniors' mental health interventions. For example, Tjam and Hirdes (2001) suggest that Chinese seniors' use of fewer drugs than older Canadians for the purpose of reducing depressive symptoms has been attributed to Chinese seniors' co-residence with their adult children who might be providing needed emotional support.

End-of-life issues are not easy topics to deal with for people of any cultural background. Chinese seniors do not want to talk about these issues or the idea of advance directives because they may burden themselves, their families, and other people around them (Bowman & Singer, 2001). Chinese people believe that talking about death when one is still alive will induce misfortune. Chinese seniors trust their children collectively to make the best decisions for them

and do not want to assign a particular child to be a proxy in health decision-making (Bowman & Singer, 2001).

Living Arrangements

Mixed findings on the living arrangements of Chinese seniors manifest a significant modification of cultural traditions among Chinese families in the West. On the one hand, the percentage of Chinese-Canadian seniors co-residing with adult children is prevalent - it ranges from 59% to 78% (in various studies), compared to only 9% of older Canadians in the general population having the same living arrangement (Chappell & Kusch, 2007; Chow, 2000; Gee, 2000). On the other hand, a substantial number of Chinese seniors (84% to 90%) have expressed their wish to not live with adult children (Chappell, 2003). Daughters and their spouses in Chinese-Canadian families are found to be involved in care-giving more than sons, contrary to the cultural tradition where sons are supposed to be the primary caregivers to elderly parents (Chappell & Kusch, 2007). Lan (2002) identifies a new option of filial practice among middle-class and upper-middle-class Chinese Americans where filial piety is "subcontracted" to home care service workers to provide daily physical care to their disabled parents. Placing elderly parents in care homes can be viewed as another form of subcontracting filial piety (Zhan, Feng, & Luo, 2008). Evidently Chinese seniors and their families have adopted diverse living arrangements to meet their living needs without over-compromising family members' lifestyles and values.

Adherence to Cultural Norms and Values

Many older Chinese immigrants report a positive migrating and aging experience in Canada, such as having a strong sense of belonging and commitment to Canada, engaging in transnationalism for psychological well-being, and enjoying better health care and environment (Li, 2009; Luo, 2011). Researchers have found that filial piety is of great importance to Chinese families in Western countries, and familial care for seniors is a duty, obligation, responsibility, and ethnic virtue (Ikels, 1998; Aranda, 2002, in Chappell, 2005). Older Chinese in Western countries adhere more to the traditional culture than the younger Chinese generation, and a high proportion of them speak little English or French (Chappell, 2005; Chappell & Lai, 1998). In her study of Chinese seniors' life satisfaction in Canada, Chappell (2005) found that besides the standard predictors of life satisfaction (i.e., health condition and socioeconomic factors), involvement in traditional Chinese culture (e.g., attending functions, seeing friends, visiting homeland) also has prevalent positive effects for people in later life.

Another aspect of traditional Chinese culture has an impact on Chinese seniors' health behaviours and their relationships to their families, community, and social services. In order to achieve collective well-being and familial harmony, some older Chinese have developed a coping strategy of not complaining about personal issues within and outside the family (Lam, 1994, in Chappell, 2005). Because of this self-restrained coping approach to health and life adversities, it is possible that Chinese seniors' resilience to health, family, and social problems has been overemphasized (Chappell, 2005). Seniors do not want to burden family members with personal difficulties or make them feel guilty if family members do not have the resources to solve the seniors' problem(s). To friends and acquaintances in the community, seniors are not likely to mention their problems because that may make them look vulnerable and judged for their difficulties; moreover, their family members may be criticized for not being able to fulfill their elders' needs, resulting in the sense of losing face to all family members. Lastly, seniors

may be even more unlikely to acknowledge their personal issues to service providers who are viewed as outsiders and do not understand the particular interpersonal and family dynamics, on top of structural obstacles such as language barriers, cultural and value differences, and insufficient knowledge of the nature and functions of social services in the host society (Makwarimba et al., 2010).

As cultural beliefs and traditional norms shift due to social changes and historical events, Chinese seniors and their families do not necessarily follow certain traditional ideals, especially after having moved to a different country with Western culture (Chappell & Kusch, 2007; Chappell, 2003, 2005). Chappell (2005) notes that family or children do not significantly affect seniors' life satisfaction, nor do certain traditional norms, such as children's need to obey parents and requiring Chinese to marry within their own culture. Many researchers have argued that the combination of democracy, capitalism, individualism, and racist discrimination have substantially reshaped Chinese culture and have created new transnational identities for Chinese immigrants (Gee, 1999, in Chappell et al., 2008; Chappell & Kusch, 2007; Li, 2009). Chinese seniors and their families have acquired different degrees of allegiance to both their traditional cultures and Western cultures in the Canadian context. For example, Lai and Leonenko (2007) reveal that assimilation to the host culture (e.g., having a Western religion and longer period of time living in Canada) correlates with Chinese seniors' choice of living alone. Another example is cited in Chappell et al. (2008), where Gee's (1999) study showed that almost half of older Chinese in Vancouver and Victoria identified themselves more Canadian than Chinese and that self-identification as Chinese was correlated with low income. Therefore, assimilation to the host culture seems to have a positive impact on Chinese seniors. On the other hand, Chinese seniors are often found to be greatly involved in traditional Chinese culture to a certain degree and manage to maintain their separate identity, and their involvement in Chinese culture is a

significant predictor of perceived quality of life for older Chinese-Canadians (Chappell, 2005). Lai and Surood's (2009) findings confirm previous research that older Chinese-Canadians present persistent Chinese traditional health beliefs when it comes to decision-making for health treatment or consulting medical professionals. Yet, there is also evidence of integration of home and host cultures in Chinese seniors' lives. Liu, Ng, Weatherall, & Loong (2000) find that the support of the traditional value of filial piety is related to both Chinese and Western identities. They suggest that Western identity "contributes to filial piety by facilitating regular positive communication between generations (e.g., contact with respect), whereas Chinese identity contributes more to material obligations (e.g., financial assistance)" (Liu, Ng, Weatherall, & Loong, 2000, p. 221). Thus, the authors point out the possibility that traditional Chinese culture may retain its strength and co-exist with humanistic ideals in other cultures.

Chinese seniors vary from the general Canadian senior population in health behaviours, lifestyle, family relationships, and social involvement. Habits, values, and beliefs that Chinese seniors have acquired from growing up in the environment of their home countries play a significant role in all aspects of the lives of these seniors who are spending their retirement years in Canada. It is vital for social workers and other professionals to understand how immigrant seniors cope with the issues and challenges facing older people in the Canadian context. What follows is a description of three useful concepts for understanding immigrant seniors' issues in order to design and conduct proper services for their needs and wants.

Healthy Aging

It is evident that current Canadian seniors are living longer and with fewer disabilities related to morbidities than previous generations, although many of them still suffer from one or

more chronic diseases or conditions (F/P/T Committee of Officials, 2006). A hundred years ago, a 65-year-old could have expected another 11 years of life (Shields & Martel, 2006); by 2005, the number of additional years after 65 had increased to 17.4 for men and 20.8 for women in Canada (Health Canada, 2006; F/P/T Committee of Officials, 2006). Health Canada for the Federal, Provincial, Territorial Ministers Responsible for Seniors (1998) states a common goal of supporting the aging population: "Canada, a society for all ages, promotes the well-being and contributions of older people in all aspects of life". The vision for healthy aging, however, needs to further specify elements and action initiatives for older Canadians to attain optimal health and quality of life.

Among the rationales of promoting healthy aging initiatives (F/P/T Committee of Officials, 2006), two are of particular importance to social service providers: 1) improvement of health in old age can help reduce the pressure to financial and human resources, and 2) caring for seniors is a social action involving and impacting all generations. According to the Public Health Agency of Canada (PHAC), treating and managing chronic conditions account for tremendous human and economic costs for all levels of governments (F/P/T Committee of Officials, 2006). For example, more than 44% of all provincial government health expenditures in health care and 90% in long-term care were to meet seniors' needs (Canadian Institute for Health Information, 2005). It has been calculated that both fall-related injuries and disabilities among those aged 65 and over cost government approximately $2.8 billion per year (Scott, Peck, & Kendall, 2004). Therefore, seniors who maintain their health and live in the community with a variety of supportive living arrangements will substantially reduce the costs for health care and long-term care (Laditka, 2001).

The F/P/T Committee of Officials strongly advocates that supporting healthy aging is "the right thing to do" (2006, p. 9) as it is not an "either-or proposition" for governments and the

public to judge whether the young or the old are more eligible for resources. The United Nations (2002) proposes a "life-course intergenerational approach to policy that stresses equity, reciprocity and inclusiveness of all age groups through all policy areas" (p. 10). The life course perspective, therefore, is introduced into healthy aging initiatives, where efforts for optimal well-being are needed at various life stages, by making strategic investment at different times and life transitions. Intergenerational approaches and activities for health promotion have gained popularity "because the benefits to old and young participants are visible and immediate" (F/P/T Committee of Officials, 2006, p. 10). Policies and programs need to assist individuals to achieve good health and healthy lifestyles throughout the life course (United Nations, 2002).

Healthy aging is commonly considered in terms of a senior's functional impairment and positive health perceptions, despite various definitions of "health" (Shields & Martel, 2006). Exceeding the earlier definition of "healthy" as the absence of disease or chronic conditions, Health Canada defines "healthy aging" in a holistic view as "a lifelong process of optimizing opportunities for improving and preserving health and physical, social and mental wellness, independence, quality of life and enhancing successful life-course transitions" (F/T/P Committee of Officials, 2006, p, 4).

Individuals with chronic conditions who can adapt to change and manage to live vital lives can also be included in this healthy aging category (Shields & Martel, 2006). In line with the World Health Organization's definition of health: "(h)ealth is a state of complete physical, mental and social well-being and not merely the absence of illness or infirmity" (WHO, 1946), Health Canada identifies four criteria of "good health" for seniors: good functional health, independence in activities of daily living, positive self-perceived general health, and positive self-perceived mental health. Healthy aging with dignity and vitality within reach of all citizens

has thus become the goal of each Canadian and public sectors. Seniors' self-perceptions of physical and mental health are crucial in determining the level of well-being because the presence of illnesses and functional disabilities does not necessarily mean that seniors are unwell. Adaptability to functional decline is a strong indicator and cause for healthy aging (Jang, Mortimer, Haley, & Graves, 2004; Knight & Ricciardelli, 2003). Social engagement and active participation in the community are also vital variables of healthy aging, demonstrated in numerous studies (more detailed discussion in the next section). Spirituality, including religious involvement, anticipation of the future and having a sense of purpose, also has a profound impact on older people's health and well-being (Knight & Ricciardelli, 2003; Lai & McDonald, 1995; Lai, 2004a; Luo, 2011). It is clear that healthy aging is by nature a holistic and complex concept which demonstrates multiple dimensions of an individual's well-being of mind and body, epidemiologically and socially.

To better assist Chinese seniors in achieving healthy aging, researchers and practitioners first need to gauge the health level of this population in order to identify the gaps in health outcomes, their plausible causes, and potential solutions. Health is a complex concept involving multiple elements; thus, studying the health and well-being of Chinese seniors requires a multi-faceted analysis of physical, mental health, and social factors in health outcomes.

Social Capital and Healthy Aging

Contemporary Understanding of Social Capital

The relationships between social factors and population health has been long identified and studied because "therapeutic medicine – although essential – does not explain all the

differences and there is a need to pay attention to these 'old' ideas" (Poder & He, 2010, p. 3). Recent large-scale research has clearly indicated the positive effects of social factors, particularly social capital, on population health (Health Canada, 2006; Campbell, 2000). While social integration is associated with good health, good health behaviours, and a low mortality rate for seniors, social isolation contributes to deterioration of both physical and mental health among the aging population (Franke, 2006).

Many different definitions and respective measurement indicators have been formed and applied in various studies (Putnam & Goss, 2002; Health Canada, 2006; van Kemenade, 2003). In the field of health alone, at least ten different definitions of social capital have been used in research conducted in Europe and North America (Murayama, Fujiwara, & Kawachi, 2012; Franke, 2005). In general and simple terms, social capital refers to the networks developed and accumulated from the myriad of everyday interactions among individuals or groups (Lai & Chau, 2010; Abdulahad, 2010). "The basic idea of social capital is that a person's family, friends, and associates constitute an important asset, one that can be called on in a crisis, enjoyed for its own sake, and leveraged for material gain" (Putnam & Goss, 2002, p. 6). Although there has not been a consensus on a specific definition, many international organizations (e.g., World Bank), governmental sectors (i.e., Office for National Statistics in UK, Public Health and Statistics Canada in Canada), and well-recognized scholars (i.e., Bryant & Norris, 2002; Green & Fletcher, 2003; Franke, 2005, 2006) seem to have framed their empirical work around the definition set out by the Organization of Economic Co-operation and Development (OECD, 2001) which states social capital as "networks together with shared norms, values and understanding that facilitate co-operation within and among groups" (in Bryant & Norris, 2002, p. 3; Green & Fletcher, 2003, p. 5). It should be noted that social capital is not merely the sum of the networks for an individual or a group, but rather, "the glue that holds them together" (Harper, 2002, p. 2).

Social capital shares some commonalities with other forms of capital, such as financial capital or human capital, in that they all need investment, with the expectation of future returns (Claridge, 2004a). Nevertheless, social capital distinguishes itself from other forms of capital in that "whereas economic capital is in people's back accounts and human capital is inside their heads, social capital inheres in the structure of their relationships" (Portes, 1998, p. 7). Because of its embedment within a group or a community, social capital cannot be traded by individuals on an open market (Claridge, 2004a).

Understanding social capital depends on the particular focus of a study or a researcher – whether it is primarily on the connections between an individual and other actors, the structure of the relations among all actors within a collectivity, or both types of linkages (Adler & Kwon, 2002). Presently two major distinct concepts co-exist within the realm of social capital: social cohesion (also communitarian or trust perspective) and network approach (Moore, Shiell, Haines, Riley, & Collier, 2005; Murayama et al., 2012; Franke, 2006). *Social cohesion* can be interpreted as resources and support that individuals draw from tightly knit communities in which they live; this approach emphasizes that social capital is a group or collective attribute characterized by mutual trust, reciprocity, public good, and social intercourse equally available to all members of a community (Murayama et al., 2012; Putnam & Goss, 2002). In empirical measurement, indicators of social capital include levels of trust, reciprocity, election participations, and civic engagement (Moore et al., 2005). In contrast, the *network* approach of social capital focuses on individuals whose resources and assets are embedded in their networks (Murayama et al., 2012). Defined by Bourdieu and Wacquant (1992), "social capital is the sum of resources, actual or virtual, that accrue to an individual or group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (in Moore et al., 2005, p. 2). In practice, the network approach attempts to focus on

the structure of an individual's or a group's networks and the resources available within those networks to individuals or groups (Moore et al., 2005).

Both formal and informal networks are central to the concept of social capital. They can be found in families, workplaces, neighbourhoods, social services, and a variety of formal or informal organizations and activities. Three types of social capital have been identified based on their nature:

- *Bonding* social capital — characterized by strong bonds; existing within a group and between people who are similar; often found among family members or members of an ethnic group

- *Bridging* social capital — characterized by weaker, less dense but more cross-cutting ties; existing between different groups; often found among business associates, acquaintances, and different ethnic groups

- *Linking* social capital — characterized by connections between those within different societal levels that allow for access to particular resources such as wealth and power. It is different from bonding and bridging social capital and relatively more difficult to measure because it involves contacts or relations between people on an unequal footing. An example would be the relationship between a person on welfare and his or her case worker.
  (Bryant & Norris, 2002; Harper, 2002; Foxton & Jones, 2011)

What is also worth noting is the diversity in other components of social capital, including *groups* and *dimensions*. Groups refer to *geographic groups* (e.g., neighbourhood), *professional groups* (e.g., union, association, volunteer organization), *social groups* (e.g., families, friends, cultural-based groups), *and virtual groups* (e.g., networks on cyber space) (Foxton & Jones, 2011). Social capital is a multi-dimensional concept (one of the major contributions to the lack of a consistent definition and conceptualization) where each dimension is essential to the entirety of the concept (Claridge, 2004b; Foxton & Jones, 2011). The five common dimensions found in various surveys and studies include:

- Trust, reciprocity, and social cohesion (e.g., trusting other people, institutions)
- Social networks, social support, and social interaction (e.g., contact with friends and relatives)
- Social participation, social engagement, and commitment (e.g., involvement in groups and voluntary activities)
- Civic participation (e.g., propensity to vote, action on local and national issues)
- Views about the area or perception of community (e.g., satisfaction with living in the area, problems in area)
  (van Kemenade, 2003; Bryant & Norris, 2002; Green & Fletcher, 2003)

Given the complexity and fluidity in the nature of the term, it is not surprising for social capital to receive skepticism and criticism at the theoretical, methodological, and political levels (Bouchard, Roy, & van Kemenade, 2006a). One obvious shortcoming of social capital theory is that the concept is "vague, slippery, and poorly specified, and in danger of 'meaning all things to all people'" (Campbell, 2000, p. 183). Gillies (1998) points out that it would be more sensible to view social capital as a descriptive construct rather than an explanatory theory, and the causality within the relationships between social capital variables and health outcomes is still unclear (in Campbell, 2000; van Kemenade, Roy, & Bouchard, 2006). One of the strongest criticisms from researchers is that social capital can be used as a convenient justification for reduction or disengagement of public services and welfare despite the proven connection between material deprivation and poor health (Health Canada, 2006; Campbell, 2000). Instead of striving for better and more comprehensive social services, governments may try to shift the pressure of promoting population health to private sectors by advocating for social capital (Lai & Chau, 2010).

In response to such criticisms, extensive discussions have been conducted among federal governmental departments, including Health Canada and the Public Health Agency of Canada (PHAC), to make recommendations, particularly in the application of social capital in working with older adults. Firstly, the development of social capital should be regarded as a means, rather than a political objective, in promoting healthy aging. Governments can facilitate the building of

social capital in communities through a variety of programs and policies (Health Canada, 2006). For example, some funding for health can be allocated more to public transportation or accessible housing for senior groups by which older adults may expand their networks through easy connection with others in the community. Using a "social capital" lens in the analysis and design of intervention programs is especially relevant in helping populations at risk of social exclusion and supporting individuals in major life transitions (Franke, 2006), such as immigrants who are aging and relocated in later life in a society different from home of origin (Bouchard et al., 2006a, 2006b).

Secondly, policies and programs for social capital development among immigrant seniors need to maintain a balance between assisting new development and respecting existing mechanisms. For example, some well-intended urban renovation projects for seniors (e.g., a new overpass intended to facilitate safe passing which may in fact increase the difficulty of mobility to seniors due to improper design) have resulted in disrupting local social networks and weakened senior residents' social connections within the community (Health Canada, 2006). As well, it is important to identify the type and level of (government) intervention that will strengthen or complement present social capital available to older adults, rather than replacing it.

Thirdly, recognizing that inconsistent approaches have affected the advancement of the research and utilization of social capital in programming, international research of social capital has invested considerable effort to achieve a relatively coherent conceptual framework of social capital (Bryant & Norris, 2002; Harper, 2002; Foxton & Jones, 2011; Franke, 2006; van Kemenade, 2003). It encompasses two *approaches* (social cohesion and network), three *types* (bonding, bridging, and linking), and five *dimensions* (trust, networks, social participation, civic participation, and perception of community) of social capital. The diversity of understanding social capital depends on the particular focus of a study or a researcher – whether it is primarily

on the connections between an individual and other actors, the structure of the relations among all actors within a collectivity, or both types of linkages (Adler & Kwon, 2002).

Social Capital and the Health Aspect of Aging

A sizable body of literature identifies the importance of social networks to the quality of life for seniors. Extensive evidence has been reported on the connection between social relations and health outcomes, including decreased mortality rates, slowing of functional decline, increased happiness, and reduced levels of stress and depression (Veninga, 2006; Zimmerman Park, Hall, Wetherby, Gruber-Baldini & Morgan, 2003). Social networks composed of informal and formal ties to other individuals and groups are the underlying mechanism for social capital to mobilize resources to those in need. Social network attributes include network size (how many), composition (who), and frequency of contact (how often) (Litwin, 1998; Bouchard et al., 2006b).

Lai and Chau (2010) used random-sampled data to examine the effects of social capital variables on health and well-being for Chinese seniors in Canada. They found that informal social contacts, affiliation to organizations, and attitudinal ties with the Chinese community significantly related to health status and well-being of older Chinese-Canadians. Immigrant seniors have been observed using mental health services with low frequency even when they experience moderate to severe level of stress or depression (Chen et al., 2009; Park, Jang, Lee, Schonfelf, & Molinari, 2012). Park and colleagues (2012) found that providing information about various social resources (informational support) can increase seniors' willingness to use mental health services. Social support that provides relevant information can motivate older adults to examine their needs and to seek help from professional service providers (Park et al., 2012).

Another important element of social capital, reciprocity, has been found to be related to various indicators of quality of life (Litwin, 1998; Lai & Chau, 2010). When seniors are able to provide support to, while receiving support from, others, they are observed to have higher life satisfaction, as well as higher levels of happiness and self-esteem than those without reciprocity in their networks; correspondingly, a lack of reciprocity is associated with feelings of guilt, dissatisfaction, low self-esteem, and an unwillingness to seek help (Litwin, 1998). For seniors, the level of reciprocal interactions increases with more seniors' contact, more friends and neighbours, and higher frequency of such contacts within the network, while contact with family and relatives actually decreases reciprocity (Litwin, 1998).

Health Canada recognizes three subpopulations - seniors, immigrants, and members of low-income households - who are vulnerable in terms of attaining sufficient social capital (van Kemenade et al., 2006). Seniors and immigrants are at risk of depletion of social capital stock because the networks of those individuals are reduced, limited, or cut off due to personal, family and social changes. Life transitions, such as declining health, reduced mobility, loss of loved ones or friends due to death or relocation, are a major theme in many older adults' lives. Social isolation may become more significant as people get older because family and community networks tend to decrease in size (Veninga, 2006).

Chinese seniors living in the Canadian context may be facing a decline or loss of social capital stock due to two major life changes - getting older and relocating for immigration purposes - according to *double jeopardy* theory (Chappell et al., 2008; McDonald, 2010; Driedger & Chappell, 1987). Social workers who work with immigrant seniors need to be aware of these issues and integrate services into their practice that can increase the possibility for higher social capital for older immigrants. For seniors of different ethnic cultural backgrounds, inadequate social networks can be a result of multiple risk factors, in addition to those commonly

observed in the general aging population: dislocation from home (a familiar environment), lack of information or access to services to utilize social support, insufficient language skills to build new networks, and cultural barriers to establish mutual trust and understanding (e.g., Makwarimba et al., 2010; Lai & Chau, 2007; Lai & Kalyniak, 2005).

Some empirical studies to examine the relationship between social capital and health for immigrant seniors have been undertaken (e.g., Lai & Chau, 2010; Veninga, 2006; van Kemenade et al., 2006). However, much work is needed to explore the appropriateness of applying the construct of social capital to immigrant seniors who are aging in a social and cultural context that drastically differs from their former one. One of the factors that can affect the level of people's social capital is their living environment, which can either increase social capital by providing support to network building, or decrease social capital by restricting access to available or potential resources. The following section elaborates in detail on the connection between a residential environment and social capital.

Residential Community Environment, Social Capital, and Aging Chinese Seniors

Residential community environment is the established physical environment in which seniors live, work, and socialize. Living environment is of particular importance to older adults because of its profound influence in determining a senior's level of independence and resources of support. Chappell, McDonald, and Stone (2008) provide one example where lack of mobility does not reduce a senior's independence in daily living. An older person having difficulties going up and down stairs usually increases his or her reliance on other people's support in everyday functions in a regular residential house, but if he or she lives in a place without stairs, that senior can perform daily activities independently. Residential environment also encourages

or limits seniors' use of health care services, in terms of location of residence, accessibility of affordable transportation, and availability of a social network that offers relevant information, advice, and support (Chappell et al., 2008). Chappell and colleagues (2008) also point out that the concept of *aging in place* does not necessarily mean that seniors want to remain in a particular house all their lives, but a place that they know well and can have their needs met. What scares people is placement in an "unfamiliar institutional environment or one distant from family and friends" (Chappell et al., 2008, p. 230) where seniors have to leave behind personal belongings with special meanings to them. A health-enabling residential environment is one that nurtures social capital (Campbell, 2000) and "benefits health based on social associations between individuals and between individuals and social institutions, including the community in which one is a member" (Lai & Chau, 2010, p. 230).

The F/P/T Committee of Officials (2006) identifies four essential components under the umbrella of social connectedness which are positively related to health: *social support, social networks, social engagement* and *supportive environments*, which are not only in line with the idea of social capital, but are also an alternative interpretation of the ecosystem perspective. A *supportive environment* includes both macro-environment (the community where older adults locate), mezzo-environment (the building or block where they live), and the micro-environment (the housing where they live) (McPherson & Wister, 2008). It serves as the hub for the other three components to establish and grow because an enabling environment, with family and community supports, often makes it possible and desirable for seniors to be active in their communities (F/P/T Committee of Officials, 2006). Further, the quality of a community environment strongly affects seniors' views about the area, and, in turn, their trust and sense of belonging to the community (Bryant & Norris, 2002; Green & Fletcher, 2003).

Family, friends, neighbours, and community or cultural group members provide *social support* to seniors, which can lead to an increase in the sense of belonging to a community. Social support can significantly influence individuals on perceived health, health behaviours, self-identity, and lifestyle (F/T/P Committee of Officials, 2006; National Advisory Council on Aging, 2006), and also enables seniors to sustain and promote their mental health during adversities such as life transitions or significant losses in life (Chen et al., 2009; Liu et al., 2008; Tjam & Hirdes, 2001). As social support is typically offered by family members, friends, and other people in the community, the availability of such individuals and seniors' accessibility to them are particularly important. In other words, residency in an environment that allows older adults easy access to resources of social support becomes a premise to quality social connectedness.

Social networks, similar to the understanding of the social network approach of social capital, are composed of friends, acquaintances, and organizations. The essence of social networks lies in the mechanism of mutual aid where individuals support each other physically and emotionally by sharing ideas, resources, and experiences (F/P/T Committee of Officials, 2006). Seniors also rely more on their proximal networks for day-to-day support such as simultaneous chatting, consistent companionship, and assistance in minor daily activities (Chappell et al., 2008; Makwarimba et al., 2010). Mutually beneficial networks of seniors are more likely to take place in cultural and linguistic homogeneous groups because individuals share the same social norms, values, and behavioural expectations (Makwarimba et al., 2010; McDonald, George, Daviuk, Yan, & Rowan, 2001; Durst, 2010b).

Seniors are more likely than younger individuals to acquire condensed but limited social networks through which they establish or maintain close emotional relationships (Pushkar & Arbuckle, 2002). Social networks tend to shrink over time due to deaths or moves of friends and

relatives, especially for older immigrants who have lost established circles of friends because of dislocation and relocation in old age. Fewer people are available for immigrant seniors to rely on in a new environment in which they did not grow up. Other practical barriers to building adequate networks posed by an unsupportive environment include insufficient provision of social services in languages other than English and French, restrained services of public transportation, and poor promotion of available services to the immigrant senior population (McDonald et al., 2001; Makwarimba et al., 2010).

Social engagement, closely related to the social cohesion approach of social capital, is defined as "sources that emerge from the networks of social interactions based on norms of trust and reciprocity" (F/P/T Committee of Officials, 2006, p.17). Individuals retain their social engagement through attending religious services, participating in political activities, volunteering, being involved in cultural organizations, and maintaining strong identification with one's own culture (Lai, Tsang, Chappell, Lai, & Chau, 2007; Lai & Chau, 2010). From the definitions (see Table 1), it is logical to view the social network as the foundation for social engagement or social cohesion, whereas social support for individuals to acquire optimal health outcomes is the result of both social network and social engagement. However, without a physical and social environment that provides the means for immigrant seniors to feasibly establish meaningful networks, it is merely a wishful idea to encourage them to vote, volunteer, or engage in cultural or religious activities.

In the articulation of its new vision of healthy aging, F/P/T Committee of Officials (2006) further makes clear that supportive environments, including policies, services, housing options, and community development programs, are the foundation for promoting social connectedness. Seniors need to have a safe and sufficient living environment in order to access relevant information, pursue healthy choices, attain necessary health or home care, and assist each other

by sharing ideas, resources, and experiences. To promote healthy aging among ethnic minority seniors, the environmental development should be tailored to suit the demands and needs of the target group (F/P/T Committee of Officials, 2006). For example, social workers in the community can provide culturally responsive information on appropriate types and levels of physical and mental exercises so that seniors can follow instructions and plans within their comprehensive and action capacities (Makwarimba et al., 2010; McDonald et al., 2001).

Housing is an essential element of the *physical environment* and is explicitly identified as a determinant of healthy aging in the Special Senate Committee on Aging Final Report (2009). As one senior notes, "as we age, it appears we become more attached to our homes and our community" (Shiner, Stadnyk, daSilva, & Cruttenden, 2010, p. 7). It is the familiarity with their circumstances that assists them in meeting their daily functional needs and maintaining the feeling of independence and enjoyment of life (Shiner at al., 2010; Luo, 2011). Seniors who are willing to move to seniors' housing or apartments express that they want to stay in the area where they currently live (Shiner at al., 2010). Therefore, creating and improving the surroundings that provide social networks already known or in place for residents is the key for building a supportive environment for older adults. According to the findings of the Canadian Community Health Survey in 2003, social networks and connection to the community create a strong sense of community belonging which is positively related to good health (Shields & Martel, 2006).

As stated previously, a community "interacts" with individuals, impacting seniors' health and well-being in either positive or negative ways. A supportive physical environment includes low curbs and stairs, properly built and maintained sidewalks and stairs, well lit streets and hallways, traffic lights that allow sufficient time for pedestrians to cross, prompt snow removal, etc. A home environment should have adequate lighting, no or minimum stairs, solid and safe

floors, grab bars in bathtubs and showers, and low cupboards for easy reach (McPherson &Wister, 2008). Much effort have been placed into designing and building physical environments at various levels to accommodate older adults' needs, determined by their physical, social, and economic considerations (e.g., Evans, 2009; Wiles, Allen, Palmer, Hayman, Keeling, & Kerse, 2009).

Assisted living has become the most popular and fastest growing residential option for seniors in many places around the world (Park et al., 2012; Zimmerman et al., 2003; Litwin, 1998). Most assisted living settings have applied a social model of care instead of the conventional medical model of which the personal care home is a typical example (Zimmerman et al., 2003). The social model emphasizes the principles of promoting community and family involvement through provision of integrative services and programs, in addition to offering a safe and convenient environment to seniors (Assisted Living Quality Coalition, 1998).

The major reason for its success owes to its provision of a broad range of social activities in the residence in order to enable seniors to accumulate and increase their social capital stock for better quality of life. While being physically present in social activities does not require a great effort from seniors who have experienced declined mobility, they will participate and interact, even if they suffer from emotional or mental limitations (Bodner, Cohen-Fridal, & Yaretzky, 2011). Otherwise, the existence of logistic limitations, such as going out in the winter or in the evening or taking buses on their own, can make it harder for the elderly to participate in social activities in the community (Bodner et al., 2011). Moreover, encouragement by staff and the social presence of people of their own age may improve the social engagement of seniors. Litwin (1998) applied the perspective of contextualized human behaviour to analyze reciprocal relationships between seniors. He concludes that "one must consider factors related to the

physical environment in which support is given and received, specifically, the nature of the housing facility" (p. 241).

Besides the physical elements and social capital factors in a community environment for seniors, another crucial component are culturally appropriate services available to residents. These includes offering various settings and care alternatives to seniors, including room and board, assistance with activities of daily living, and services for un-systemized demands and needs (Park et al., 2012). Previous research has indicated that facility characteristics such as size, resources, and type of social programs affect residents' levels of participation in social activities. In particular, a social climate that encourages supportive interpersonal relationships is related to older adults' social functioning (Timko & Moos, 1990, in Zimmerman et al., 2003). Provision of social and recreational programs, especially group activities, such as working on a hobby, attending arts and crafts, or playing cards and games, is found to be consistently associated with the social engagement level of residents in assisted living facilities (Zimmerman et al., 2003). In their study comparing social engagement in conventional and new models of assisted living facilities, Zimmerman and colleagues (2003) have identified that an increase in the availability of social activities (group activities or outings) is positively correlated with a significant increase in social engagement. "Specifically, for every 20 percent increase in the availability of social activities, participation in overall activities increased by .65 activities per week" (Zimmerman et al., 2003, p. 12). In general, assisted living housing programs emphasize promoting older residents' independence and dignity through building home-like environments (Park et al., 2012).

The literature on the connection between social capital and residential environment, however, has not been systematically examined. It is unclear how the latter enables or limits the former for older immigrants to actively take advantage of available resources. It is crucial for

social work practitioners to understand the mechanisms underlying this connection in order to design and build proper residential environments that assist in building solid social capital for immigrant seniors. The relationships of the major elements within a community environment are illustrated in Figure 2.1.

Three concepts - healthy aging, social capital, and community environment - and the connections between any two of them have been discussed. The next section is going to articulate the relationship among all three concepts under the overarching ecosystems perspective and present a theoretical framework as the guiding map for the proposed research.

Residential Environment, Social Capital, and Healthy Aging

Studies on and policies to promote supportive environment are an emergent area in gerontological social work. One of the latest examples is the cross-nation multi-disciplinary campaign of building age-friendly communities as Canada's answer to the WHO's call for global age-friendly cities (Public Health Agency of Canada, 2012) (e.g, Age-Friendly Communities – CURA, Centre on Aging, University of Manitoba, http://umanitoba.ca/centres/aging/cura/cura_index.html). Ecosystems, social capital, and the F/P/T Committee of Officials' framework of promoting healthy aging all regard the environment as the foundation for the development of social networks which, in turn, mobilize resources and support to seniors in need of various types of support. Individuals and environment interact with and influence each other at all levels: the macro-environment (the community where older adults locate), the mezzo-environment (the building or block of seniors' homes) and the micro-environment (seniors' homes) (McPherson & Wister, 2008).

All levels of governments and the majority of practitioners and researchers in Canada believe in "aging in place" or "aging in community". In Manitoba, "aging in place" is a matter of preserving the ability for Manitobans from every culture to remain safely in their own community, to enjoy the familiar social, cultural and spiritual interactions that enrich their lives even though their health may be compromised (Manitoba Health, 2012). Therefore, "aging in place" is the primary principle in the planning of all provincial government initiatives on housing, community development, and long-term care for seniors.

Various types of housing environments for seniors have been established around the world and studied for their impact on seniors' social capital and healthy aging; some types of housing are able to facilitate the interaction among elderly residents, as well as improve connections between seniors and the broader environment, while other types almost induce or re-enforce social isolation or segregation (Evans, 2009; Cannusciol et al., 2003). For instance, gated or guarded communities, which are neighbourhoods surrounded by walls, can provide security, neighbourliness, and seeming social cohesion and social capital, but cost and available services may exclude older adults who are faced with financial barriers or who have special needs, such as ethnic diet, or services provided in the seniors' mother tongue. As well, "have nots" are often segregated from the "well offs", and the former are also less likely to have the social capital to advocate and lobby for themselves for needed services and amenities, such as seniors' centres, accessible transportation, or maintenance and renovation of public parks (Cannusciol et al., 2003). Other types of housing arrangements, including assisted-living developments and multi-tenant multi-level retirement houses, usually adopt a continuum of services to facilitate seniors with diverse needs in order to maximize the opportunities for social capital development. An inclusive listing of all housing options for seniors in Winnipeg is compiled by the Aging and

Opportunity: Support for Older Adults (see http://www.ageopportunity.mb.ca/housing/housing.asp).

To facilitate building a supportive environment for seniors of various cultural and social backgrounds, the WHO's report (2002) addresses the prevalence of culture in its *Active Aging* framework. Culture is one of the cross-cutting determinants of health because it influences individuals and populations in multiple aspects of life from personal/biological and behavioural/beliefs to physical and social environments. Including analysis of culture in empirical and practical work is to help social service providers to better understand cultural diversity and, in turn, increase cultural competence of social services in Canada. Research has informed us about immigrant seniors' needs and preferences in terms of general support intervention programs. Makwarimba and colleagues (2010) have found that older immigrants prefer services and programs that bring people together to conduct social or cultural activities and that help enhance communication within immigrant seniors and between them and others in the mainstream Canadian society; the service providers that immigrant seniors prefer are those of the same age, ethnic group, and who speak the same language; older immigrants also want to have their own cultural or ethnic senior centres where they can meet, speak their own language(s), cook their ethnic food, and have service information delivered through dissemination activities; seniors recommend a combination of one-on-one and group support, such as translators, transportation, meals, bill payments, and counselling; location and duration of services are also important to immigrant seniors as they need the locations of required services to be convenient and accessible, and the length of services should be extended to ensure sustainability and consistency. Such recommendations are relevant to researching and designing housing services for immigrant seniors because housing is one of the most significant factors

affecting health in later life, and direct evidence of immigrant seniors' housing needs are lacking in the current body of literature.

Housing environment is the context in which social capital can be either nurtured or restrained to generate a positive or negative effect on healthy aging. Investigation in this area is still in its infancy with minimal representation of academic endeavour (e.g., Moore et al., 2005; Cannusciol et al., 2003). No research has been devoted to the examination of the role of the housing environment in building social capital for immigrant seniors to achieve healthy aging, let alone a particular ethnic minority group like older Chinese-Canadians, despite the increasing size of this population and related social issues. Proper utilization of social capital in policy-making and social work practice to promote supportive environments requires more information and empirical evidence, particularly on the relationship between social capital and health outcomes and between social capital and residential environment for Chinese seniors.

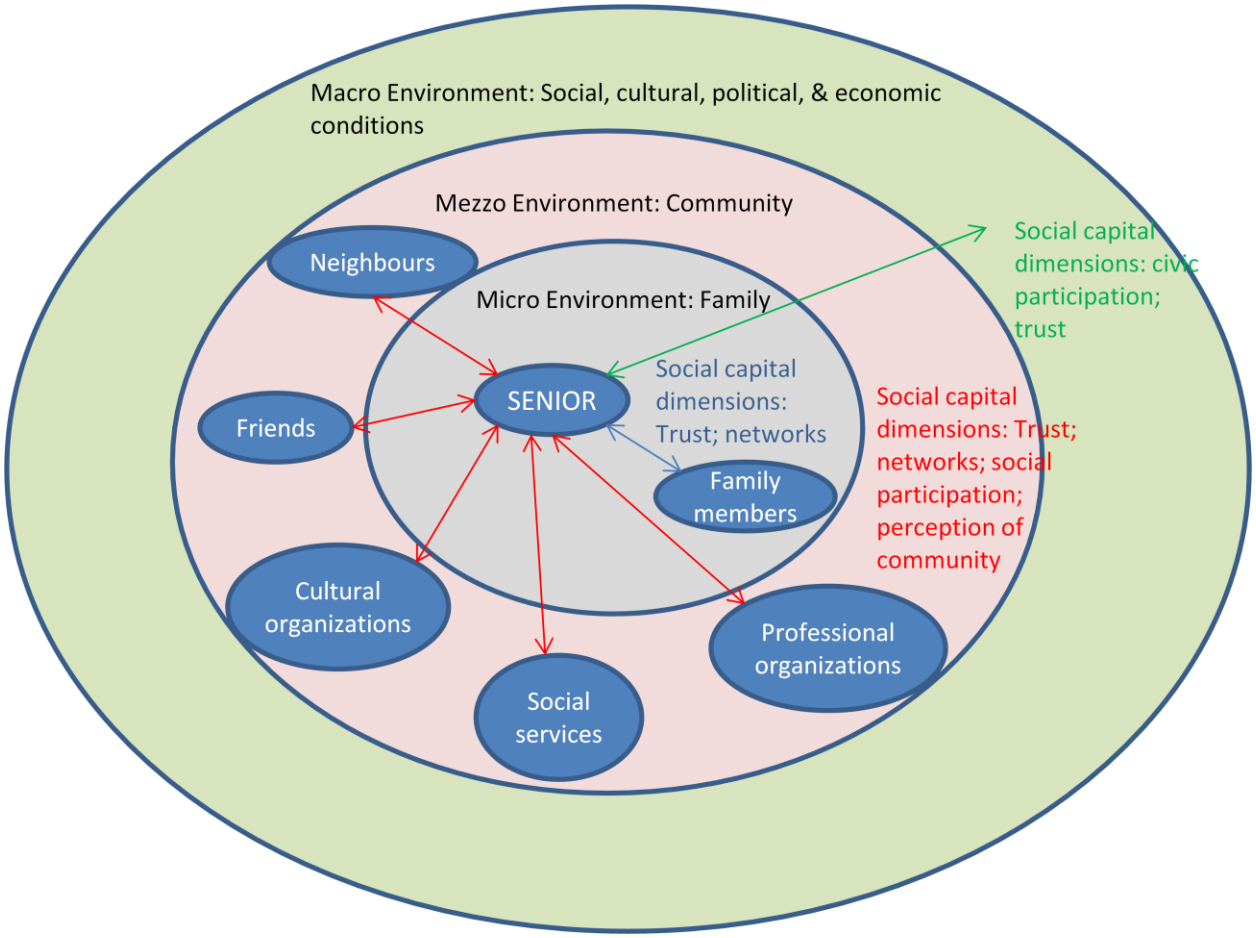
Summary

Social work as a human service profession aims to "help people develop their skills and their ability to use their own resources and those of the community to resolve problems" (Canadian Association of Social Workers, 2013). Using the ecosystems perspective to assess the problems, causation, and potential solutions for individuals, through analyzing their relationships with other actors (e.g., networks, culture, policy, economics, etc.) within an organic system, social workers formalize the important notion of environmental development (Payne, 2005; de Hoyos, 1989). Seniors' health and well-being, their social capital, and the residential environment in which they live are interrelated and interact with one another.

In order to illustrate the linkages among major relevant concepts, a conceptual framework (Figure 2.1) is presented based on *person-in-environment* (PIE) which is both a popular practice

approach in the field of social work and a graphic instrument to capture and classify the issues and relations at personal, family, community, and societal levels (Karls, Lowery, Mattaini, & Wandrei, 1997). The rubric of PIE vividly demonstrates interpersonal forces in a dynamic, complex context (Karls & Wandrei, 1992).

Figure 2.1 Framework of Key Concepts



In this framework, the senior is placed at the centre of various levels of environment, embedded in which are examples of diverse connections the senior has. "Senior" represents both personal factors contributing to health outcomes (i.e., SES, health behaviours) and health outcomes per se. The arrows signify the interactions between the individual and other key players in the environment. It should be noted that all other persons or organizations, shown in

the framework, also interact with each other, along with their connection to the senior at the centre. It is worth noting that cultural values and norms, although only indicated at the macro level, are influential to individuals and groups at all levels, affecting their behaviors and results in all social capital dimensions and health.

Healthy aging is a common goal for both individuals and Canadian society. Social capital has been proven to be positively correlated with health outcomes and well-being for immigrant seniors in previous studies (e.g., Lai & Chau, 2010; Campbell, 2000; Franke, 2006; Murayama et al., 2012). Although researchers and policy-makers have realized the importance of supportive environments for achievability of healthy aging, the elements of such environments and how they enable the mechanism for healthy aging of older adults still remains unidentified. This study aims to explore and identify the critical elements in the relationships among the three key concepts - healthy aging, social capital, residential environment - which lead to a preliminary understanding of the mechanism of a health-enabling environment. Building an environment that nurtures social capital is essential to maximize health outcomes for the Chinese senior population and the general society.

Besides the framing and enabling forces - community environments and social capital, other factors are also generally considered influential to older adults' well-being (WHO, 2002; Chappell et al., 2008; Litwin, 1998). For example, the World Health Organization (2002) notes six key determinants of health in its *Active Aging: A Policy Framework*: behavioral determinants, personal determinants, physical environment, social determinants, economic determinants, and health and social services. Chappell et al. (2008) describe a slightly different structure with similar elements in health promotion among Canadian seniors, using three categories: *biological*, *lifestyles*, and *environment*. *Biological determinants* include genetic and physiological factors that are personal and less modifiable than other determinants. Examples of biological influences

are our immune and hormonal systems, and hereditary factors that may make us susceptible to certain diseases. *Lifestyles* are composed of *health beliefs* and *health behaviours* (Chappell et al., 2008; WHO, 2002). Health beliefs are not only greatly shaped by individuals' cultural and social backgrounds, but are also closely related to health locus of control, a person's mindset of his or her health conditions, that is, whether or not the illness can be managed by the individual, other people in the network, or health care professionals (Chappell et al., 2008). Individuals' health beliefs, in turn, directly affect their health behaviours, such as whether to use preventive care services, and whether to conduct self-care activities like reducing smoking or having nutritious meals (Chappell et al., 2008). *Environment* includes *physical environment* and *social determinants*. Physical environment has been elaborated upon in preceding sections; social determinants are different, although related to the social factors including social capital. Social determinants - socio-economic status (income, occupation, education, and location of residence), social class, gender, age, and ethnicity - are all considered to have a profound impact on individuals' health and their accessibility to needed services (WHO, 2002; Chappell et al., 2008). These health determinants, although not the focus of this study, should not be ignored in understanding the relationship of social capital, a supportive environment, and healthy aging for immigrant seniors.

Previous research has indicated that both the residential environment and social capital are essential to seniors' health and well-being (e.g., Health Canada 2006; Lai & Chau, 2010), but how environment directly or indirectly affects accumulation or depletion of social capital remains understated and unclear. Many previous studies on social factors of health have tended to focus more on the direct personal, emotional, and social support provided by seniors' networks, rather than on the provision of *access* to supporting resources (Bouchard et al., 2006a, 2006b; Franke, 2006). The study here, however, aims to explore the relationship between social

capital and health outcomes by analyzing how social capital and community environment prevent or encourage the access to resources. Once seniors are able to connect and utilize the programs, services, and supports available to them, it is expected that they will form a solid foundation to achieve healthy aging.

The proposed research attempts to answer the following questions:

- What are the relationships between social capital and health indicators for Chinese seniors in Winnipeg?
- What are Chinese seniors' experiences and expectations of their residential community environment and social capital in relation to their health and well-being?

Chapter Three

RESEARCH DESIGN

Methodological Issues in Studying Older Chinese-Canadians

Minority gerontology has, unexceptionally, presented an unbalanced amount of quantitative and qualitative empirical research. Based on the researcher's calculation of ongoing collection of recent publications of research on older Chinese-Canadians in the last decade, 90% of the studies have been conducted with quantitative methods (e.g., Chappell & Kusch, 2007; Lai & Chau, 2007) while only 10% are qualitative (e.g., MacKinnon, Gien, & Durst, 2001). More qualitative studies regarding older Chinese can be found in American literature (e.g., Lee & Chan, 2009; Dong, Chang, Wong, Wong, & Simon, 2010). Among the research that has been done to investigate health aspects of Chinese seniors in Canada, none is qualitative. Quantitative methods have been applied in all recent important studies on the relationship between social capital and health for immigrants and seniors (e.g., Veninga, 2006; Lai & Chau, 2010; van Kemenade et al., 2006).

Given the prominent use of statistical analysis in research of seniors' and minorities' health, the power of qualitative approaches is largely neglected and underestimated, while the disadvantages of quantitative methods are over-tolerated, sometimes at the cost of false or incomplete explanations of researched phenomena (e.g., Lai & Kalyniak, 2005). Little information on how minority seniors perceive and take care of their lives and health has been provided. Seniors' own narratives are excluded in most analyses and discussions. Furthermore, the complexity of social and environmental factors is undermined and oversimplified in quantifiable data (Lai & Leonenko, 2007).

In spite of very lively debate of research paradigms, consistent agreement about combining quantitative and qualitative methods can be found in various fields of health and social sciences research (Galo, Braakmann, & Benetka, 2008). With the appreciation of philosophical diversity (i.e., all philosophies are equally useful in directing research), researchers are able to adopt a third paradigm where social reality is both causal and contextual, and use methods responding to the demands of research context (Greene & Caracelli, 2003, in Galo et al., 2008). A strategic integration of quantitative and qualitative methods has assisted the current study in mitigating predicaments in researching social phenomena for minority seniors.

Previous studies involving the analyses of social capital and health were mostly conducted with quantitative methods using secondary data from earlier social surveys (e.g., Bouchard et al., 2006b; Lai & Chau, 2010). Not only were the variables for social capital limited by the measurement developed within different theoretical frameworks, but the perceptions of social capital of the research participants were also missing from findings. Immigrant seniors' needs and concerns in relation to supportive environments, however, have often been studied with qualitative inquiry methods, including individual and group interviews and community consultation (e.g., Makwarimba et al., 2010; McDonald et al., 2001). Results of these studies were more applicable to their samples than to bigger groups, increasing the difficulty of developing programs and services for a certain population in a balanced perspective for all groups. Researchers, therefore, have suggested treating some of these as pilot studies and their findings as a starting point to develop further research projects (Makwarimba et al., 2010). This study aims to obtain Chinese seniors' perceptions of their social capital, residential environment, health, and the relationships among them, as well as to assess the needs of services related to a supportive living environment for these seniors. Therefore it is vital to collect perceptive

information and survey data from participants in the above-mentioned areas in order to describe the issues in a comprehensive manner.

Research Design of the Proposed Study

Methodological Framework of the Study

Given the discussion of the presented research questions and topics in relevant literature, a convergent mixed methods approach was adopted to study the issues faced by and the needs of Chinese seniors in Winnipeg, Manitoba. The model developed by Creswell and Plano Clark (2011) was applied to guide the design of the research structure. The convergent design is a research method by which both quantitative and qualitative data are collected and analyzed during the same stage of the research process, and then the two sets of results are merged into a general interpretation of findings (Creswell & Plano Clark, 2011).

Initially applied as a "triangulation" approach to obtain triangulated results of a single topic, the convergent design is often used for the purpose of "obtain(ing) different but complementary data on the same topic" (Morse, 1991 in Creswell & Plano Clark, 2011, p. 77). The key concepts of this study - health and well-being, social capital, and residential environment - require different types of data to describe and analyze what they mean for Chinese seniors. Quantitative and qualitative data of the particular phenomena are synthesized to develop a more comprehensive multi-faceted understanding of the topic.

Methods

This mixed methods study examines the effects and mechanisms of social capital in maintaining health and well-being of Chinese seniors in Winnipeg, as well as the interaction of

social capital and community environment, and how environment can nurture or limit individuals' social capital growth. In this study, a survey research approach was used to collect quantitative data of the health and well-being and social capital of the target group. The data were then analyzed with statistical methods to identify the relationships between the variables.

To collect the information of Chinese seniors' experiences of how their living environments had affected their social capital level, focus group interviews, with representatives of the target population, were conducted. Seniors were invited to express their concerns and expectations of their residential community environment enabling the promotion of health. Qualitative data analysis methods were applied to analyze the interview data.

The collection of both types of data was carried out at the same time, but were organized and examined separately. The respective results are combined and reviewed together to reach comprehensive, cohesive conclusions.

The review of previous research has offered useful measurement tools for two of three major components in this study - health and social capital of immigrant seniors - thanks to abundant literature in the two fields. A survey questionnaire was designed to collect data of Chinese seniors' social capital level and health status (see Appendix I). Seniors' needs and preferences in housing nurturing social capital, however, were collected by proposing research questions in focus group interviews. Chinese seniors had a chance to elaborate in a group setting with the researcher how their living environments had encouraged or limited their social capital, and how they perceived a better environment could improve social capital, and, in turn, well-being and health.

Collecting Quantitative Data

As dependent variables, health outcomes are measured by the Medical Outcomes Study 36-Item Short Form (SF-36). SF-36 is a well-established assessment instrument of health and quality of life. It has been used to measure indicators of concepts beyond narrow health outcomes, such as quality of life (e.g., Bodner, Cohen-Fridel, & Yaretzky, 2011), and has been applied to diverse cultural and social groups (Ware, Kosinski, & Keller, 1994; Yu, Coons, Draugalis, Ren, & Hays, 2003). The inventory measures eight categories of individuals' well-being: 1) physical functioning; 2) role limitations due to physical health; 3) bodily pain; 4) perceived health; 5) vitality; 6) role limitations due to emotional problems; 7) mental health; and 8) social functioning. The measures yields scores for two dimensions, the *physical component summary (PCS)* and the *mental component summary (MCS)* (Ware, Kosinski, Bayliss, McHorney, Rogers, & Raczek, 1995). Both summary scores range between *0* and *100*. The higher the scores, the better the quality of life of respondents. The scale has also been translated and adapted for respondents of Chinese background, and psychometric evaluation confirms its reliability and validity (Ren, Ameick, Zhou, & Gandek, 1998).

Cronbach's α reliability coefficient over .80 and good construct validity for each of the scales have been found with the original English version of SF-36 (Bodner et al., 2011). For the Chinese version, adapted particularly for Chinese people in North America, the internal consistency reliability is estimated .60 to .88 across the scales; test-retest reliability ranges from .67 to .90; and equivalent-forms reliability ranges from .81 to .98 (Yu et al. , 2003). When the North American Chinese version was applied in a cross-Canada study of older Chinese, a Cronbach's α of .90 was reported for the PCS and .85 for the MCS (Lai et al., 2007; Lai & Chappell, 2006).

When selecting an appropriate instrument to measure social capital, the researcher must pay particular attention to both the comprehensiveness and applicability of the instrument to the

Canadian context. Several Canadian-based questionnaires and research models, such as the network approach recommended by Bouchard and colleagues (2006b), and a more inclusive questionnaire proposal by van Kemenade (2003), both commissioned by Health Canada, were examined. However, the former seems to have simplified the complexity of social capital to a short 6-question scale, while the latter includes certain measures that appear less relevant to the understanding of social capital in this study, including the questions which supposedly indicate social cohesion about broad and abstract social values, such as what the goals of the country should be in 10 years, economic growth, strengthening armed forces, empowering people in employment, or beautifying cities and countryside. British and Canadian government sectors and scholars joined in the international discussion and development of the concept of social capital a decade ago (e.g., the UK ONS International Conference on Social Capital Measurement in London, 25-27 September, 2002) which concluded that social capital measurement should cover at least five important dimensions — trust, social networks and support, civic participation, social participation, and perception of community. To date, the UK ONS has established a comprehensive database of social capital indicators and measurements based on a consistent definition and interpretation of the social capital construct (please see more details at http://www.statistics.gov.uk).

The operational definition of social capital in this study is "networks together with shared norms, values and understanding that facilitate co-operation within and among groups" (in Bryant & Norris, 2002, p. 3; Green & Fletcher, 2003, p. 5). The measurement framework is the latest and most comprehensive one developed by Foxton and Jones (2011) for the UK ONS. It encompasses five dimensions (trust, networks, social participation, civic participation, and views of community) of social capital (Table 3.1). A few minor changes in wording were made to adjust the questions into a Canadian context. For example, "Welsh Assembly" and "Scottish

Assembly" in the question set for *trust* were replaced by the equivalent institute in Manitoba, the Government of Manitoba. British spelling of certain words such as "organisation" were re-spelled in the Canadian way as "organization".

Table 3.1 Social Capital Measurement Framework (Adapted from Foxton & Jones, 2011)

Dimension	Definition	Examples of Indicators
Views of the local area	Individual perceptions of the area in which they live. This dimension is included as an aid for analysis and is not considered an aspect of social capital. Positive views of the local area are a good correlate for how happy, safe and secure people are within their environment.	• Views on physical environment • Facilities in the area • Enjoyment of living in the area • Fear of crime
Reciprocity and trust	The amount of trust individuals have in others, those they know and do not know, as well as trust in formal institutions. Trust is seen as being closely linked to social capital, either as a direct part of it or as an outcome.	• Trust in other people who are like you • Trust in other people who are not like you • Confidence in institutions at different levels • Doing favours and vice versa • Perception of shared values
Civic participation	Individual involvement in local and national affairs, and perceptions of ability to influence them.	• Perceptions of ability to influence events • How well informed about local/ national affairs • Contact with public officials or political representatives • Involvement with local action groups • Propensity to vote
Social networks and social support	Contact with, and support from, family and friends. These are seen as important sources of social capital. The number and types of exchanges between people within the network, and shared identities that develop, can influence the amount of support an individual has, as well as giving access to other sources and help.	• Frequency of seeing/speaking to relatives/friends/neighbours • Extent of virtual networks and frequency of contact • Number of close friends/relatives who live nearby • Exchange of help • Perceived control and satisfaction with life
Social participation	Involvement in, and volunteering for, organized groups. Some indicators measure sources of social capital (e.g., those related to the personal contacts and interactions that are made by meeting people through clubs, churches, organizations, etc). Others are measuring outcomes of social capital. For instance, voluntary work is an important indicator of people's willingness to undertake activity that benefits others and the wider community.	• Number of cultural, leisure, social groups belonged to and frequency and intensity of involvement • Volunteering, frequency and intensity of involvement • Religious activities

To understand other factors in the community environment for Chinese seniors' to achieve healthy aging, use of health support services were included in the questionnaire as well.

Information about seniors' demographic background, SES information, such as gender, age, marital status, living arrangement, education, personal monthly income, and English competence were also collected to provide contextual interpretation to the relationships of key variables. All the variables were measured with the respective scales developed by Lai and colleagues in a large-scale survey study of older Chinese in Canada which has generated a considerable number of publications (e.g., Lai et al., 2007; Lai, 2004a, 2004b; Lai & Surood, 2009; Lai & Kalyniak, 2005; Lai & Hui, 2007). The use of the Available Services Scale contains ten categories of services that respondents could check *yes (1)* or *no (0)* to indicate whether he or she has used the service. A higher score means a higher level of use of health support services. Gender was grouped into *male* and *female*. Age referred to the chronological age of the respondents. Marital status was grouped as *married* or *unmarried*. Education level was presented by four categories: *no formal education, elementary, secondary,* and *post-secondary*. Personal monthly income was be grouped into eight categories: *less than $500, $500 to $999, $1,000 to $1,499, $1500 to $1999, $2000 to $2499 , $2500- $2999, $3000 - $3499*, and *$3500 and over*. Living arrangement referred to with whom the respondents are residing at the time the survey is conducted. Self-rated English competence was assessed by two Likert-scale questions, *understanding English (not at all, a little, or very well)* and *speaking English (not at all, a little, or very well)*. Respondents received a score ranging from 2 to 6 with higher scores representing a higher level of English competence.

Collecting Qualitative Data

Upon finishing recruitment of focus group participants with the sampling methods in the preceding section, two focus group interviews were conducted with seniors in central Winnipeg and two with seniors in Winnipeg south. Focus groups are structured group interviews that bring

together a group of 6 to 10 individuals to interactively discuss topics of interest, under the guidance of a facilitator (Hoyle, Harris, & Judd, 2002). Too few participants make it less likely to generate a desired diversity of opinions, whereas too many makes it difficult for everyone to secure enough time to express themselves (Hoyle et al., 2002). Focus group participants were provided an opportunity to fill out the questionnaire before the focus group interview.

The use of a facilitator in all group interviews distinguishes focus groups from unstructured group discussions (Hoyle et al., 2002). The researcher/interviewer engaged in considerable preparation to ensure the quality of focus group interviews by encouraging elicited and focused discussions. A focus group guide was developed to provide a road map in the interview. The guide contained the major topics and questions that were raised in a focus group (Hoyle et al., 2002). Given that an interview often lasts 1 to 2 hours, two major issues with two or three

Table 3.2 Focus Group Interview Guide

Objective: Determine the characteristics of the community residential environment that nurtures and promotes social capital for Chinese seniors.

Suggested explanations to *social capital*:
Social capital can be understood as the people, groups, and organizations you know in your life. You trust them, and they trust you. If you have a problem, you know you can rely on one or some of them for help. You also help them, too, if they need it.

Topic 1: Participants' perceptions of their current life, social capital level, and environment

Questions:
1. Could you please share with me what your life is like? What do you like and/or dislike about your life?
2. Could you describe to me your home and the neighbourhood in which you live? What do you like and/or dislike about your home and neighbourhood?
3. How are your relationships with people around you? Anything you like or dislike?
4. Could you describe any organizations or activities outside your home that you have been involved in?
5. Could you please tell me about any social or health care services that you have received? How did you learn about them and attain them?
6. Are you aware of other services or activities that you would like to have but have not had? Why have you not had pursued them?

Topic 2: Participants' expectations of social capital and environment

Questions:
1. If you could change or improve your relationships with people around you, what would you like them to be?
2. Are there organizations you would like to be involved in more? Or less? How do you think you can achieve that?
3. What kind of changes or improvements would you like to see in your neighbourhood?

questions each were presented in the focus group interviews of the study. All interviews were audio-taped, after acquiring informed consent of all participants (more detail in the Ethical Considerations section). The interview guide included, but was not restricted to, the above open-ended questions (Table 3.2).

Implementation of the Research

Pretest of the Survey Questionnaire

The questionnaire was available in traditional Chinese, simplified Chinese, and English to allow prospective respondents to choose their preference. It was designed to be conducted by the researcher or a research assistant with respondents on a one-on-one basis, either in person or by phone. An introduction on the front page explained the purpose of the research and participants' rights. Participants could choose to read the introduction themselves or request the interviewer to read it aloud to them. They were provided the opportunity to ask questions and to decide whether to grant or decline their consent to participate in the research (see Appendix I).

Three seniors from mainland China were recruited from the mainland Chinese community in south Winnipeg on May 17 and 19, 2013, and five seniors from a retirement building in Chinatown on May 27 to participate in the pretest. The simplified Chinese and traditional Chinese versions of the questionnaire were used in the pretest. Respondents' ages ranged from 67 to 82, included four males and four females, and they had been living in Winnipeg for from four to thirty-four years. After the purpose and the procedure of the research survey and their rights had explained to them, all participants signed the consent. Prospective respondents were offered the choices of self-administering the questionnaire or having the researcher filling it out for them. All seniors chose to fill out the questionnaire by themselves. Two seniors requested

questions to be read aloud and explained to them when they were reading, and others required minimal assistance and explanations from the researcher. The two seniors, with some assistance in reading and explaining the questions, needed 1 hour to finish the questionnaire; the seniors requiring minimal assistance completed the questionnaire in 45 minutes. The respondents were asked their opinions on the questionnaire, including meaningfulness of the questions, wording, format, and structure. The respondents in the pre-test commented that the questions were "very detailed", "clear and understandable wording", and that "multiple choice is easy for seniors to respond to the questions". One senior said, "The questions show the (researcher's) concerns of average people: their daily lives, their activities, their emotions, their networks, and their rights, particularly human rights. All these are embodied in the questions." As a result of the overall positive feedback, no major changes, except a few typos, were made to the questionnaire. The questionnaire in both traditional and simplified Chinese was then finalized for collection of quantitative data with Chinese seniors in Winnipeg. No changes were made to the English version.

Sampling and Recruitment of Respondents

The number of Chinese seniors born outside Canada, whose first language was not English or French, who had obtained Canadian citizenship or landed immigrant status, who were currently residing in Winnipeg, and who were 60 years of age or older (Statistics Canada, 2010; Centre on Aging, 2010; Li, 2009) was estimated to be between 3,200 and 3,500. This population formed the sampling framework for the proposed study. These seniors were independent immigrants, family-sponsored immigrants, or refugees over the last several decades, and they

lived either with their families or independently in the community. A complete list of all eligible respondents was not available for sampling purposes.

The Chinese population in Winnipeg is concentrated in Chinatown (downtown Winnipeg) and Fort Richmond (south Winnipeg). In Chinatown, most Chinese, including seniors, reside in two not-for-profit community apartment buildings, Sek On Toi Building (seniors' apartment housing) and Harmony Mansion, whereas in Fort Richmond, seniors generally live with their adult children in private houses. Some seniors also reside in apartments in other areas of the city which accept senior housing subsidies, such as the City Oasis Building in central Winnipeg and 2900 Pembina Highway in south Winnipeg. Seniors living in the central area, but not in Sek On Toi, often have a strong connection to the Winnipeg Chinese Cultural and Community Centre, visiting regularly and participating in activities and programs designed for seniors or the general population. Many Chinese seniors living in the south end of Winnipeg attend the Chinese Epiphany Lutheran Church on a regular basis, usually with friends or family members. In addition, some Chinese seniors take part in the programs and services provided by A & O: Support Services for Older Adults, the largest agency that offers social support to older adults in Winnipeg, in various community locations.

Nonprobability sampling strategies were applied to recruit respondents. Given the situation of the unavailability of a complete list of the target population and other limited resources, seniors were recruited to fill out survey questionnaires through convenience sampling as well as snowball sampling, in which the researcher simply gathered data from the individuals close at hand and recruited new respondents through existing respondents' networks (Hoyle et al., 2002). As frequently used purposive sampling strategies, convenience sampling and snowball sampling provide researchers with accessible and volunteer respondents, at relatively low cost and in a shorter period of time (Kemper, Stringfield, & Teddlie, 2003). However, there is no known

statistical way of assessing sampling errors, the deviation of the sample means from the population values, in research of accidental sampling (Fowler, 2009).

One way to improve the representativeness of the sample is to ensure as many eligible individuals of the population as possible be included in the recruitment process. Two presentations of the study were made to two groups of seniors for recruitment purposes, one in the Chinese Epiphany Lutheran Church in Winnipeg south, and the other at the Sek On Toi Building. Seniors attending the presentations were encouraged to share the research information with their friends, neighbours, and within their networks. The recruitment notice and a short article on the project were published in five Chinese print media, including *Chinese Tribune* which targets relatively new immigrants from mainland China, and *Manitoba China Times* targeting Cantonese from Hong Kong, Cambodia, Laos, and Vietnam who are usually longer-term immigrants. Recruitment posters were placed in the Chinese Cultural and Community Centre (WCCCC), two residential Buildings and some Chinese restaurants in Winnipeg. With the multi-location, multi-method, and multi-media strategies of recruitment, it was anticipated that a considerable number of qualified individuals were reached and encouraged to complete the survey questionnaire within the data collection timeline.

As strongly suggested by the WCCCC, the recruitment poster indicated that all eligible seniors (i.e., those born outside Canada, first language not being English or French, aged 60 and over, being a Canadian citizen or landed immigrant, and currently living in Winnipeg) were invited to one of the four research gatherings held in the boardroom of WCCCC. The poster informed audiences that they could choose to participate in either or both of the questionnaire survey and the focus group interview at each gathering. Light refreshments and honourariums were provided. The four times were: 1:30 – 4:00 p.m. June 8, Saturday; 1:30 – 4:00 p.m. June 15, Saturday; 1:30 – 4:00 p.m. June 19, Wednesday; 1:30 – 4:00 p.m. June 22, Saturday. Seniors

who were willing, but not able, to attend any of the above-mentioned gatherings were encouraged to contact the researcher by phone or email to arrange a suitable time and location for them to partake in the research.

Data Collection in the Field

As a result of the presentations and advertisements in the community, the researcher received enthusiastic responses from Chinese seniors. Ten seniors called to invite the researcher to visit their residences at their convenience to conduct the research with self-organized groups. Seniors who made the initial calls usually had the influence of the community as "leader" of small groups of friendship, Bible study groups, or English classes. Therefore, they arranged to have qualified respondents attend the questionnaire sessions and focus group interviews, as well as locating venues for such interviews. Four of the five such self-arranged research gatherings took place in someone's home, and one in a neighborhood park, where a dozen to twenty Chinese seniors met every morning to do recreational exercises, if weather permitted.

During the first four gatherings of prospective respondents, all seniors were offered the choice of participating in focus group interviews upon completion of the questionnaire. All questionnaire respondents agreed to take part in the focus group interviews. Four focus groups interviews were thus conducted: two with seniors in central Winnipeg and two with seniors in Winnipeg south. These focus groups were structured group interviews which brought together a group of 7 to 13 individuals to interactively discuss topics of interest, under the guidance of the researcher. Separate consent forms for the questionnaire and the interview, approved by the Ethnics Board of University of Manitoba, were explained to and signed by each respondent before they proceeded to the questionnaire/interviews.

Each interview lasted 1 to 2 hours; two major issues with three to six questions each were presented in the focus group interviews. . The interview guide (Table 3.2) included, but was not restricted to, these open-ended questions. All interviews were audio-taped, after acquiring informed consent of all participants.

Sixty respondents of the questionnaire and all 43 focus group interviewees were recruited through the gatherings initiated and coordinated by respondent seniors. Thirty-three seniors attended the meetings at the WCCCC, but no focus group interviews were conducted, as all four proposed interviews had been completed before the first meeting date at the WCCCC. There was another reason for not conducting interviews with the attendees at WCCCC meetings: most seniors were dropped off and would be picked up by their family members at predetermined times, and they were unable to stay long enough to participate in both questionnaire and interview sessions. Upon offering the chance to choose, most opted for filling out the questionnaire only, except for one senior who insisted on being interviewed regardless of lack of a focus group circumstance. Therefore, she was the only one interviewed among the respondents attending the WCCCC gatherings. As it was proposed that the data collection process would end when either the three-month timeline or a total of 80 questionnaires and four focus groups interviews of 40 seniors were reached, data collection activities ended when 101 questionnaire copies were completed and collected and four focus groups with 43 seniors were conducted.

Data Analysis

Mixed methods data analysis involves looking across the qualitative results and the quantitative findings to make an interpretation of how the information answers the research questions in a study (Creswell & Plano Clark, 2011). It consists of analytical methods applied to

both quantitative and qualitative data. Teddlie and Tashakkori (2009) consider "mixed methods as a vehicle for improving the quality of inferences that are drawn from both the quantitative and qualitative methods" (in Creswell & Plano Clark, 2011, p. 213). Upon separately analyzing the quantitative data and qualitative data, the study integrated all data into a coherent whole to answer the research questions (Onwuegbuzie & Teddlie, 2003).

Quantitative Data: Survey

PASW Statistics 18 for Windows software was applied to enter and organize the data gathered in the questionnaire survey. Descriptive statistics, including frequency distributions and means, were used to examine the demographic information. Data screening processes were used to evaluate the extent to which the raw data met the assumptions of desired statistical tests. Distributions of values were examined for variables with interval values (e.g., PCS, MCS). Bi-variate statistics were applied to test the relationships between each IV and DV (Tabachnick & Fidell, 2007).

Qualitative Data: Focus Group Interviews

Four focus groups interviews with 43 seniors yielded five hours and twenty-three minutes of audio recording. Audio-taped interviews were fully transcribed and entered into the Nvivo 8 program. Grounded theory data analysis methods were applied to guide the coding and analysis of data. Initial coding was used to examine data line-by-line in a spontaneous manner to stay close to the data and remain open to all possible theoretical directions (Charmaz, 2006). Focused coding (or axial coding) helped to sort, synthesize, and organize large accounts of codes, labels, and categories (Strauss & Corbin, 1990). Constant comparative methods were applied to identify

and modify significant themes and sub-themes (Charmaz, 2006). Memo-writing was helpful in conceptualizing "blocks" to build a theoretical model by making connections and comparisons between and within data, codes, and categories (Charmaz, 2006).

Combining Quantitative and Qualitative Results

To address the two major research topics, *the relationships between social capital and health* and *environmental factors to improve social capital*, the analyses of both quantitative data and qualitative data will be merged in the presentation of the results (Creswell & Plano Clark, 2011). Seniors' social capital assessment and their use of supportive health services will contextualized and interpreted with the qualitative findings of their experience of social network in their living environment. The two types of data can provide diverse perspectives to answering the research questions that share one common topic: how to improve Chinese seniors' physical, mental, and social health. While the quantitative statistics aim to identify the relationship between social capital and mental and physical health of Chinese seniors, focus group interview data offers insights on how seniors view their lives and how social capital could be built and strengthened through environmental support. Understanding the importance and means of community development is crucial for social work professionals who work with immigrant seniors, because their mission is to provide support and advocacy at personal, family, community, and social levels. The integrative analysis will lead to a discussion on implications for policies and practice that attempt to improve Chinese seniors' social capital through building a supportive environment in order to achieve optimal outcomes for healthy aging. A synthesis of the quantitative and qualitative data results will be presented from Chapter Five to Chapter Ten.

Ethical Considerations

The research was approved by the University of Manitoba Psychology/Sociology Research Ethics Board, which is organized and operates according to the Tri-Council Policy Statement. For focus group interviews, respondents were provided with a detailed letter describing the research purpose, confidentiality issues, respondents' rights during and after the research, and the benefits and potential risks of taking part in the research. Respondents, if they agreed to participate, then signed the letter of consent to continue with further research activities. All consent was obtained in written form, after the detailed research information and consent form had been explained and all questions had been answered. Respondents were reminded that their anonymity could not be guaranteed and that they were free to withdraw from the research at any given time, stop the audio taping and/or refrain from answering questions that they preferred to omit, with no repercussions.

In order to protect respondents' confidentiality, the researcher is the only person who has full access to the information collected in the project. No individual names and personal identifiers, but file numbers, were used on completed questionnaires. All data were analyzed in an aggregate form. In the case that individual personal information was necessary in the transcripts and publications of the study, pseudonyms were assigned and used. All information is kept strictly confidential. Documents related to the interviews are stored on the researcher's password-protected personal computers. Respondents' signed consent forms, interview tapes and hand-written notes, if any, are stored in a locked cabinet in the researcher's home. Documents with respondents' identifiable information will be destroyed within 12 months of the completion of the research.

Summary

A convergent mixed methods approach was employed to study older Chinese immigrants' health status, social capital levels, and residential environments. Collection and analyses of the quantitative and qualitative data were parallel, followed by integration of the groups of findings. The quantitative data was collected with 101 Chinese seniors in Winnipeg, applying a questionnaire composed of a Chinese version of SF-36 (Ren et al., 1998; Lai et al., 2007; Lai & Chappell, 2006), a five-component social capital measurement (Foxton & Jones, 2011), and demographic items from Lai and colleagues' studies of older Chinese-Canadians (Lai et al., 2007; Lai, 2004a, 2004b; Lai & Surood, 2009; Lai & Kalyniak, 2005; Lai & Hui, 2007). The qualitative data was collected through focus group interviews with 43 Chinese seniors with the use of an interview guide. Pre-test of the questionnaire was conducted; then nonprobability sampling was deployed to recruit research participants in collaboration with local Chinese community organizations and media. Descriptive and interferential statistics and grounded theory analysis methods were applied to analyze the quantitative and qualitative data respectively. The findings will be presented in the following chapters.

Chapter Four

DEMOGRAPHICS OF OLDER CHINESE ADULTS INVOLVED IN THE STUDY

This section describes the demographic variables of the sample, which provides contextual information for the analysis and discussion of data in later sections. The demographics of the focus group participants will be examined and presented separately, as they demonstrate certain traits deviated from the larger group, which may provide alternative interpretations to data analysis outputs. The demographics of the sample of the Chinese senior population in Winnipeg will then be compared with those of their national counterparts.

Demographics of the Sample

The demographic variables include age, gender, marital status, living arrangement, country of origin, English proficiency, years of residency in Canada, income, and educational level.

Description of Respondents by Age and Gender

Seven out of 101 respondents chose not to report their age. Among those who did, the youngest was 60 years old and the oldest 96. The average age was 73.87 with a standard deviation of 7.58. Table 4.1 presents the number and percentage of the respondents in different age groups. Half of the respondents fell into the age group of 70 to 79(n = 47, 50%); and the second largest group were the “young old” who were in their 60s (n = 29, 30.9%). Almost one out of five respondents was over 80 (n = 18, 19.1%).

Table 4.1 Age of Respondents

Age Group	Frequency	Percent	Cumulative Percent
60 – 69	29	30.9	30.9
70 – 79	47	50	80.9
80 – 89	17	18	98.9
90 +	1	1.1	100
Total	94	100	
Missing	7		

Older women outnumbered older men almost two to one in the study.. 35.6% of the respondents were male (n = 36) and 64.4% female (n = 65).

Description of Respondents by Marital Status and Living Arrangement

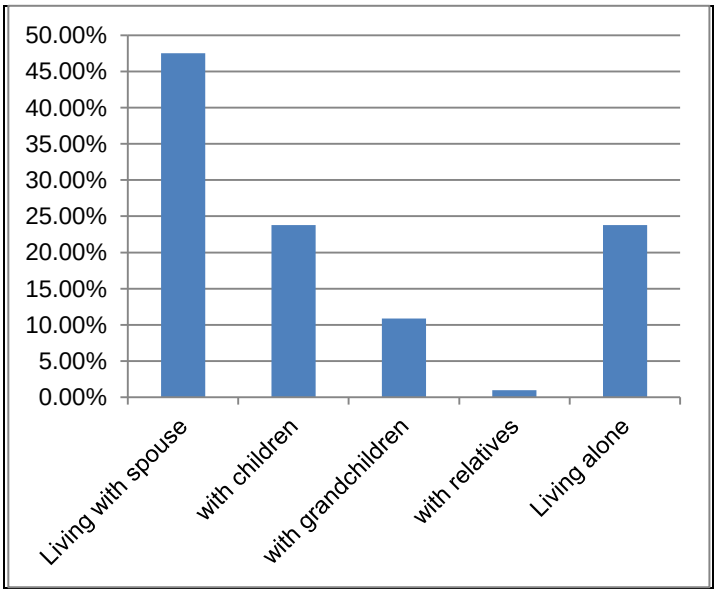
Table 4.2 illustrates that more than two thirds of the respondents were married (n = 69, 68.3%), a quarter widowed (n = 25, 24.8%), and three seniors had never married.

Half of the respondents lived with spouses (n = 48, 47.5%), and equal numbers of seniors either lived with their adult children or lived alone. Seven seniors (6.9%) lived with more than one category of family members including spouses, sons or daughters, grandchildren, or other relatives. None lived with siblings or friends (Figure 4.1).

Table 4.2 Marital Status of Respondents

Marital Status	Frequency	Percent	Cumulative Percent
Married	69	68.3	68.3
Widowed	25	24.8	93.1
Separated/Divorced	4	4	97.1
Single	3	3	100
Total	94	100	
Missing	7		

Figure 4.1 Living Arrangement of Respondents



Description of Respondents by Country of Origin, Length of Residency in Canada and English Proficiency

Table 4.3 indicates the countries/areas that the respondents were originally from. The majority were from mainland China (n = 72, 71.3%), and small percentages from Hong Kong (n = 16, 15.8%) and Vietnam (n = 11, 10.9). It is unfortunate that no seniors from Taiwan, which is another major source country of Chinese immigrants, participated in the research.

Table 4.3 Country of Origin of Respondents

Country of Origin	Frequency	Percent	Cumulative Percent
Mainland China	72	71.3	71.3
Hong Kong	16	15.8	87.1
Vietnam	11	10.9	98
Other	2	2	100
Total	101	100	

The average length of time living in Canada for the respondents was 19.78 years with a standard deviation of 14.19 years. The longest was 58 years and the shortest 1 year.

The Canadian government describes immigrants as "persons who are, or have ever been, landed immigrants in Canada. A landed immigrant is a person who has been granted the right to live in Canada permanently by immigration authorities." (Citizenship and Immigration Canada, 2009). Newcomers are often grouped under categories such as *long-term* (17 plus years), *short-term* (7 to 16 years), and *immediate* or *recent* (1 to 6 years), based on the length of the period of time an immigrant has been living in Canada (Elgersma, 2007; Dempsey, 2005; Palameta, 2004; National Advisory Council on Aging, 2006; Citizenship and Immigration Canada, 2009). Table 4.4 shows that more than half of the respondents of the research had been living in Canada for 17 years or longer (n = 55, 59.9%); nearly one out of four seniors were recent newcomers to Canada (n = 22, 23.9%), and 16 percent (n = 15) were short-term immigrants.

Table 4.4 Length of Residence in Canada

Years of Living in Canada	Frequency	Percent	Cumulative Percent
1 – 6	22	23.9	23.9
7 – 16	15	16.3	40.1
17 +	55	59.9	100
Total	92	100	
Missing	9		

Description of Respondents by Income and Education

Half of the respondents who reported personal income had a lower monthly income than $1,000 (n = 42, 50%); however, the largest income group was between $1,000 and $1,499 (n = 37, valid percent 44%). Nearly 17% of the seniors did not reveal their income (n = 17).

Only five percent (n = 5) of the respondents had not had any formal education, while more than one out of five (n = 24, 23.8%) had obtained university education. Most seniors had gone through secondary education including high school, community colleges, or vocational schools (n = 48, 47.5%).

The means of income are compared across the groups of different education levels through statistical tests for ordinal data (Spearman Correlation, Gamma, and Kendall's tau). No significant correlation is found between the respondents' income and education level.

Demographics of Focus Group Interview Respondents

The descriptive data of some of the variables of the focus group interview participants are summarized in Table 4.5. Among the 43 participants, 16 (37%) were male and 27 female (63%). One was under 65 years old, 9 (22.5%) between 65 and 74, 27 (67.5%) between 75 and 84, 3 over 85, and 3 seniors did not reveal their ages. The majority were married (n = 29, 67.4%); more than one in four was widowed (n = 12, 27.9%); one senior was divorced; and one never married. The average length of time living in Canada was15.8 years (SD = 9.6), the minimum being 1 year and the maximum 43 years. 23.1% had been living in Canada for 1 to 6 years, 23.1% for 7 to 16 years, and 53.8% for more than 17 years. 77% of the participants had been Canadian residents for more than 10 years. Thirty-eight participants (88%) were originally from mainland China, three from Vietnam, and only one from Hong Kong.

Almost half (48.8%) of the participants claimed that they understood a little bit of English and the other half (46.3%) not at all; only two seniors agreed that they understood English very well. Slightly more than two thirds of the seniors (n = 29, 67.4%) were living with their spouses,

children and/or grandchildren, while 14 lived alone. Only six (14.3%) of the seniors expressed their expectations of living with their adult children in the same household, while the majority (n = 32, 76.1%) were inclined to live in separate households from their children.

Table 4.5 Comparison of Descriptive Data of Focus Group Participants and Overall Sample

		Focus Group Participants	Overall Sample
Gender	Male	37%	35.6%
	Female	63%	64.4%
Marital Status	Married	67%	68.3%
	Not married	33%	31.7%
Country of Origin	Mainland China	88%	71.3%
	Hong Kong	2.3%	15.8%
	Vietnam	6.8%	10.9%
Length of Residence in Canada	1-6 years (recent)	23.1%	23.9%
	7-16 years (short-term)	23.1%	16.3%
	17 + years (long-term)	53.8%	59.9%
Understanding of English	Most of it	4.7%	12.9%
	A little bit	48.8%	45.5%
	Not at all	46.3%	36.6%
Physical Component Scale (PCS)	Mean (SD)	43.5 (20.5)	43.1 (11.1)
Mental Component Scale (MCS)	Mean (SD)	50.1 (10.1)	49.1 (9.8)
Living Arrangement	Living with someone	67.4%	76.2%
	Living alone	32.6%	23.8%
	Living with children	10 (23.3%)	N/A
	Living in separate household from Children	33 (76.7%)	N/A
Expectation of Living Arrangement	Living with children	14.3%	29.2%
	Living in separate household from children	76.2%	60.4%

Overall, the demographics appear similar between the focus group participants and the entire sample of the study, except the country of origin (variables with larger differences in percent are in grey shading). The percentage of seniors from Hong Kong was much lower in the focus group than in the overall sample, which may cause the qualitative data and findings more representive for Chinese senior population from mainland China than for those from Hong Kong. The focus group participants also indicated a slightly lower level of capacity to understand English. A lower percentage of the seniors in the focus group interviews than in the overall

sample lived with their spouses, children, grandchildren, and/or siblings (67.4% vs. 76.2%); and fewer of them wanted to live with their children (14.3% vs. 29.2%). In a rough description of a typical focus group interview senior, he or she was more likely originally from mainland China, speaks and understands little English, more likely living alone, and more likely prefers living in a separate household from his/her children's.

Comparison of Demographics between the Sample and General Chinese Seniors in Canada

The characteristics of the aging older Chinese in Canada were reported in a nation-wide study conducted by Dr. Lai (e.g., 2004a, 2004b) at the University of Calgary. Using a comprehensive survey including the SF-36, the study provided a detailed report on the demographics and health variables of the general aging Chinese population in Canada. The descriptive data of the sample

Table 4.6 Demographics of Winnipeg Sample and Older Chinese in Canada

		Overall Older Chinese (N = 2,272)	**Winnipeg Sample (N = 101)**
Age	In years, mean (SD)	69.8 (8.7)	73.9 (7.6)
Gender (%)	Male	44.2	35.6
	Female	55.8	64.4
Marital status (%)	Married	66.0	68.3
	Not married	34.0	31.7
Living arrangement (%)	Living alone	13.8	23.8
	Not living alone	86.2	76.2
Country of origin (%)	Born in Canada	1.6	0
	Mainland China	27.1	71.3
	Hong Kong	51.1	15.8
	Taiwan	4.4	0
	Vietnam	7.9	10.9
	Southeast Asia or other	7.9	2
Length of residence (%)	In years, mean (SD)	19.0 (13.7)	19.8 (14.2)
Education (%)	No formal education	12.7	5
	Elementary	28.3	23.8
	Secondary	37.8	47.5
	Post secondary	21.1	23.8
Monthly income (%)	Less than $500	16.4	23.8
	$500 - $999	38.0	26.0
	$1000 - $1,499	34.2	44.0
	$1,500 & above	11.4	4.8

of Chinese seniors in Winnipeg are compared with that of the general Chinese seniors in Canada in Table 4.6 to identify the discrepancies and similarities of the two populations.

Compared to the general aging Chinese population in Canada, the seniors in Winnipeg were slightly older by 4 years (69.8 vs. 73.9 years); and there were more female seniors by roughly 9% in the Winnipeg sample (55.8% vs. 64.4%). The number of seniors who were married and not married (including divorced, separated, widowed, and single) was similar in both populations; however, about 10% more of the Winnipeg seniors lived alone, compared to the Chinese senior population in Canada (13.8% vs. 23.8%). There were no representatives from the Taiwanese community and those who were born in Canada in the Winnipeg sample. The number of seniors in Winnipeg whose country of origin was mainland China was 2.6 times of that of the national survey (71.3% vs. 21.7%), while those from Hong Kong were much fewer in the Winnipeg sample than in the general older Chinese-Canadian population (15.8% vs. 51.1%). There were also more Chinese from Vietnam in Winnipeg than in the national survey (10.9% vs. 7.9%). Regardless of the discrepancies in country of origin, the average length of residence in Canada was similar for both populations (19 – 19.8 years).

More seniors had obtained formal education in Winnipeg than in the national survey. While generally one out of eight (12.7%) of the older Chinese-Canadians had never attended school, only one out of twenty Chinese seniors in Winnipeg had not. Furthermore, a higher percentage of Winnipeg Chinese seniors had completed both secondary (47.5% vs. 37.8%) and post-secondary (23.8% vs. 21.1%) education than their counterparts across Canada. Compared to their national counterparts, a Chinese senior in Winnipeg was more likely to be a woman with secondary school education from mainland China who presently lives alone.

In Winnipeg, the percentage of seniors in the lowest income bracket (< $500) was higher than that of the Canadian Chinese senior population (23.8% vs. 16.4%), but the percentage of seniors in the highest income bracket (> $1,500) was much lower (4.8% vs. 12.4%). More than four out of ten seniors enjoyed a monthly income between $1,000 and $1,499, the percentage of which is higher than that of the national estimate; however, more seniors were living at the lowest income (less than $500 per month), and fewer were at the highest income bracket ($1,500 and above).

Summary

This chapter focuses on providing a general picture of the targeted group of the research. It has been a common phenomenon to see more female senior citizens than male, including the national Chinese senior population. It was similar in this study except that the number of female seniors were almost double that of male, with a female-male ratio of 1.8:1. More seniors from mainland China than from other Chinese speaking countries/regions participated in both the survey and the focus group interviews. More than half of the participants had been living in Canada over 17 years; but the majority of them did not speak English or only spoke a little English. Compared to the overall older Chinese population in Canada, more Winnipeg Chinese seniors had acquired formal education and almost half of the sample had completed secondary education. Approximately half of the seniors lived on a monthly income under $1,000; however, a slightly smaller but similar number of seniors enjoyed stable financial incomes between $1,000 and $1,499, which exceeded that of their national counterparts by ten percent. Although a large percentage of them lived with a spouse, an adult child, or other family members, about a quarter of Chinese seniors lived alone.

Chapter Five

ALL-ENCOMPASSING FACTORS IN CHINESE SENIORS' LIVES

Two groups of factors that seemed to have an impact on multiple dimensions of seniors' lives emerged from the analysis of the data. However, some factors affected their daily lives directly and others were subtle but sett the attitudinal foundation for seniors' perceptions and expectations of other issues. The two groups are: 1) general attitudes toward old age life in Canada; and 2) challenges related to language.

General Attitudes toward Old Age Life in Canada

Comments such as "we Chinese seniors are happy living here" or "the government supports us; it's good, and we're happy" were frequently expressed at the beginning of each focus group interview. The respondents were generally appreciative of the natural environment in Canada, social environment and interaction, and social support and welfare for seniors.

Comparing the natural environment in Canada with that in China, the seniors were honest about the water, air, and food pollution in China which has affected the health and safety of the general public; whereas "Canada had been rated as one of the top five countries in the world for best countries to live in". Some indicated their health had improved as chronic conditions like asthma had been reduced or almost disappeared since they had moved to Canada. The seniors also mentioned that many outdoor activities were available free of charge throughout the summer to provide entertainment to the general public. Regardless of partaking in those activities or not, the seniors considered them as a positive element in their lives in Winnipeg.

The Canadian social environment received equivalent compliments from the respondents. Canadians had generally been friendly and willing to conduct positive interactions with Chinese immigrants in everyday life. One respondent noted: "I think foreigners [Canadians] are very pure and friendly, especially Canadians. They have positive impressions of Chinese." The seniors felt welcomed by and accepted as part of the society: "I felt that we are part of Canada since we have come here and been living in the society. No matter we live here permanently or have become citizens, we are part of Canada."

Canadian welfare supporting seniors' old age living was commented on the most during the discussion of current living situations. The seniors expressed gratitude for the stable financial support they received from the government because they felt generously taken care of even though they had not worked here before retirement or contributed to Canada's revenue, and most of them did not have any other sustainable sources of income. Health insurance was the most important benefit to seniors, due to their frequent use of health care services, especially compared to the significant costs for health care paid by individuals and families in China:

> "[The welfare for] health care costs is pretty good here. The health insurance has taken a large amount of the government's budget. I read some reports and they said that the health care expenses were only a small portion of the government budget in China, and here it's a big portion of the budget. Therefore you have to pay so much yourself for the health care services you need [in China], but here [in Canada] individuals don't have such a burden."

In summary, positive attitudes and comments regarding natural environment, social environment, and social support to old age life in Canada were commonly demonstrated by the interview respondents. Nevertheless, the seniors also reported struggles in everyday life, particularly struggles to integrate into the local community. The seniors were open and willing to interact with local people in order to expand their social networks and get to know the society.

Being restrained within the small circle(s) of Chinese acquaintances by language barriers was a disappointment to some of the respondents:

> "Only in the church, Chinese church. Our activities only take place within the Chinese church, because of language [barriers]. Our English is not good, therefore, we can't communicate with foreigners [Canadians] and can only interact with people within the Chinese circle. Only being able to communicate with Chinese people after so many years of living in Canada, I think it's sad. It's sad to Canada as well. These people are unable to integrate into the Canadian society; it's sad for them."

Several other seniors also expressed similar concerns about relatives and friends who had been living in Western countries for decades who still experienced hard times in terms of truly merging into the mainstream society. They had westerner friends with whom they communicated, but they could hardly communicate with them in-depth like they could with Chinese people. Although Canadians were courteous and friendly, conducting heart-to-heart conversations with them were generally considered difficult by the Chinese seniors. "Our communication with Canadian friends can ONLY reach that basic level."

Chinese immigrants from different source countries such as Hong Kong and mainland China speak different dialects of Chinese language; but with the same written language and similar cultural backgrounds, Cantonese speakers, Mandarin speakers, and speakers of other dialects can understand one another over time, as one senior stated: "We can't accept [understand] westerners. In our church, we are all Chinese, came from China, Hong Kong, or other places. But we can communicate in our languages."

The seniors mentioned they had been aware of many free outdoor activities in the summer and programs with minimal costs in the apartment buildings in which they lived. Due to language barriers, they did not attend, let alone integrate into the local community (Language

Barriers will be analyzed in detail in the following section). One respondent conveyed a helpless feeling about the situation: “The next generation, our grandsons and granddaughters, they won’t have this problem. Our generation has the most struggles.”

Challenges Related to Language Barriers

Unsurprisingly, language barriers were one of the major issues reported in all focus group interviews. Most survey respondents reported proficiency in Chinese language (93.1%, n = 94); however, most of them also indicated insufficient English skills (82.1% for understanding English and 88.1% for speaking English) (Table 5.1). It is interesting to note that seniors’ proficiency of English does not positively correlate with the number of years of living in Canada. It is quite the opposite: the longer they had been living in Canada, the lower their English levels. Understanding and speaking English are significantly negatively related to respondents’ length of residence in Canada, $r_{understand} = -.38$, $p < .01$; $r_{speak} = -.36$, $p < .01$ (Table 5.2). Newercomers appeared to be more capable of their use of English.

Language barriers cut across most aspects of Chinese seniors’ lives. Many focus group seniors reported that they did not speak or understand English at all or very little. A few mentioned that they knew several words such as “thank you”, “hello”, “yes”, and “no”, but those were “just a few words, and that’s not enough to go anywhere or do anything”. One senior indicated that she was able to read in English but listening and speaking skills were much weaker. “I can read, but my speaking, talking on the phone … I don’t understand every phone call. Sometimes I know what he says, if it’s simple, like telling Rachel [granddaughter] to go practise”.

Table 5.1 Language Proficiency of Respondents

Language Proficiency	Fluent/Most of it	A little Bit	Not at All	Missing
Understand and Speak Chinese	93.1% (n = 94)	5% (n = 5)	1% (n = 1)	1% (n = 1)
Understand English	12.9% (n = 13)	45.5% (n = 46)	36.6 (n = 37)	5% (n = 5)
Speak English	6.9% (n = 7)	49.5% (n = 50)	38.6% (n = 39)	4% (n = 4)

Table 5.2 Correlation between Language Proficiency and Residential Length in Canada

		Number of Years in Canada
Understand English	Pearson Correlation	-.378
	Sig. (2-tailed)	.000
	N	87
Speak English	Pearson Correlation	-.358
	Sig. (2-tailed)	.001
	N	88

The interview respondents all agreed that the challenges related to language cut across most important aspects in their lives. As one senior said: "All our problems are caused by and related to our poor (English) language skills." Another senior described that he felt he became "mute", "deaf", "blind" and "illiterate" upon arriving at the Winnipeg Airport. Other comments were similar:

> "Language barriers, transportation, all kinds [of difficulties]. We have experienced the most difficulties. Although we have suffered a lot, we survived over a decade."

> "Language barriers are our biggest difficulty. Whatever you want to do, you can't get around with it. Like me, I'm not literate, haven't done much schooling. I don't even know ABCD. How can I learn? So I can only remain 'mute', like what Mr. XXX said, be a mute. I have been 'mute' for so many years and I'm used to it now."

As indicated by many respondents, the challenges related to language barriers not only present inconvenience in daily functional activities, but also in learning per se, given the personal and social conditions the seniors were facing. These challenges are illustrated in detail below.

Language Barriers in Health Care Services

Lack of sufficient English skills caused Chinese seniors the most problems in the health care field. Many of the respondents suffered from chronic conditions such as diabetes, high blood pressure, cancer, and gynecological diseases. Therefore, visits to the doctor's office and hospital were frequent. The majority of the interviewed seniors did not seem to be aware of interpretation/translation services available in the community, such as the Language Access Interpreter Service at Winnipeg Regional Health Authority (WRHA) which has provided in-person or over-the-phone interpretation in 33 languages for health care providers and patients free of charge since 2007. The Immigrant Centre in Winnipeg also offers assistance in interpretation and translation for a small fee through their Language Bank Services program.

There are only a few family doctors in Winnipeg who can speak and understand Chinese. Actually all seniors from mainland China in the focus group interviews claimed that they were patients of one family doctor who was originally from Taiwan. However, not everyone could be accepted as a patient by this physician as demand was high due to the growing Chinese population in the local community. Appreciating the Chinese doctor's services and his Chinese proficiency in working with his patients, the interviewed seniors were seriously concerned about who could continue to provide a similar quality of care and service after the doctor, who himself was a senior, retires in the near future.

Some seniors have needed to visit English-speaking family doctors if they were not able to attain a doctor who spoke their language. In order to express as clearly as possible the health issues they were concerned about, the seniors wrote down their questions on paper at home and brought them to show their doctors. That was not the most difficult part, however. Greater problems arose when doctors tried to answer the written questions, because the seniors did not

understand what was being said. Thus, doctors were requested to write down their answers on paper so the seniors could bring them home to read with a dictionary or with the help of their family members. Sometimes doctors were not willing or too busy to write down the responses by hand.

Although many of the seniors were able to find a Chinese family doctor, few specialists, hospital doctors, or medical technicians could understand or speak Chinese. Poor communication between Chinese seniors and medical professionals, caused by language barriers, not only triggered or increased frustration in both parties, but also important information seemed get lost as demonstrated in the disconnected conversation demonstrated below:

> "When it comes to medical check up, it's all westerners. It was impossible for my children to arranged time to come with me. So I went there, I can't say that I understand one hundred percent. My grandson accompanied me to the check up. When I was asked of the start time of my menopause, my brain went blank. I had never thought about [I'd need to use] this term. … many of those medical words, I only know the most common ones such as high blood pressure and low blood pressure or heart disease. … I don't even know some of the terms in Chinese. … my grandson told me, 'if you don't know how to answer, just say NO to anything'. So that's what I did. He couldn't come into the examination room with me, of course. … the doctor asked me questions while examining me. I think I understood and answered most of them, and guessed 10 to 20 percent."

How to obtain check-up or medical test results was another challenge. As patients were responsible to contact the doctor's office or hospital to ask about and/or pick up test results, the seniors did not have the English skills to conduct such complex conversations and make arrangements for pick-up, if their children were not available to do so. In the case of potential diseases such as cancer, any delay in the medical examination and treatment process could result in irreversible consequences.

Seniors' adult children were usually their primary assistance for translation in medical appointments and needed care. Adult children often had to ask for time off from work or sacrificed their leisure time when their elderly parents needed to go to the hospital. Several seniors reported unpleasant emergency room experiences.

> "My children have to ask for time off whenever I'm ill. There were times I had to go to the hospital for a whole day and night, like 24 or 36 hours. I went to the emergency room once. My son had to ask for so much time off from work [to accompany me to the emergency room]. He didn't sleep all night, and he couldn't leave the hospital while I was [arranged to be] laying down. He's afraid of leaving me, worrying that I couldn't answer doctors' questions. For over 30 hours, my son didn't eat anything and couldn't leave the hospital, just to wait for a doctor to come to see me."

The interview respondents pointed out that they would not have visited hospitals or emergency rooms often over these years had they not experienced serious health conditions. The combination of long waiting times due to systematic flaws and language barriers has created tremendous stress to Chinese seniors. "I wouldn't have gone to the hospital if I was not in a critical condition. I was nearly dead. … I had two experiences [in the emergency room], and I'm really afraid [of going there again]."

Language Barriers in Social Networks and Social Support

Many of the seniors expressed their willingness to get to know more people in order to integrate into the local society, as reported by a female senior: "…some older fellow students – I went to an English class for seniors – they all made great efforts. On the aspects of both life and study, they tried very hard to integrate into the local culture." Another woman from a different focus group stated explicitly: "We should integrate into the local society, the community, and Canadian society." However, they realized immediately the importance of personal English skills. The woman continued: "Therefore I must say that English [proficiency] is very important.

Because we older people don't have a work environment and a [English] language [learning] environment, and we don't have many interactions with neighbours." They recognized that they did not have sufficient social networks and social support.

Over three quarters of the interviewed seniors indicated that they were living in separate households from their adult children – in four different retirement apartment buildings, only one of which specifically targeted the Chinese population in Winnipeg. Although living in a community environment with many other seniors and various programs designed for retired individuals, Chinese seniors felt that their social networks were actually limited. They either hung out with a few other Chinese seniors in the same building or with those in a Bible study group for seniors organized by a Chinese church (which involved approximately ten regular attendees). Seniors living with adult children reported even smaller networks of people because they hardly had any chances to get to know and integrate with people other than family members (usually an adult couple and one grandchild) and fellow church-goers.

When seniors first started living on their own in the community, it took them some time to get used to the way things were organized in retirement buildings run by Canadians. Eventually becoming aware of and interested in the programs or activities arranged by residence management or senior organizations, some of the interviewed seniors tried to participate in several activities, such as dinner parties during holidays or regular coffee gatherings. However, they felt that language barriers had hindered their interactions with fellow participants, except with those who spoke one or several dialects of Chinese. A senior in a focus group noted:

> "We felt we are most unhappy with our language skills. We can't communicate [with people who speak English]. We can only communicate with our Chinese friends. We are not really on top of the activities in the apartment building, although notices are posted [on the bulletin board]. – We can read simple English … we're not willing to participate in those activities; the number one reason is language barriers between them [English speakers] and us."

Even if older Chinese immigrants have access to opportunities to make friends with people of similar ages and establish social networks, they are not able to do so due to lack of a common language with which they and local seniors can understand one another. Living in a retirement building occupied mostly by Western residents, the Chinese seniors in one of the focus group interviews had some painful experiences of failing to build networks despite having strong intentions.

> "For example, dinner parties. We understood the idea was for everyone to have fun together. But when we were there, we felt the language blockage right away. We're unable to laugh on the things they found funny or interesting. We felt like idiots. The essential reason is language. Besides, in this building, due to language barriers, we cannot make frequent interactions and in-depth conversations with local residents, right. We know simple English, able to conduct simple and shallow communication; but it's impossible to conduct heart-to-heart conversations."

About one out of four seniors in all focus group interviews co-resided with adult children and/or grandchildren. These seniors demonstrated different needs and wants from social networks. Those who lived with children were taken care of by younger family members who handled all their issues that required English skills, such as grocery shopping. This resulted in two consequences for Chinese seniors' in terms of their social networks and social integration. Firstly, they were not as eager as those who lived independently in the community to improve their English skills, as they were not in urgent need of applying their English into handling daily issues such as doctor appointments, grocery shopping, and management of mail and bills. One senior said: "Because I live with my children, this problem (language barriers) doesn't bother me much. … I'm not like Ms A and Mr. B who have their independent lives, and they are eager to learn the [English] language. Me, I don't need to shop myself; I write a list of items for them [adult children] to get for me." Secondly, they expressed contentment with their family circle,

instead of enthusiasm to expand their networks in a community context. The following comment illustrates the combination of lack of interest in learning English, low motivation to expand networks, passive recognition of difficulties for both English learning and networking, and satisfaction of family life.

> "I'm not so eager to learn English, and I don't have the intention in this area like communicating with [people in] the mainstream society. A circle of English [speaking friends]? I'd say it's quite impossible. So I am not thinking of integrating in to the society or the like; I just want to integrate into my family, and serve my family."

Social networks and social support is indicated by the extension to which seniors contact their relatives, friends, and neighbours, and whether those individuals provide physical, emotional, and financial support to and received from the senior. Due to language barriers, older Chinese immigrants reported limited social networks and social support, regardless of their living arrangement. The difference is that seniors who lived in separate households from their adult children expressed much higher motivation to improve English skills and expand their social interaction circle beyond the family and the Chinese community. Despite strong intention of integrating into the local community and great efforts to befriend with non-Chinese speakers, most Chinese seniors found their social networks unsatisfactorily insufficient.

Likewise, Chinese seniors' *social participation* was fairly low due to language barriers. In general the interview respondents reported minimal social participation, and that involved attending English as Additional Language classes for older adults.

Only a few seniors in the focus group interviews reported that they had become involved in several organizations like A & O: Support Services for Older Adults, hobby or sports groups, or adult education programs. In particular, one woman reported she had been requested by a housing manager to run a dance workshop for fellow residents but it lasted for only a few

months; two seniors mentioned that they went to a nearby community centre to play ping-pong every Saturday; approximately ten out of the 43 interviewed seniors had experienced taking English as Additional Language (EAL) for seniors at various locations across the city; and about a dozen people indicated that they attended services or activities at a Chinese church from time to time. However, at the time when the research interviews were taking place, only three seniors were actively participating in EAL classes. The evidence of inadequate social participation echoes the low scoring of *social participation* in the quantitative component, with a mean score of 5.4 out of a full score of 112. Both types of research data indicate that Chinese seniors' participation in social activities, groups, or programs was fairly low.

Challenges for English Learning and EAL Programs

The majority of focus group respondents noted personal challenges in learning English, such as deterioration of memory and declining language abilities. As one senior said, "We're all 70 or 80 years old … in our conditions, our language abilities and communication abilities are getting worse. I can't even speak Chinese fluently now, let alone a foreign language. [laugh with other respondents] I spoke very fast before, but now mumble a lot." Several seniors attributed their declining abilities to memorize new knowledge to aging, comparing their learning capacities and memory with those of younger people. One respondent realized that his English vocabulary was so limited that he could not hold long conversations with English speakers. Sometimes they were able to ask or answer a question with an English speakers; but once that person responded, the seniors would not understand due to their limited vocabulary, which usually resulted in the end of an otherwise well-intended conversation. And expanding one's vocabulary required good memory. Another senior admitted that she had not had a good

foundation for learning English as she had been taught Japanese in her elementary and high schools, instead of English like in most Chinese schools now. The youngest respondent, who had just turned 60 not long before the interview, expressed her observation emotionally: "…some older fellow students – I went to an English class for seniors – they all made great efforts. On the aspects of both life and study, they tried very hard to integrate into the local culture. But I could tell that their abilities did not match their desires [of mastering English]."

Many seniors did not want to and had not given up on improving their English, despite various challenges caused by social, organizational, and personal factors. One said, "No matter what, we must learn English." Another senior constantly tried to persuade the senior friends around her to study English: "I think it's important to learn English. I need to improve my English as well. What if you have to go out to buy something necessary, what are you going to do if you don't know any English? What if you get lost like me last time, what are you going to do? Are you going to wear a card [with name, address, and contact information on]?"

The interview respondents noted several strategies that they had applied in their learning English. The first was to memorize and practise speaking several key words for each of the possible situations in which they had to communicate with English speakers on their own, such as finding one's way home when lost or taking a bus to a certain place. The second strategy was to be brave. One senior said, "I think we just need to be more brave to speak English, and practise to be more brave. Pick up the phone [when the phone rings and try to answer it]. If you really can't understand, just say 'pardon' and 'please say that again'." The senior who provided that advice stated that she currently was able to answer phone properly eight times out of ten.

The seniors had also developed certain ways to cope with problems caused by language barriers. For example, they would write down their questions on paper and present them to the

doctor during a doctor's appointment, if they were not confident to communicate clearly verbally on medical issues. Quite a few seniors had trained themselves to read price tags of vegetables at grocery stores, if they had to shop for groceries on their own, by matching items with prices. When the cashier talked to them, they assumed that he/she had asked them whether they needed plastic bags or not, and they simply said, "No". The seniors might or might not have provided the proper response to the cashier every time, but it seemed to have been working because those seniors had been doing grocery shopping successfully for years.

Some seniors, regardless of various difficulties, were persistent in learning and improving their English skills, whereas others seemed to have given up on trying. One senior claimed that "I have no connection with English. Therefore I don't have strong motivation to learn it. I'm also so old, almost 80 …"

EAL classes for seniors were the most common social groups that the interview respondents had participated in and the major means to learn or improve their English. The popularity of this adult education program was closely related to low English proficiency and high motivation to integrate into the local community and expand social networks. The respondents described the issues they had regarding their efforts and their experience of learning English in a semi-formal educational setting.

Firstly, EAL classes for seniors were almost the only place where older Chinese immigrants had the chance to learn and improve their English skills. Some of them had tried to purchase palm translation machines or electronic dictionaries before coming to Canada, knowing that low English proficiency would be a serious issue in their immigration lives. However, those electronic translation tools generally require a certain level of computer literacy and English writing and reading skills. In order to apply an electronic translation instrument to a verbal

communication situation, one must record the words of the other person, and then the instrument is supposed to recognize the words from their sound and translate them into Chinese on the screen; with a similar procedure to translate Chinese into English. The process of machine translation is longer than in a real conversation. Therefore, seniors' effort of getting assistance from technology did not bear successful fruit due to the demand of a certain level of computer and English skills and unsatisfactory functioning of available products.

The respondents pointed out that their younger counterparts could continue improving their English skills at work after they found jobs, whereas they had no workplace but English classes to practice their English. As they did not have opportunities to speak English at home or at the Chinese church, they valued the time spent at English classes. One older Chinese woman who might have possessed the best English skills in her focus group stated, "I have made several [Chinese] friends of my age … I always try to persuade them to go to [school to] learn English. But it's hard for them to keep it up."

Secondly, the cutting of funds for social services, especially those targeting seniors and older immigrants, had affected the quality of EAL classes. The respondents stated that their English class had replaced their former instructor, who was Chinese, with a volunteer teacher from Mexico who could not facilitate in Chinese the already difficult learning process for the seniors.

> "Canada's economics were not doing well, so the funding for teachers was cut. Our former teachers, XX and XXX, were both Chinese. We understood [the course content] better with Chinese teachers. She pointed at something, and said what this was called in Chinese and English, and we understood immediately. But later because of the economic situation, they [English classes] didn't use Chinese teachers any more, but foreigners, Mexicans to teach us. We didn't understand him, and he didn't understand Chinese, and us."

Moreover, the current policies of EAL classes for seniors only allowed recent older immigrants to attend the classes. Those who had been in Canada for a certain period of time and/or had attended the courses before were not given priority to class vacancies. Some seniors felt stressed over losing the opportunities to continue their learning because that was their only place to learn and improve English skills.

> "My [English] listening is regressing [after summer the holiday season] …. Now I just learned that there is a requirement of [residence] years. Only recent immigrants can [attend the class to] learn English. Immigrants who have been here for several years cannot [go to the class to] learn any longer. Older people are different from younger people [in learning]. Younger people are able to reach certain goals after several years of learning, then they will find jobs and don't need to [go to classes to] learn any more. We older people don't have a [language] environment at work, neither in everyday life. We only have the English class to communicate [with others]. I think longer English training should be provided, in order for older immigrants to truly integrate into the Canadian society."

Thirdly, also because of reduced funding, most EAL programs had discontinued the previously free transportation for participants. A shuttle vehicle used to pick up the seniors who needed transportation assistance from their residences and then dropped them off at home after the class. As the pick-up services were no longer in place any longer, seniors who were older (75 +) and suffered from physical disabilities found it extremely difficult to attend the English classes on their own, particularly in the winter. (Transportation, another essential challenge faced by seniors, will be analyzed in detail later.) The discontinuation of transportation meant quitting the EAL classes for some seniors, while they were not only enthusiastic about learning but had also made progress in English improvement through the classes.

> "There is a problem for seniors to go to the classes. The winter here is very long, and now there is no more transportation [service]. It is already difficult for us to take buses, and it's impossible for us to take buses in the winter. Thus, no transportation means no school [to us]. I think, no matter what there should be one or two English classes for us seniors to improve on our English, in order to integrate into the society. I think this is important."

Issues around language barriers and learning are complex due to diverse individual interests, needs, and skill level, as well as inconsistent resources and support available in the community. They are also interwoven with other issues in immigrant seniors' lives, such as health care, service availability and accessibility, transportation, and other environmental factors. Suggestions for potential solutions will be provided in the context and analyses of these factors in later sections of the paper.

Summary

This chapter has described two contextual issues in seniors' lives: general attitudes toward old age life in Canada and challenges related to language. Chinese seniors in general possessed positive attitudes toward living in Canada, a cultural context different their home countries. However, obstacles to integrating into the local society was reported to be a common challenge as reported by the majority. Language barriers were the most frequently mentioned obstacles at a personal level (e.g., difficulties to learn and maintain English skills), at the institutional level (e.g., lack of support services in health care), and in the community (e.g., lack of language proficiency to participate in activities or programs).

It is interesting that newer immigrant seniors appeared to demonstrate higher English skills than long-term immigrants. Furthermore, those who lived in separate households from their adult children expressed higher motivation to study English to reach a satisfactory level for daily communication, as opposed to the seniors co-residing with adult children. EAL classes for seniors were essential to improving their English level in order to better integrate into the local

society. As well, English classes were one of the very few socialization activities that many interviewed seniors had had. However, the accessibility and availability of learning services were inconsistent to immigrant seniors due to funding policy changes. For example, the termination of shuttle buses in winter was the primary reason to discontinue attending the program; for others, they were no longer qualified for free EAL classes after they had been living in Canada for a certain period of time.

The following chapters will focus on analyzing the major variables of the study: seniors' health status, social capital level, and residential environment.

Chapter Six

HEALTH AND HEALTH CARE

Health of the Sample

The health status of the respondents was measured with the Medical Outcomes Study 36-item Short Form (SF-36). The inventory measures eight domains of individuals' well-being: 1) physical functioning; 2) role limitations due to physical health; 3) bodily pain; 4) perceived health; 5) energy and vitality; 6) role limitations due to emotional problems; 7) mental health; and 8) social functioning. The score of each domain was calculated using PASW 18, following the scoring manual developed by Ware and colleagues (Ware et al., 1995). All scores range between 0 and 100, with a higher score indicating better condition within the health domain. The measures then yielded scores for two dimensions: the *physical component summary (PCS)* and the *mental component summary (MCS)* to represent the general physical and mental health status (Ware & Kosinski, 2004). PASW 18 was applied to perform the three-step scoring algorithms constructed by Ware and Kosinski (2004) to reduce "the SF-36 from an eight-scale profile to two summary measures without substantial loss of information" (p. 171). Both summary scores range between 0 and 100. Higher scores indicate better health status in the overall physical or mental domain of respondents. Descriptive statistics of the eight domains and two summary scales are presented in Table 6. 1.

The focus group interview participants expressed concerns about their health and health care services they had experienced in greater detail. The qualitative data related to seniors' health are presented along with the quantitative results where applicable and available.

Table 6.1 Description of Health Status of respondents

	# of Cases	Missing cases	Mean	Standard Deviation	Median	Mode (# of cases, percent)	Minimum observed value	Maximum observed value	Skewness	Kurtosis
Physical Functioning (PF)	101	0	67.0	24.2	70	95 (12, 11.9%)	0	100	-.58	-.60
Role Physical (RP)	100	1	61.0	42.0	75	100 (44, 43.6%)	0	100	-.46	-1.5
Bodily Pain (BP)	101	0	69.0	26.8	67.5	100 (25, 24.8%)	0	100	-.43	-.75
General Health Perception (GH)	97	4	58.5	23.4	55	50 (10, 9.9%) 55 (10, 9.9%)	5	100	-.10	-.71
Energy/Vitality (VT)	96	5	63.4	21.3	65	50 (12, 11.9%)	0	100	-.38	-.12
Social Functioning (SF)	98	3	75.1	25.0	87.5	100 (31, 30.7%)	0	100	-.87	-.02
Role Emotional (RE)	99	2	64.0	42.2	66.7	100 (49, 48.5%)	0	100	-.64	-1.31
Mental Health (MH)	96	5	72.7	17.4	72	72 (13, 12.9)	20	100	-.50	-.04
Physical Component Scale (PCS)	93	8	43.1	11.1	43.1	-	11.8	60.6	-.45	-.53
Mental Component Scale (MCS)	93	8	49.1	9.8	50.2	-	26.2	65.1	-.46	-.76

Physical Functioning

Physical Functioning is demonstrated by the extent that seniors' health affects the activities they might do during a typical day, from vigorous activities such as running, moderate activities such as carrying groceries and vacuuming, to basic functions like bathing oneself. All respondents provided complete information in this domain, and the average score is 67 with a standard deviation of 24.2 (Table 6.1). The most frequently obtained score was 95. Twelve seniors had the score of 95, presenting nearly 12% of the sample. The negative value of skewness (-.58) indicates a cluster of scores on the left of the distribution of *physical functioning* scores of the sample while the negative value of kurtosis (-.60) indicates a flat and light–tailed distribution (Table 6.1). Both figures do not imply a significant deviation of the sample from a normal distribution.

The focus group interview participants did not indicate major physical functioning difficulties. However, some seniors mentioned certain housework as a challenging physical demand for them. For example, preparing meals for the whole family – including themselves, their adult children and spouses and grandchildren - was physically tiring and "the burden was heavy, my burden was heavy."

Role Limitations Due to Physical Health

Seniors reported whether their physical health had limited their work or other regular daily activities through four "yes-or-no" questions. One respondent did not have complete data. The mean score of role-physical for the seniors is 61 with a standard deviation of 42. It is worth pointing out that more than four out of ten of the respondents (n = 44) reported that they had not been limited by their physical health in daily activities or work at all. The distribution is slightly negatively skewed and moderately flat distribution (Table 6.1). The histogram illustrates that more respondents score at both ends than the middle, which is the opposite of a normal distribution.

Bodily Pain

Two questions were used to measure seniors' bodily pain by asking how much bodily pain they had had and how much pain interfered with their daily activities in the past four weeks. All respondents completed these questions; and the average score of this domain is 69 with a standard deviation of 26.8 (Table 6.1). One quarter of the respondents (n = 25, 24.8%) obtained a full score of the bodily pain domain, indicating that they had not experienced any physical pain

recently. The distribution of this variable has a slight negative skewness (-.43) and moderate kurtosis (-.75) (Table 6.1). The variable *bodily pain* may not be appropriate for parametric statistics.

General Health Perception

Seniors' perception of their general health conditions was scaled with five questions, including whether they considered themselves to get sick easier than others and whether they expected their health to get worse. Ninety-seven completed cases presented two modes: 10 respondents at score 50 and another 10 at 55, which are close to the mean (58.5) and the median (55) (Table 6.1). The average score is 58.5 with a standard deviation of 23.4. The distribution of the scores of *general health perception* of the seniors is close to a normal one, with a slight negative skewness (-.10) and kurtosis (-.71) (Table 6.1).

Many focus group interview respondents reported or demonstrated chronic conditions such as cancer, arthritis, and lameness, and a few had cataracts. One senior pointed out that about a quarter of the participants in the focus group in which she was involved were relatively healthy, about half were in "sub-health conditions", and the rest suffered from chronic or acute diseases. A male senior stated, "We all are getting old. As getting older, our physical functions are declining. There are (health) conditions here and there (in our bodies); so we need to see a doctor or go to a hospital quite often."

Anticipating their health would decrease over time, most seniors expressed worries about the availability of reliable care in the future. Some seniors stated that the most important thing to them at present was to take good care of themselves so as to delay any possible dysfunctions and

avoid illnesses. One respondent believed "the most important thing is to take good care of my physical health, understand and nurture my body, and avoid getting sick, in my opinion. How I can reduce the burden on my children is to avoid getting sick."

Energy and Vitality

The energy and vitality domain was measured by requesting the respondents to indicate to what extent they felt energetic or tired in response to five different questions. Five cases contain missing data. The respondents have an average score of energy and vitality of 63.4 with a standard deviation of 21.3 (Table 6.1). The mode is 50, acquired by 12 cases or 12% of the sample. The score distribution is very close to a normal one.

Social Functioning

Respondents answered two questions to indicate their level of social functioning: to what extent, and how often, their physical health or emotional problems had interfered with their social activities with family, friends, neighbours, or groups. Most seniors were able to provide complete information for this domain (n = 98, 3 cases of missing data). The mean is 75.1 with a standard deviation of 25 (Table 6.1). Nearly one third of the respondents (n = 31, 30.7%) reported excellent social functioning in their lives. -.87 indicates a moderate negatively skewed distribution although kurtosis (-.02) is very close to normal. The histogram indicates that more respondents reported higher social functioning levels than those who reported lower levels.

Role Limitations Due to Emotional Problems

Respondents reported on whether their emotional well-being had affected their regular daily activities or work through three "yes-no" questions. The mean is 64 with a standard deviation of 42.2 (Table 6.1). The mode is 100, with almost half of the sample (n = 49) scoring that. Both skewness (-.64) and kurtosis (-1.31) are between moderate to significant, which indicates that the score distribution of *role limitations due to emotional problems* scores is not normal. The histogram clearly illustrates more scores piling up at both ends than the middle of the distribution. Non-parametric tests are recommended for further analysis.

Mental Health

Five questions regarding mood and emotional well-being (e.g., "Have you felt downhearted and blue?") were used to investigate the respondents' mental health. Ninety-six seniors answered all the required questions of the domain, while five did not. The mean of seniors' mental health measure is 72.7 with a standard deviation of 17.4 (Table 6.1). The mean score is also where the median (Mdn = 72) and mode (Mo = 72) fall. Thirteen respondents, or 13% of the sample, scored 72. Both skewness and kurtosis are slightly negative, which does not affect the distribution too much from a normal one. The histogram also confirms the normal distribution of scores for the *mental health* variable.

Physical Component Scale (PCS) and Mental Component Scale (MCS)

Due to cases of missing data in different domains, the two summary scores, PCS and MCS, are composed of 93 valid cases, 92% of the sample. The average PCS score is 43.1 with a

standard deviation of 11.1 (Table 6.1). The highest score is 60.6, and lowest is 11.8. Both skewness and kurtosis are slightly negative, which does not affect the distribution too much from a normal one. The histogram also confirms the normal distribution of scores for the *PCS* variable.

The mean of MCS is 49.1 with a standard deviation of 9.8 (Table 6.1). The highest score is 65.1, and the lowest 26.2. The skewness is slightly negative, while the kurtosis is moderately negative which indicates a pointy shape of the distribution. Parametric statistics may be tolerated but non-parametric tests can be applied to compare the results in further analyses.

Because the PCS and MCS scores were calculated with the formulas for z-score standardizations and T-score transformation of all eight domains, the respondents rarely share same scores. Therefore, the mode is not applicable for describing the two summary scales.

Comparison of Health Status between the Sample and General Chinese Seniors in Canada

The overall health status of the aging older Chinese in Canada was examined and reported in a nation-wide study conducted by Dr. Lai (2004a, 2004b) at the University of Calgary. Using a comprehensive survey including the SF-36, the study provided a detailed report on the health variables of the general aging Chinese population in Canada.

The health status of the Winnipeg sample and that of the general older Chinese-Canadians also demonstrates some similarities and differences. The SF-36 scores from the Health and Well Being of Older Chinese in Canada Study (Lai, 2004a, 2004b) were stratified and reported according to different age groups with detailed mean scores. In order to compare the results of the two populations, the researcher grouped the means of the SF-36 scores from the Winnipeg

sample in the same way (Table 6.2). However, without the original dataset of the national study, tests for the significance of differences cannot be performed.

Table 6.2 Mean Scores (SD) for the Eight Domains and Two Summary Scales of the SF-36 for Respondents and Older Chinese in Canada

Domains	< 65 Years		65 – 74 Years		>75 Years	
	Winnipeg Chinese Seniors (n = 13-14)	Canadian Chinese Seniors (n = 692-686)	Winnipeg Chinese Seniors (n = 32-33)	Canadian Chinese Seniors (n = 896-922)	Winnipeg Chinese Seniors (n = 40-46)	Canadian Chinese Seniors (n = 642-652)
Physical functioning	81.1 (15.0)	87.9 (16.1)	73.1 (20.9)	81.2 (19.3)	60.0 (26.0)	64.3 (27.0)
Role-physical	86.5 (21.9)	83.0 (33.4)	56.1 (41.5)	78.1 (36.6)	58.2 (45.7)	65.8 (43.0)
Bodily pain	85.9 (17.1)	83.2 (24.3)	68.3 (26.4)	82.2 (24.6)	63.6 (28.1)	76.3 (29.0)
General Health perception	70.4 (18.3)	63.3 (19.7)	58.0 (25.0)	62.2 (20.5)	56.3 (22.1)	56.6 (20.6)
Energy/vitality	75.0 (19.7)	68.0 (21.6)	62.0 (21.7)	65.4 (22.4)	61.0 (22.1)	60.1 (23.2)
Social functioning	86.5 (13.0)	89.7 (17.6)	76.1 (24.1)	87.3 (20.2)	70.7 (28.1)	79.5 (26.5)
Role-emotion	74.4 (27.7)	84.4 (33.0)	66.7 (41.7)	83.7 (33.9)	60.7 (45.7)	75.2 (40.4)
Mental health	72.6 (20.2)	79.2 (17.7)	74.2 (17.4)	79.2 (17.3)	72.6 (17.1)	77.0 (18.0)
Summary Scales Physical Component Scale	52.2 (5.5)	51.7 (8.0)	43.2 (10.3)	51.2 (8.6)	40.3 (11.9)	50.6 (9.3)
Mental Component Scale	50.2 (7.2)	48.7 (10.5)	49.5 (10.1)	48.9 (10.1)	49.0 (10.9)	47.5 (10.7)

As samples were divided into different age groups, the numbers of sub-groups are specified under each group title. In the youngest group of those who were under 65 years old (the threshold for this group is 55 years of age for the national data and 60 for the Winnipeg sample), both general physical health and mental health of the Winnipeg sample are slightly better than that of the general Chinese seniors in Canada (PCS: 52.2 vs. 51.7; MCS: 50.2 vs. 48.7). Among the eight individual domains, the means of half of them are higher for the Winnipeg seniors than for the general Chinese seniors. Overall, Winnipeg Chinese seniors who were younger than 65 enjoyed similar health status with Chinese seniors across the country.

Among those 65 to 74, Winnipeg Chinese seniors reported poorer overall physical health (PCS) than the general Chinese-Canadian senior population (43.2 vs. 51.2), and similar but

slightly better mental health status (49.5 vs. 48.9). In each of the eight domains, the mean for Winnipeg seniors is lower than that for the general Chinese seniors, with a greater standard deviation (except for *energy/vitality*). It seems that a higher percentage of Chinese seniors in Winnipeg had either much better or worse conditions than average in the individual domains (e.g., physical functioning, bodily pain, mental health, etc.) than the general Chinese seniors in Canada.

The health status for Winnipeg seniors 75 years or older appears similar to that of the 65-74 age group, in comparison with their national counterparts. Winnipeg seniors' overall physical health is poorer than that of the general Chinese-Canadian seniors (40.3 vs. 50.6), while mental health status (MCS) is better (49.0 vs. 47.5). The *energy/vitality* level is similar for both Winnipeg and the general Chinese seniors (61.0 vs. 60.1). The same similarity is found in the *perception of general health* as well (56.3 vs. 56.6), which indicates that Winnipeg seniors who were 75 or older considered their levels of healthiness similar to how the general older Chinese-Canadians perceived their healthiness. However, in the majority of the health domains and the general physical health (PCS), Winnipeg seniors on average scored lower than the overall Chinese seniors.

As the original dataset of the study with Chinese-Canadian seniors was unavailable for statistical tests, it is not safe to draw statistical conclusions concerning the comparison of the populations in Canada and in Winnipeg. Based on the observations of the summary table (Table 6.2) of the SF-36 scores of the two groups, it is possible that Chinese seniors in Winnipeg enjoyed slightly better mental health than the overall older Chinese population in Canada; Winnipeg seniors' physical health, however, appeared worse than that of the general Chinese seniors, except for the youngest group of under 65 years.

Health Care and Health Support Services

Health is a vital component in the quality of life for Chinese seniors. As indicated by the respondents in the focus group interviews, a major goal in the seniors' lives was to maintain or promote their health conditions to assure daily life functionality. Seniors' experiences of seeking and receiving health care and health support services, and interactions with health care professionals emerged as a prominent theme from the interview data.

Use of Health Support Services

The survey results provided some perceptive information to the utilization of health care related services by the seniors. In the quantitative data, the respondents' use of health support services is represented by the number and types of the services they had used in the last year. These services include services offered by senior centres, fitness programs, counselling, home support services, meals-on-wheels, and services provided by community nurses or health care workers.

Table 6.3 Description of Use of Health Support Services of Respondents

# of Services Used	Frequency	Percent	Cumulative Percent
0	57	56.4	56.4
1	35	34.7	91.1
2	7	6.9	98
3	2	1.2	100
Total	101	100	
Missing	0		

If a senior had used all the most common services, including *other* services not listed in the survey, he/she would receive a full score of 10. However, as denoted in Table 6.3, more than half

(56.4%) of the respondents had not taken advantage of available services in the community; one in three (34.7%) seniors had used one type of service, while less than 10% had tried two or three types of services.

Table 6.4 reveals more details of the extent that services had been used by the sample under study. *Seniors' housing* is the most frequently indicated of service used because some respondents (approximately 25 to 30) were residents of government subsidized senior housing apartments. A small percentage of seniors had attended fitness programs (12%) or programs from senior centres (8%), and a few took advantage of home care, personal care, and community health care services. Only one senior had used counselling services.

Table 6.4 Extent to Which Services Used

Type of Services	Frequency (N = 101)	Percent
Seniors' Housing	21	20.8
Fitness Program	12	11.9
Programs from Senior Centre(s)	8	7.9
Home Support Services	8	7.9
Community Nurse/Health Care Worker	4	4
Personal Care Services	1	1
Counselling	1	1
Adult Day Program	0	0
Meals-on-Wheels	0	0

The use of health support services did not demonstrate any relationship with the seniors' mental health, but was negatively correlated with their physical health (r = -. 23, $p < .05$). The poorer a senior's physical health was, the more likely she or he was using one or some of the support services available.

Satisfaction with Health Care System

Comparing the quality of health care in Winnipeg with that of the health care system in their former countries, Chinese seniors acknowledged that they were happy with the free health care services they received. One senior repeated "satisfaction" four times in her statement regarding health care. First of all, most costs for medical check-ups, treatment, and medications were free of charge to seniors, whereas some fees were applicable to them in China if they were to receive health care services – those who enjoyed state health insurance needed to cover partial costs themselves, and others who were not entitled to insurance coverage would have to pay for everything themselves, which would be a fortune to individuals or families who lived on restrictive salaries or pensions.

Second, medicines and treatment, if received promptly, were reported to be of high quality medications. Medicines, though more costly in Canada than domestically produced medicines in China, were obtained at no cost by the Chinese seniors in Canada. One senior who had received a cataract operation claimed that the treated eye had been performing very well and she did not need glasses for reading.

Third, most respondents expressed an appreciative attitude toward the health care that they had received in Canada, particularly from the perspective that they had not contributed much to this country through work, taxation, or community services. Despite all the difficulties and practical problems they were facing (detailed in later sections), the seniors understood that those problems were not isolated or particularly applied to them but also other Canadians. Systematic issues would take time and recourses to be modified and improved, usually involving concerns of resource sharing with other groups in the society. For example, one senior said: "My son told me, 'Mom, don't ask for more services. It takes money to do that, and we are already paying very high taxes.' I said I know."

Inefficient Health Care Procedure

The seniors' greatest concern regarding the health care system was the slow process of health care services. The seniors complained that the wait time at hospitals was much longer than they could bear. One senior reported that she was accompanied by her son to the emergency room at 7 p.m. and was unable to go home until 12 noon the next day. While she was allowed a place to lay down over night, her son had to sit through the night without any food and rest – her son was afraid of leaving his mother alone even for a short period of time in case the doctor came to ask her questions (in English). Another senior waited for ten hours before finally being seen by a doctor in a hospital near her home. The respondents who were from mainland China had been used to receiving timely services and treatment at hospitals in China as long as they were able to pay the fees. While payment of fees was not an issue in Canada, all patients had to wait for their turn to be scheduled for appointments or check-ups, regardless of their financial status.

The seniors who needed diagnoses by specialists experienced waiting times of between three and five months. Three respondents had been suspected by their family doctors to have cancer and were scheduled to see an oncologist. The seniors were seriously concerned that their conditions would develop rapidly during the waiting period and reach a stage more difficult to cure, as illustrated by the following quotes.

> Male respondent: "She had liver cancer, and had to wait for five month to see an oncologist."
>
> Female respondent: "In China, I would have been hospitalized immediately and subject to treatment, upon the diagnosis. Well, here we are not talking about [the negative sides including] grey income [of doctors and hospitals that is generated by convincing patients to accept more expensive treatment and medications]. Here in Canada, the procedure of

> health care system is too slow. **This can result in delaying necessary treatment and loss of lives that can otherwise be saved**. This is the first point I want to make. [For the same amount of time,] a diagnosis would have already been made in a China's hospital while we are still waiting to see a specialist in Canada."

Incomplete Treatment

Once they received health care services, the seniors realized the treatment they had been provided was intended for only the elimination of acute conditions to be able to return basic physical functioning. For example, most of the seniors who had had cataract operations had them done in China, while one senior received the operation in Winnipeg. However, although both of her eyes had had cataracts, only one eye had been treated and the doctor told her that "one eye will be sufficient for functioning in everyday life for you". She reported that the treated eye had been performing very well and she did not need glasses for reading, but her eyesight was unbalanced because with the untreated eye she could not see things clearly. Another senior described how her relative had been treated in a Toronto hospital. The relative had been sent to the emergency room due to a high fever. He was treated and sent home while still taking intravenous medication. Fortunately, the relative, who was formerly a hospital director in China, was knowledgeable of handing IV treatment by himself. As most seniors did not have a medical professional background and relevant skills, they stated that they would not have known how to handle the situation if they had been in his place.

Overall, the interview respondents felt that their treatments were incomplete and only executed to the level to ensure only fundamental, rather than optimal, functioning for daily life. Otherwise the health care quality in Canada was felt to be satisfactory. The seniors suspected that a shortage of funding to sustain sufficient health service providers and materials might be the reason behind the status quo.

Outdated Equipment

Outdated and ineffective medical equipment was a topic that emerged in the focus group interviews, an issue related to a shortage of funding, long wait periods, and limited quantity of services. The seniors, particularly those with some professional medical background, described what they had seen and experienced in terms of medical equipment for check-ups. Compared to the popularity of coloured ultrasound examinations in China, including at clinics, most Canadian hospitals were still applying monochromatic ultrasound equipment for examinations. The outdated black-and-white ultrasound machines were unable to produce pictures with sufficient detail for diagnosis in Canada. One senior went back to China and paid to have a coloured ultrasound examination. Then the senior's adult children translated the report of results from Chinese to English and presented it to a Canadian doctor. With pictures of much better quality and more detail, the doctor immediately provided a treatment plan. And he reminded the senior and her family to remember to bring him any other examination reports and check-up pictures if they were going to get more examinations done in China in the future.

While many people in China believed that Western countries had better health care systems and medications, it appeared to be a different case in the area of medical equipment. Although they understood that upgrading equipment would bring significant budget implications to each hospital and the health care system, the seniors strongly suggested that Canada's medical equipment be replaced with those that could effectively serve health care professionals and patients – not only Chinese seniors, but all Canadians.

Shortage of Health Care Professionals

The shortage of three different types of professionals in the health care system was observed by the focus group respondents. This first type was general practice physicians because the process of qualification recognition for health care professionals is lengthy and challenging. Some seniors mentioned that some of their relatives or friends who had been physicians in their home countries did not want to pursue the qualification recognition paths due to the level of difficulties. Shortage of general doctors was considered by the seniors as a relevant reason for the long wait periods in emergency rooms and medical examinations.

The second type of professional in demand was doctors and medical technicians who could communicate with Chinese seniors in Chinese. As indicated earlier, most interview respondents from mainland China shared the same family doctor who spoke Chinese and was therefore able to deliver services directly to the seniors without interpreters. However, this Chinese doctor was retiring. To the seniors' and their families' knowledge, there was no other family doctor who spoke Chinese in Winnipeg. The seniors were deeply troubled by the fact that they might be left without proper health care providers in the near future when most of them would be facing chronic conditions. Some seniors expressed the expectation that more doctors from China, or who could speak Chinese, could be hired by hospitals or clinics, "even for lower salaries", to provide care to the growing Chinese community; nevertheless, others pointed out that it was a matter of the licensing and regulation process of the entire health care system, which could not be easily and rapidly changed "based on our suggestions here". "One can be a professor [in a medical school] but not a doctor [if you don't have the license], even if you have a doctoral degree."

Specialists were the third type of health care professional that the seniors considered lacking. Many female respondents stated that they and their friends of the same age had been suffering from various gynaecological diseases. But when they requested a gynecologist for further examination and treatment, according to the interview participants, they could not find one available in the city. One older Chinese woman said, "We have too few gynecologists in Canada, very few. We are lacking good doctors. You can search the whole Winnipeg but cannot find any. I'm serious. You can't find any. I know many of my friends have women's diseases, but we can't find any specialists to see us. It's not easy to get looked at."

Transportation to Access Health Care Services

Besides observations of the Canadian health care system, the interviewed seniors also revealed that it had been very challenging for them to obtain proper and timely transportation to access the health care services that were needed.

Unlike Canadian seniors, older immigrants from China did not generally obtain drivers' licenses or own vehicles. Living in Canada, they did not have the driving skills, experience, and language proficiency to pass the driver's license exams. For outings, the seniors usually took strolls in the neighbourhood or community parks nearby, or walked to a grocery store to get groceries. If they needed to go further, they might take advantage of public transit as an alternative, but under certain conditions, such as having basic sufficient English skills to ride the bus, having their residence close to bus routes, accessible weather, a limited number of required transfers, and familiar bus routes and places to go. Most Chinese seniors did not meet these conditions, however. Getting rides from their younger family members became the means they could go to the places much further than the park or grocery store in their neighbourhood.

One senior had been scheduled for a type-B ultrasonic check in a hospital that was 40 minutes drive from her residence. She had requested a spot at a closer hospital, but had failed to be accommodated due to the unavailability of the service at that site. Unable to manage to get there herself, the senior was dependent on her daughter to drive her. Occupied by work, the daughter had to call to re-schedule the appointment twice. While she could not schedule it again the third time since she had to deliver an important presentation at work, the granddaughter, who was a college student and just received her driver's license, stepped in and offered to drive the senior to her medical appointment to which she should had gone two months earlier. Many seniors agreed that they had no one else but their adult children to depend on for transportation to go to doctors' offices, hospitals, or medical checks. Adult children had to plan ahead of time to arrange work schedule and ask for time off from their supervisors. If a senior frequently had medical appointments, it became demanding for his/her adult children to ask for time off from their jobs. As a result, seniors' appointments were often delayed, or they had to appear at appointments without family support, in particular language assistance and emotional support.

Home Care Services

Home care was mentioned by the interview respondents as an area related to health care. It appeared a significant issue for the seniors when recovering from surgeries or when terribly ill. When the seniors were unable to function on their own and if their children could not supply care because they were at work, they would need to find other options for care.

One senior noted that in China she could have hired a live-in maid or housekeeper paid at an hourly rate because there were such workers available at an affordable rate in the labour market. In Canada not only was the labour supply not as available, but the senior also claimed

that she wouldn't be able to afford such a helper.. She described that she was desperate, worrying about the situation she would have to face without help for daily life issues once her knee surgery was performed.

Some seniors were aware of and had used the home care services available through the Winnipeg Health Regional Authority (WHRA). They reported multiple issues in terms of the gaps between their expectations and current quality of the services. Language barriers were again a problem because most home support workers spoke English, not Chinese. The types of services provided by home care workers were defined by their job or task descriptions; therefore, the workers had the right to reject extra work that seniors may have requested they do. There seemed to be some discrepancies between current services and recipients' needs and expectations.

> "She brought me my medication, then ran away immediately, [because] that's what she was assigned to do."
>
> "When it comes to cooking, she would only help you for warming up a pie, using the microwave. It's impossible for her to do real cooking for you."
>
> "I asked her to clean the oven. The oven, she just wiped the top for you, wouldn't touch the inside. She said that's not her job. That is what XXX (name of the home care worker) told me the other day. Now we have to clean the oven ourselves. My husband is so old, and my knee isn't good; but we have to do cleaning ourselves."

The utilization rate of home care services was low among the overall sample of the study, less than 8% (in Table 6.4). The reasons for scarce use of the services were unclear but could be attributed to the following potential situations. First, seniors were not aware of the services, their eligibility, and the procedures of applying for such services. Second, accessibility could be an issue for the seniors, such as language barriers in the application process or eligibility requirements. Third, some individuals might have doubts about the quality of services, such as mentioned above in the interviews; therefore, they might have chosen not to apply for the services. Fourth, certainly, seniors who enjoyed satisfactory health and were able to function in

their daily living activities would not be in need of such services. As indicated in previous analysis, many respondents reported average to high levels of physical functioning and vitality that enabled them to have sufficient self-care.

Summary

Winnipeg Chinese seniors' physical health conditions appeared similar to those of their national counterparts; mental health conditions seemed slightly higher. Although overall satisfied with the quality of the health care services provided by the local system, most seniors experienced the difficulties related to health care in everyday life after they had arrived in Canada. Younger Chinese immigrants, after having settled in Canada, eventually invited their parents to come to Canada for family reunion. The health conditions of elderly parents had become a critical factor in family decision-making on seniors' trips or immigration to Canada, because of all the reasons above, in addition to language barriers in the health care system in Canada. One senior noted:

> "To come or not to come to Canada? My daughter told me to consider carefully. I'm lucky that my health is pretty good, and I didn't feel that it'd be a big problem [as I wouldn't need to frequently go to the hospital]. But for those whose health is not good, like my in-law family, they are afraid of coming here. In China, you can see a doctor any time as long as you have money. Here, even if you have money, 'sorry, we can't see you.' You have to wait for several months [before being able to see a specialist]. Seniors who need to often go to a hospital will not be able to stand this."

Chapter Seven

SOCIAL CAPITAL AND HEALTH

Despite the diversity of the construction of the term, *social capital* has been found to consist of five common dimensions in various surveys and studies:

- Trust, reciprocity, and social cohesion (e.g., trusting other people, institutions)
- Social networks, social support, and social interaction (e.g., contact with friends and relatives)
- Social participation, social engagement, and commitment (e.g., involvement in groups and voluntary activities)
- Civic participation (e.g., propensity to vote, action on local and national issues)
- Views about the area or perception of community (e.g., satisfaction with living in the area, problems in area)
  (van Kemenade, 2003; Bryant & Norris, 2002; Green & Fletcher, 2003)

The quantitative data of all the five dimensions were collected to depict the respondents' level of social capital. The full score of each category varies due to different numbers of items and scales. Scores were summed from individuals' responses to individual items; a higher score indicates a higher level in a certain category of social capital. Respondents were offered the opportunity to say "Don't know" to all of the social capital variable questions. Possibly because many of the concepts were foreign to Chinese seniors or they had rarely thought about questions like these, many of them opted for "Don't know" instead of choosing a statistically valid answer. As a result, only nine cases had provided complete valid answers to all the social capital variables. For example, when being asked whether they thought most people in their neighbourhood could be trusted, some seniors replied, "I don't know. I don't go out often and haven't met a lot of people." This mentality was found quite common among individuals of the sample in responding to statements regarding social capital. It can be interpreted not only that the respondents did not have any ground to provide valid answers, but also they *lacked* the experience of necessary interactions and activities associated with social capital. Therefore, it is

likely that a *Don't know* answer is an indicator of a low level of a certain social capital domain. Another example is a question in the *Social Participation* domain where respondents were asked if they had been involved in any groups where people got together to do an activity or to talk about things. These groups were listed as 12 different types with an *Other* option to fill in any groups that had not be named. When a senior chose *Don't know* to a question like this despite an explanation of the concept (social group in this case) in everyday language, he/she might have little idea what the activities were and how they were related to them. It was unlikely that he or she had been involved in any of some types of activities, especially he or she was able to identify other activities that he or she had been taken part in. Upon careful consideration, most *Don't know* answers were replaced with a score of 0 to signify a low level of a certain measurement item, rather than being treated as missing data. This strategy was *only* applied to the data of social capital.

Table 7.1 displays the descriptive statistics of the social capital variables of the sample. Most respondents completed the social capital section of their survey, with one to three cases with missing data (no indication to any of available choices) for different variables.

Table 7.1 Description of Social Capital of Respondents

	# of Cases	Missing cases	Full score	Mean	Standard Deviation	Median	Minimum observed value	Maximum observed value	Percentiles			Skewness	Kurtosis
									25	50	75		
Views of Community	100	1	47	27.4	11.1	26	6	47	19	26	36	.10	-1.05
Reciprocity & Trust	100	1	31	18.8	6.7	19	4	31	15	19	24	-.12	-.74
Civil Participation	101	0	38	6.1	3.9	6	0	22	3.5	6	8	1.07	2.14
Social Networks & Social Support	101	0	111	32.3	12.0	30.5	6	64	23	30	40.5	-.48	-.14
Social Participation	98	3	112	5.4	5.9	3.5	0	24	0	3.5	9	1.20	1.06

Forty-three out of 101 seniors expressed their opinions about the social capital variables in more detail in the focus group interviews, particularly in relation to the quality of their current lives and their expectations for their living arrangements in the future. The qualitative data complemented the survey results in manifesting the multiple layers and perspectives of Chinese seniors' lives. For this reason, both quantitative and qualitative data will be analyzed in each dimension of social capital.

Views of Community

Quantitative Findings

Respondents expressed their views of the community in which they lived by answering questions on length of residence in the area, their satisfaction level to the community, and their opinions of drinking, rubbish, gangs, and other possible problems in their immediate neighbourhood. The longer a respondent lived in a particular community, the higher a score he/she receives. In the Likert-scale measures of opinions of neighbourhood problems, *Not a problem at all* and *Very satisfied with this area* score 5 while *Very big problem* and *Very dissatisfied* score 1. The full score of *Views of Community* is 47, which would indicate that a respondent had lived in a community for 20 years or longer and had been very satisfied with the neighbourhood, noticing no problems like drinking in public, drugs, gangs, or vandalism.

The average score of *Views of Community* is 27.4 with a standard deviation 11.1 (Table 7.1). The lowest observed value is 6 while the highest is 47. Half of the respondents fall into a bracket of 19 to 36. Although the skewness of the distribution of this domain is not significant, the kurtosis is to a moderate degree negative (Table 7.2).

To further examine the relationships between each of the social capital variables and the health status of the sample, correlation tests have been performed to identify if, and how, social capital factors might have affected Chinese seniors' health. In testing the relationships between certain variables, cases have been split to explore the differences between sub-groups, such as women versus men.

Pearson Correlation Coefficient was employed to test the relationship between *views of community* and the Physical Component Scales (PCS) and Mental Component Scales (MCS) for the seniors. As all variables contain interval data and distributions that are close to a normal curve, Pearson's *r* is appropriate. However, no significant correlation is found between how seniors viewed their communities and their health status.

The cases were split by gender and age to explore the relationship of the variables in different sub-groups. No evidence was found to point to any correlations in either male or female seniors. For the seniors under the age of 65 or over 75, *views of community* did not seem to have a significant relationship with either their physical or mental health. However, for seniors who were between 65 and 74 years old (n = 31), how they viewed their community is significantly correlated with both their physical and mental health. For the relationship between views of community and physical health (PCS), $r = .35$, p (one-tailed) $< .05$; for the relationship between views of community and mental health (MCS), $r = .43$, p (one-tailed) $< .01$.

The statistically significant relationships between social capital variables and the two health domains – overall physical and mental health – are summarized in Table 7.2. For reading convenience, parts of the table will also be presented under each heading respectively.

Table 7.2 Summary of the Relationships between Social Capital Variables and Health of the Respondents

	Physical Component Summary (PCS)						Mental Component Summary (MCS)					
	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75
Views of Community	-	-	-	-	r = .35 p <.05	-	-	-	-	-	r = .43 p <.01	-
Reciprocity & Trust	-	-	-	-	-	-	-	-	-	-	-	r = .27 p <.05
Civil Participation	τ = -.14 p <.05	-	-	-	-	-	-	-	-	-	-	-
Social Networks & Support	-	-	-		-	-	r = .29 p <.01	-	r = .41 p <.01	r =.55 p <.05	r = .41 p <.01	-
Social Participation	τ = -.13 p <.05	τ = -.32 p <.05	-	-	τ = -.32 p <.05	-	-	-	-	-	-	-

Qualitative Findings

The interviewed seniors' views about the community can be roughly grouped into two perspectives: the perspective of living with multiple cultural and ethnic groups in a general retirement housing setting or in regular residential areas, and living in an ethnically homogeneous residential building located in the Chinese community. Those who lived in retirement buildings and residential areas that were not designed for any particular group of seniors reported general satisfaction toward their living environments. The cleanliness level of public space in a building or a neighbourhood was noted as excellent; and nutritious meals available in retirement buildings were provided to residents upon pre-order with minimum cost. The seniors living in such buildings appreciated the low cost of food services at a not-for-profit rate. Various activities were usually organized within these buildings for socialization purposes such as coffee time chatting or playing chess, at an affordable cost, such as $5 a month. Regardless of these affordable programs, activities, and services, the seniors living in multi-ethnic buildings expressed moderate satisfaction about the physical environment, but did not find their lives fulfilled simply by being located in such an environment.

The seniors living in a retirement building in the Chinese community depicted a different picture. Few activities or programs had been organized for building residents to participate in. Most seniors reported inadequate interaction, as well as limited conflicts, with neighbours in everyday life. They did not initiate visitations to others' homes but merely greeted each other if they encountered neighbours in the lobby. One senior described:

> "We all close our doors and live our own lives behind the doors. We hardly sit down together to chat, probably once or twice, as far as I remember. We sometimes go down to the lobby to chat; but more often just to say Hi when we run into each other. Just like that. No fights, there have been few fights between neighbours."

The seniors complained that they did not have a place for recreational activities and there were no organized activities of any kinds. They needed to go to a nearby community centre to pay rent for activity space and equipment if they wanted to partake in some activities or physical exercises such as playing ping-pong. Not only was it inconvenient to go out of the building for recreational exercises, particularly in the winter, but rental fees were a concern, due to limited finances, to the seniors who liked doing such exercises frequently. Seniors expected the community centre would offer free services or free use of space to Chinese seniors, but were disappointed to find that its management policies did not meet their expectations and needs.

Certain problems in the physical environment were mentioned in relation to improvement of quality of daily life. For example, the management had informed residents about making curtains for each unit but this had not been implemented. The residential building had been designed without windows in the hallway, which caused the building to be hot in summers and stuffy in winters. Senior residents did not have a chance to have some fresh air for days or even weeks when the weather was harsh outside. The residents had been raising this issue for years but only received a response from the management stating that windows would not be installed

due to security considerations, without any further accommodations or discussions on possible alternatives. Several seniors described the issue:

> "Many seniors have raised this problem: no windows on the hallways. When it's cold outside, older people can't get out to have fresh air. They can only walk up and down the hallway [for minimal exercises]. But the hallway is all sealed. We hope that some windows can be installed, with bars. They [the management] said they considered windows are not safe for seniors as they might crawl out of the window. [Another respondent said and laughed: Jump out of the building.] They just said that, but didn't consider the majority."

The respondents in the Chinese seniors' building also indicated that caretaking in the common places in the building had not been maintained to a satisfactory level. For instance, the handrails and floor of the hallway had rarely been cleaned. Vacuuming the floor was not done regularly, and it was not done thoroughly and properly each time.

Summary

The survey sample represented a moderate satisfaction level in the overall evaluation of the community in which they lived. But few details were provided with respect to the domains of a community about which the seniors were content or discontent. The interview participants, however, revealed that Chinese seniors resided in different types of community environments, and in turn, they perceived diverse views with respect to their environments. Seniors in different communities did share some similarities in their views of community, but they stressed different issues that had affected their lives.

The seniors in both mainstream retirement buildings and regular residential neighbourhoods and Chinese-oriented retirement buildings indicated insufficient social interactions in their daily lives, but these were hindered by languages barriers for Chinese seniors in mainstream buildings or by neighbours, and by lack of organization of social activities for

those in Chinese buildings. Cleanliness in public spaces was mentioned by both groups as an essential factor in their assessment of the community. The individuals in mainstream buildings seemed satisfied with the level of public hygiene maintenance, while those in a Chinese building stated their concerns of the quality of cleaning, as well as comments on a few architectural and interior design issues of the building, such as lack of windows and curtains to allow fresh air in.

For those living in a Chinese-oriented building, the benefits of being surrounded by familiar languages and culture in an ethnic-homogeneous environment seemed to be undermined by the unsatisfactory quality of the physical residential environment and its services. Seniors living in an environment that had not been designed to accommodate people from different cultures, on the other hand, were unable to take full advantage of available services and activities in the community, despite their high quality and quantity, due to language obstacles. It is not surprising that the overall view of community was in moderation among the survey respondents because seniors in both Chinese-speaking environments and non-Chinese-speaking environments could not enjoy the convenience and facilities to their full extent.

Trust and Reciprocity

Quantitative Findings

This domain is measured through six questions, which include whether the respondent trusts their neighbourhood, civil services like police and governments, and whether they believed that their lost wallets would be returned by people in the community. Higher values indicate higher levels of trust. For example, *Trusting police* (the courts, Government of Canada, Government of Manitoba, and Winnipeg City Council) *a lot* received 3 for each institute, while

Not trusting at all received 0. *Definitely agree that this neighbourhood is a place where people from different backgrounds get on well together* also scored 3, and *Definitely disagree* on the above statement scored 0.

The full score is 31. The observed minimum value is 4 and maximum 31. The mean is 18.8 with a standard deviation 6.7 (Table 7.1). Fifty percent of the respondents acquired relatively high scores of *Reciprocity and Trust*, between 15 and 24. The distribution, as indicated by both the skewness and kurtosis values and the histogram, is close to a normal curve.

Table 7.3 Relationships between Trust and Reciprocity and Health of the Respondents

	Physical Component Summary (PCS)						Mental Component Summary (MCS)					
	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75
Reciprocity & Trust	-	-	-	-	-	-	-	-	-	-	-	r = .27 p <.05

Pearson Correlation Coefficient was also employed to test the relationship between *reciprocity and trust* and the Physical Component Scales (PCS) and Mental Component Scales (MCS) for the seniors (Table 7.2 or 7.3). No significant correlation was found between the level that the seniors trusted the people in their community and their health status.

The cases were split by gender and age to explore the relationship of the variables in different sub-groups. No significant correlations were found between the variables in most groups, except in the group of seniors who were older than 75 (n = 40). For the oldest age group, reciprocity and trust were positively correlated with their mental health status (MCS), r = .27, p (one-tailed) < .05.

Qualitative Findings

Some seniors demonstrated a strong sense of trust toward fellow Chinese immigrants, especially those who attended the same church. One senior said, "We care for one another, not only because we share the same belief but we can also help one another. Because we are all Chinese, we feel more bound here in Canada than in China. [Back home] in China, people live their own lives behind closed doors. Even neighbours don't visit one another very often. But here, people greet one another even from distance." The feeling of trust was not restricted to the seniors' Chinese networks, but expanded to a broader community. The seniors with a certain degree of English skills tried to partake in daily activities, such as taking a bus ride to an appointment or having a walk in the neighbourhood. They constantly expressed their willingness to request support or assistance from service providers or ordinary people in the society. One older woman shared her experience of receiving help from a stranger:

> "I needed to take a walk every day, and I got lost once. I probably didn't pay attention to where I was going that day, because I just followed my habit. I don't know what I was thinking, and I didn't know where I was. All roads looked the same to me, I couldn't find my way home. I couldn't find home for two hours. I knew it was nearby, but I just couldn't find it. I spoke some English; so I was looking for someone for help. Children wouldn't do, so I was looking for an adult. I found a person, telling him that I had got lost and asking him for help. He asked me my address, and I told him. And he said he had just moved here, too, as it was a newly developed neighbourhood. He said he had moved in two months ago. He said, I had an iPad and I could find your home with it. At the end he drove me home. It took only one minute driving!"

Trust in people in the community enabled the seniors to expose themselves to the outside world rather than just the family setting; in turn, they could enjoy more recreational activities and socialization opportunities available in the community for both mental and physical health, with the support of the individuals in all aspects of their lives, such as giving or showing directions on the street or providing accommodation for seniors getting on and off buses.

On the opposite spectrum, lack of trust creates tremendous stress to seniors in their everyday lives and mental health, particularly for the interviewed seniors who had been residing in one particular retirement building. Most seniors in the building were long-term immigrants and only one couple had immigrated about ten years previously. Living on their own in the retirement building, they enjoyed the comfort and convenience of communication as they shared similar cultural backgrounds and dialects. However, when problems arose in the mezzo-environment, they affected everyone living there. The respondents reported multiple issues related to the management of the building, which had severely shaken their levels of trust of the community and certain governmental sectors and authorities.

Financial mismanagement was the first issue that came out from the engaged focus group participants. According to the seniors, only one individual had been in charge of all financial affairs, hiring, building maintenance, handling donations from community partners to seniors, and other management-related work. The building caretaker was noted to have embezzled cash by entering smaller amounts of money into a book than what she had received as payment from residents, such as the tenant club membership fees, so that she could keep the discrepancies to herself. Another example of abuse of group funding dealt with the funding issued by the government to support community development activities and programs for the residents in the building. The building manager/caretaker had not organized any programs or activities during that time period. It was particularly unacceptable to the interview respondents that the caretaker withheld the one-dollar *fortune money*, that signified the wish of good fortune in the New Year, for at least half of the residents.

When financial abuse expanded beyond public or collective management and took place in the personal sphere, seniors' attitudes toward the manager exceeded the level of distrust; rather,

they began to feel threatened and unsafe in their lives. One respondent described an incident that had happened to a friend of his in the same building:

> "Mr. C's nephew had arranged C's phone bills to be paid through automatic transfer from his bank account. Therefore Mr. C didn't need to deal with the payment every month. However, M [the caretaker] claimed that she was taking care of paying of the bills for Mr. C. although a phone bill was usually around $30 a month, M asked him for over $100. This was straight extortion. Two days later, she went to ask Mr. C for money to pay a phone bill again. Mr. C was shocked and scared. He left his apartment right away, and called his nephew to come to pick him up at 11 p.m. He spent the whole night at this nephew's, afraid of staying home alone."

Financial abuse targeting individuals caused feelings of helplessness and insecurity. The feelings deepened for those seniors who possessed more vulnerability, such as disabilities, on top of common obstacles to immigrant seniors (e.g., cultural differences, discrimination toward senior citizens). The story of another senior demonstrates the issue:

> "She collaborated with D [a lawyer] – because Ms. E was handicapped and had to use a wheelchair to move around – to set up a so-called authorization letter to appoint M to handle Ms. E's bank book. Ms. E told us that M had taken out $100 to buy something worth ten dollars without returning any change. She took the money out from the bank, and didn't bring back any change. When Ms. E needed several dollars for a haircut, she had to ask M for it. This is not right. Ms. E is still alive [and clear-headed]. I think this is extortion."

It was fairly difficult, if not impossible, for other seniors living in the mezzo-environment to develop or strengthen any trust of the immediate authority upon witnessing or hearing about the experience of fellow residents. Not only were the seniors sympathetic of those targeted and angry about the maltreatment, but they also started to worry about their own security and wondered whether they had been or would be treated unfairly as well.

The unfair treatment to building residents extended into other aspects of seniors' lives. Having realized tenants' dissatisfaction and complaints, the caretaker tried to segregate those

who were courageous to stand up for their rights from those who were submissive to her management, isolating them, and denying them of universal benefits to all building seniors, such as distribution of donated food. The residents allying with the caretaker sometimes received so much food that they had to call their children to come to help consume it, while many other building residents did not receive any. Believing the unfairness had been generated from their upholding of tenant rights, a respondent noted:

> "We gave our comments and revealed these [management] problems in a general meeting last year… the board members got to know as well. Then, we [people who had spoken up] feel as if we had been sentenced to death penalty [analogy of the untouchable]. Three friends of mine had been coming to my apartment frequently to play mah-jong for seven years. After that meeting, they all disappeared [and never came to my apartment again]! Instead, they joined the mah-jong group in M's apartment. They were even afraid of saying hello to me when we ran into each other. We, who spoke up, have been discriminated."

The seniors who stood up and tried to protect their rights were segregated and punished with denial of materials. Not only did they suffer from material losses, but their deprivation of the entitlement to universal benefits for invalid reasons also worsened their distrust of management.

Summary

The average score of *trust* was similar to that of *views of community* among the overall sample of the study. The seniors living in a multicultural community indicated a high trust level toward people in the community; whereas those in a particular retirement building demonstrated significantly more problems related to trust. It did not appear that the cultural homogeneity contributed to the trust issues; rather, it was the unhealthy management in a mezzo-environment (e.g., an apartment building, a neighbour, or an immediate community) that had created

tremendous distrust and negative feelings in the community, especially towards particular individuals with a particular level of authority. Unhealthy management generated, and included, financial mismanagement, financial abuse, discrimination in distributing universal benefits, bribing, and polarizing residents to create hostility between groups. When seniors encountered unfair treatment or experienced difficult situations related to managerial mechanisms within the community, they needed to have a safe place to express their concerns, which in turn, should then improve or change the problems they had experienced. If they were not granted the chance to voice their comments, or worse, if they were penalized for speaking out for reasonable requests, thus upholding their rights as community members and human beings, those problems in the community would not be dealt with and actually were more likely to become more serious issues. Moreover, seniors felt financially and physically unsafe, discriminated for holding different opinions while being courageous to stand up for themselves, and helpless in terms of solving the problems.

Civil Participation

Quantitative Findings

Five questions of *civil participation* required respondents to report whether they believed they could influence decision-making in their domains, individually or within a group, whether they had taken action in an attempt to solve problems in their community, and whether they had voted. The respondents were allowed to make multiple choices among the actions they had taken to solve problems or express concerns over social issues, such as contacting media and/or politicians, attending meetings, forums, or groups, and organizing petitions. The more actions a respondent reported, the higher score he/she received.

If a respondent strongly agreed that he/she could influence decisions affecting his/her local area, had taken all listed actions to affect local and national issues, and had voted in both the latest national and local elections, a full score 38 was granted. The minimum value the sample obtained is 0 while the maximum was 22. The average score is 6.1 with a standard deviation 3.9 (Table 7.1). Most respondents (75%) had a score 8 or under, which indicates an overall low participation in civil activities among the sample of seniors. The distribution is positively skewed in a pointy and heavy tailed distribution, as denoted by the skewness value (1.07) and kurtosis value (2.14) (Table 7.1).

Table 7.4 Relationships between Civil Participation and Health of the Respondents

	Physical Component Summary (PCS)						Mental Component Summary (MCS)					
	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75
Civil Participation	τ = -.14 p <.05	-	-	-	-	-	-	-	-	-	-	-

As indicated before, *civil participation* does not present a normal distribution. Therefore, non-parametric statistics were applied to explore the relationships between civil participation and the health status of the seniors. For the overall sample (n = 93), civil participation appeared to have a small negative correlation with physical health (PCS) but no relationship with mental health (MCS) for the seniors: Kendall's correlation coefficient τ = -.14, p (one-tailed) <.05; Spearman's correlation coefficient r_s = -.21, p (one-tailed) <.05 (Table 7.2 or 7.4).

The cases were split by gender and age for further exploration. No significant relationships between the variables were identified in individual sub-groups stratified by gender or age.

Qualitative Findings

The management issues in the Chinese seniors' building that had contributed to the seniors' feelings of distrust did not affect only particular individuals but all residents in the mezzo-environment. Those who spoke up were motivated by the pursuit of fairness and collective wellbeing, believing both individual rights and group benefits should be protected, rather than being abused by one or a few people in power.

> "Therefore, we, this group of people, had made many efforts [to ensure everyone's voice was heard] to elect the Tenant Club Executive Committee. It's not that we want to do this work; and [the unhealthy management] hadn't harmed me directly in any way. Why are we taking the initiative [to make changes]? Because we cannot stand watching older seniors being deprived of welfare and benefits…. I could not stand [the injustice], so I stood up."

During the lengthy process of advocating rights protection for all tenants, the seniors had demonstrated incredible strength and resourcefulness in civil participation and reaching out for aid. Their first ally was a local Chinese community leader who was invited by the caretaker to a tenants' meeting to settle the disputes between her and her unhappy residents. Upon listening to all the aspects of the situation from both sides, the community leader began to assist the seniors, instead of the caretaker, in the process of dispute settlement.

As the seniors' civil participatory actions progressed, the community leader introduced the seniors to a local Member of the Legislative Assembly (MLA), the Elder Abuse Prevention Services at a senior centre, and the Residential Tenancies Branch of the provincial government; however, the MLA later withdrew from her supportive position, due to the negative influence of a member of the building's board. Eventually the seniors were connected with two lawyers through the community leader, considering legal solutions as their last means to solve the problems. The second lawyer agreed to accept the case for a total token fee of $650. The group

of seniors made their best effort to collect donations from concerned tenants to pay the legal fee. For over a year, the lawyer, together with the senior centre, the community leader, and the Residential Tenancies Branch, worked with the seniors on setting up a Tenant's Club through an election, aiming to set up a healthy, self-sustainable management mechanism within the building.

Regardless of the outcomes of the seniors' appeal, and their attempt to uphold their rights right up to date the data were collected, this group of seniors had revealed significant persistence and tremendous courage in reaching out for assistance to protect collective rights with their group effort. Poor English proficiency, especially in preparing required documents, hindered but did not stop the seniors in having their voices heard. English translation or interpretation was usually undertaken by individuals who sympathized with the seniors, including a community leader, their family members, and volunteers. On their own initiative, the seniors had contacted and work with a variety of resource people or organizations, from community leaders, social agencies, governmental sectors, to legal professionals, to solve community issues. Overall, Chinese seniors' civil participation was highly active in relation to the issues in their immediate living environment, despite the direct causes of such extensive civil participation were fairly harmful to seniors' wellbeing.

Summary

Civil participation is commonly manifested through actions in an attempt to partake in solving problems at local or national levels. These actions include people in the community working together to influence decision-making on local issues and voting in council or national elections. Aiming to solve, or, at least, to bring to discussion the management issues in the mezzo-environment, the interviewed seniors demonstrated their persistent effort in solving

problems through a series of civil actions, including seeking support from political or community leaders and organizing elections for a tenants' club.

Such civil participatory efforts, however, were evident only among the seniors who had been experiencing management problems in one certain building and who had been actively seeking potential solutions internally and externally. This specific group of seniors demonstrating significant civil participation was approximately only half of the focus group, consisting of 10 – 15 percent of the entire sample. The majority were those who lived in other communities, such as residential neighbourhoods or mainstream retirement buildings; and they did not report any significant involvement in local, municipal, provincial, or national affairs. Adversities in a living environment, on one hand, generated enormous stress to the elderly who were affected; on the other hand, they activated the seniors' inner strengths to overcome tangible and practical hindrances and take action through civil participation in order to improve their living environment. Common obstacles, such as language barriers or lack of resources and information for social support, seemed more possible to overcome for the seniors who were motivated to resolve the challenges they were facing.

Social Networks and Social Support

Quantitative Findings

Social networks and social support was measured through nine questions that specified the extent that seniors connected with their relatives, friends, and neighbours, and whether the seniors provided physical, emotional, and financial support to and received from people in their networks. The more types of support the respondents provided and received, the higher their scores were.

The total score is 111; but most respondents (75%) reported lower than half of the full score (75 percentile = 40.5) (Table 7.1). The average is 32.3 with a standard deviation 12.0. The lowest observed value is 6 while the highest 64. The skewness and kurtosis values, as well as the histogram, indicate that the *social networks and support* variable enjoys a normal distribution.

Table 7.5 Relationships between Social Networks and Support and Health of the Respondents

	Physical Component Summary (PCS)						Mental Component Summary (MCS)					
	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75
Social Networks & Support	-	-	-		-	-	r = .29 p <.01	-	r = .41 p <.01	r =.55 p <.05	r = .41 p <.01	-

As the category of *social networks and social support* has a relatively normal distribution, parametric statistics were applied to test the relationships between this social capital domain and seniors' physical and mental well-being. Social networks and social support were significantly positively related to the overall mental well-being (MCS); for the sample, r = .29, p (one-tailed) <.01 (Table 7.2 or 7.5).

Further analysis of social networks and social support in different gender groups indicated no significant relationship between this social capital domain and health for older Chinese men, but for older Chinese women, social networks and social support was significantly related to female Chinese seniors' overall mental well-being, r = .41, p (one-tailed) <.01.

When stratified by age, younger seniors seemed to be positively affected by the degree of social networks and support. For those under age 65 (n = 13), social networks and social support is significantly positively correlated with their overall mental health (MCS), r = .55, p (one-

tailed) <.05. For the age group of 65 to 74 (n = 32), the level of social networks and social support was positively related to seniors' overall mental health, r = .41, p (one-tailed) <.01.

Qualitative Findings

A summary of connections with relatives, friends, neighbours, and other individuals in life, s*ocial networks and social support* is a complex area because it encompasses multiple groups or circles of individuals in seniors' lives. The interview participants described different categories of their networks and support within the Chinese community, from family to broader networking circles; some of them also mentioned the interactions with individuals and groups outside of the Chinese community. All types of social networks and support can cause both positive and negative effects on individuals, depending on the dynamics of their relationships in the context of everyday life. This section will illustrate the networks of interviewed seniors and the impact of each category of networking on older Chinese immigrants.

The essential component of the networking of most Chinese seniors was within Chinese circles, in which the focus is family, particularly adult children and grandchildren. Children and grandchildren were the seniors' primary network to receive practical, financial, and emotional support. Younger family members usually were the first resource to provide support to seniors, for example, transportation and translation for medical appointments and other functional activities outside the family. As major bread-winners for the family, adult children were sometimes at work and unable to provide assistance for timely tasks. Grandchildren who were high school or college students would step in to assist where they were able. A grandson accompanied his elderly grandmother to a doctor's appointment and acted as interpreter for her and the doctor. A granddaughter who had just received her driver's license drove her

grandmother to an ultrasonic check in a hospital a 40-minute drive away, upon learning that Grandmother's appointment might have to be rescheduled the third time because the daughter who was supposed to drive her mother was unable to get away from work every time on the scheduled appointment dates. Support from family members may not be the best solution to seniors' needs; for example, the grandson could not enter the examination room to translate for his grandmother, and the granddaughter was not comfortable driving to a distant unfamiliar place. Nevertheless, they are undeniably reliable resources for seniors if they needed help.

The emotional support of family was considered of most importance to the seniors. The respondents expressed strong bounding with their children despite minor disagreements or different lifestyles in their lives with children and their families. The seniors depended on children and grandchildren for emotional intimacy and comfort when feeling loneliness. Regardless of living arrangement, the connections and interactions between the seniors and their offspring created tremendous sentimental effects for the older Chinese immigrants:

> "I am afraid of loneliness, and my husband already passed away. If I'm alone, I will feel isolated. [So I like] living with my children. Though there may be small disputes between them and me, I don't take them seriously; and the life for me with my children is easy."
>
> "The third generation [grandchildren] love to visit us grandparents, as they can have a free delicious meal at the grandparents'. Offering such a free meal will make grandparents so happy that their life spans would be extended for one more year. It [the intergenerational interactions] seems to represent a positive cycle in Chinese families."

Those who did not co-reside with children indicated strong emotional dependency on children to feel needed and cared for. They particularly felt vulnerable as passive recipients of emotional support from children who were not always available due to other important commitments in life such as work (for income to provide financial means for both the younger and older generations), child care, professional development studies, and socialization. Living in

separate households caused physical interactions to be less frequent which might in turn reduce the quantity and quality of emotional interactions between seniors and their children. Some seniors noted:

> "We want to receive warmth and care, that's right. We'd like our children to come to visit us. If they haven't come for a while, we may not be very happy about that, especially when seeing other tenants' children visiting them. This is because we have feelings … first is about the bounding [between parents and children]; and second is that [our] emotion can be vulnerable. We feel sad [if our children don't visit us] while other seniors' children are visiting. [We wonder ourselves] maybe he doesn't remember to visit, or maybe he's too busy at work…"

> "Children may come visit me once a week, or they may take me for an outing. This cannot be prohibited [by the senior home]. Or it will harm our emotions and rights, against human nature."

In spite of the magnitude of the family in seniors' social networks, there are certain concerns in support from family. First of all, not all seniors' adult children were residing in Winnipeg. A small number of seniors had immigrated to Canada when their children were working here; and eventually those children found employment in a different province or in the U.S. and moved away, leaving the elderly parents living by themselves in Winnipeg. Secondly, even if the adult children lived in the same city, they might not be physically available as indicated earlier, or necessarily supportive when the seniors were in need of assistance. In the discussion of learning English and EAL classes for seniors, one elderly couple mentioned, "She (their daughter) said that she didn't have time to drive us to the English class. She said [half jokingly], forget about learning English. It'd be already great for you to speak Chinese fluently." Most seniors who had attended EAL for Seniors travelled to the venue either by bus(es) or on foot (if it was within walking distance) on their own. Not too many adult children were able to give rides to their parents to activities during office hours (when those classes were occurring) on a regular basis.

Friends and neighbours were other important sources for networking and support for the seniors. One male senior met some younger Chinese immigrants while they were all enjoying their common hobby activity – fishing – and befriended them. The age difference of 30 to 40 years did not create a big gap between the senior and his fishing buddies; actually, besides going fishing together, the friends often give the senior rides to do grocery shopping or doctors' appointment. Two friends living in the same apartment building regularly offered to buy groceries or small household items for him. For most seniors, friends were those of similar age. They might gather together to play mah-jong if they lived within walking distance or in the same building. They would ask one another for advice or ask questions such as how to cook a special kind of food. However, they were hardly able to aid one another for tangible and practical demands like transportation to doctor appointments or translation of mail into English, as one elderly woman stated:

Interviewer:	"Ms. D, you mentioned that you could only ask friends for help if you have problems. Who are your friends?"
Ms. D:	"Other older people. But we all have many difficulties. If my friend comes to me asking for help, but I have my own difficulties, how can I help her even though I want to? I can only say, Call me if there are any problems. That's it, that's how much I can do."

The most common help that seniors provided one another was advice. Older immigrants might not be able to speak English fluently or drive a car to a doctor's office, but they had abundant life experience and sometime professional experience from previous employment. One female senior was a physician who had specialized in gynaecology and she became health "consultant" to many older Chinese women in the community. As indicated in foregoing sections, Chinese seniors' accessibility to full health care was greatly hindered by language barriers. Unable to accurately describe their feelings and symptoms of their illnesses and express their

expectations to health care professionals, the seniors often had immense trouble in understanding professionals' inquiries or instructions for medications, treatment, or post-treatment care. Seniors and their family members' insufficient knowledge in medical terminology, in both Chinese and English, worsened the quality of communication, especially in cases of more severe conditions or diseases such as ovarian cancer. Fortunately, the retired woman doctor was able to provide sound explanations of doctors' instructions after being translated by the seniors' adult children, as well as advice on treatment, care, and questions to their doctors in the future. As a result, the seniors felt relieved about understanding details of doctor's diagnoses and instructions. One senior expressed her gratitude toward the doctor friend: "I really didn't want to bother Ms. C, but I had no choice. When I wanted to consult someone about the situation of my illness, it was very useful to talk with her. Once she explained the situation to me, I was relieved. We are in need of, great need of [doctors who can speak Chinese], particularly for someone like me who has a serious woman's disease."

Neighbours were seniors' immediate contacts besides family. Positive relationships with neighbours brought fun to seniors' lives through partaking in small-scale activities, including playing mah-jong at someone's home, having a dinner together, or playing ping-pong. The interview participants, however, reported that such activities took place either occasionally or with only a very small group of people. While most Chinese seniors living with adult children or in a general retirement building acknowledged the lack or insufficiency of interactions with neighbours in their lives, the seniors in the Chinese senior residential building pointed out the reduced amount and quality of neighbour interactions in recent years.

The segregation of building residents due to unhealthy management led to a significant split between the seniors in the same mezzo-environment. Friends turned strangers because the caretaker discouraged tenants from associating with those who spoke up on collective rights and

benefits. One senior said that there used to be more interactions between neighbours a decade before where many tenants would gather in the lobby on the main floor to watch TV or chat, but "it has quieted down in the last several years". A fellow tenant confirmed the inactive dynamics among neighbours:

> "We all close our doors and live our own lives behind the doors. We hardly sit down together to chat, probably once or twice, as far as I remember. We sometimes go down to the lobby to chat; but more often just to say Hi when we run into each other. Just like that. No fights, there have been few fights between neighbours."

A third notable networking resource for Chinese seniors were the individuals or groups in Chinese religious or spiritual circles. Although some respondents claimed to be followers of Buddhism or other religions, many seniors from mainland China reported their affiliation with a Chinese Christian church. The seniors described that they had not only benefitted from mutual practical support among church members, but also a bond of friendship and trust which had been lost in their home country – mainland China – was reignited in the local community:

> "The church is a fairly good group. People in the church are very kind and like to help one another. I feel that I have received more help here [in Winnipeg Chinese community] than in China. People in the church care about one another. It's not only because we share one belief, but we do care about one another and help one another. We are all Chinese, so we feel close to each other. This is not like that in China where we all close our doors [and live our own lives]. Neighbours don't bother to interact. But here, people like to greet each other even from distance when we encounter on the street. … I think the church is a nice group as it can integrate us and allow us for mutual aid."

The seniors seeking external assistance in solving management issues in their apartment building were able to acquire a crucial contact who was the first step for them to reach out to authorities and organizations through a series of civil efforts. The contact person, a Chinese community leader, not only provided enormous support to the seniors, including acting as a

translator and interpreter and advocating for the seniors' rights and appeal, but also introduced the seniors to an entirely different circle of individuals whom the seniors otherwise would not know. Although the community leader was not highly active or visible in recent Chinese community affairs, his connections with individuals and sectors with the power for potential policy change and decision-making were undeniable. The linking function of social capital introduced a relatively less common networking source for Chinese seniors: individuals or organizations outside typical Chinese circles in the local community.

The interviewed respondents who had not experienced difficulties, such as the mismanagement of the apartment building previously described, did not report any networking efforts outside Chinese circles. But for the seniors who had been seeking external assistance to problem-solving, they had to reach out to higher authorities in order to appeal because their issues could not be settled within their immediate community. They had contacted a Member of Legislative Assembly, a senior centre that operated an "anti-abuse against seniors" program, the provincial government office in charge of tenancy management, and at least two lawyers. In general, all the contacts had been helpful to the seniors in need of help as they were able to provide necessary information and direction or referrals for moving the seniors' pursuits forward in a formal appeal journey. Due to various reasons, however, some of the contacts disappointed the seniors to a certain degree, and, in turn, affected their trust of authority figures or organizations in a negative manner. For example, the MLA who had been sympathetic at first to the seniors' situation changed her attitude and stopped assisting the seniors after communicating with her friend, a board member who did not support the seniors' efforts of upholding their rights.

The motivation of a group of seniors to solve the management problems in their building activated them to constantly expand their social network; if a contact could not help them solve

their problems, they moved to find another one. If not for operational and practical reasons, the seniors might not have obtained such a network. It was actually more common for the majority of Chinese seniors to have relatively limited networks.

Language barriers were the major obstacle that hampered Chinese seniors in making connections with people in the community. Some seniors had been open to diverse activities in their apartment buildings or in the city, such as coffee parties, games, or free open concerts. Once they were in attendance at those activities, however, they found they could not understand what fellow attendees, who were Canadian, were trying to communicate with them, which could have been jokes, instructions for chess games, or comments on certain music. Without a clue about what others were laughing or talking about, Chinese seniors felt not only excluded from social activities but also inadequate in social skills.

> "We're unable to laugh on the things they found funny or interesting. We felt like idiots. The critical reason is language. Besides, in this building, due to language barriers, we cannot make frequent interactions and in-depth conversations with local residents, right. We know simple English, able to conduct simple and shallow communication; but it's impossible to conduct heart-to-heart conversations."

Another obstacle was faced by Chinese seniors was the limited number of individuals they could meet in daily lives. Most seniors were retired, and, therefore, they already lacked an essential source of social contact. Language barriers further restricted Chinese seniors' interaction with individuals in daily life, community programs, or social activities. Seniors co-residing with adult children usually had regular interactions only with family members and people in the church they were affiliated with; those living in retirement apartments might see fellow tenants and conduct small talk with them if they spoke the same languages. Either way their networks were restricted in size, because the places and opportunities the seniors could

create or increase social contacts were fewer than for younger immigrants. When asked whether they had other social networks or circles they had connections with besides the church, most respondents remained silent except one or two who replied "no". One senior mentioned that no one in her and her husband's life had been available to meet their needs:

> "It is extremely difficult for us to go out or travel. My husband has been wanting to visit Toronto – since we are in Canada, a huge country – he wants to see [the well known place]. But no one is available [to go with him]. How can he go by himself without know any English]? No one [can help]."

Summary

In general the seniors' networks included family, friends, neighbours, and church members in the local Chinese community, and they provided seniors with practical support (e.g., transportation), informational support (e.g., health care advice), and emotional support (e.g., bonding with children and grandchildren). The level of social networks and social support appeared to be positively correlated with the Chinese seniors' mental health status in the research, but not physical health. Furthermore, it was *only* positively correlated with mental health for female seniors, when broken down by gender. In other words, it was true for older Chinese women that the more social networks and support they possessed, the better mental health they enjoyed.

The impact of social networks and support on mental health also varied by age groups. Younger seniors seemed to be affected more by the level of social networks and support for their mental health; or the better mental health they had, the higher level of social networks and support the seniors were likely to have acquired. However, this correlation appeared only among seniors who were 74 years old or younger. No signification correlation was found between social networks and support and mental health status for seniors older than 75.

The most substantial characteristic of Chinese seniors' networks was they were within certain Chinese circles in the local community. Not working or attending school and low English proficiency confined Chinese seniors' interactions with others in the immediate social circles, such as family, their apartment building, or church. It was not surprising that both the survey respondents and the focus group interview participants reported low levels of social networks and social support and limited engagement in networking activities. Many seniors expressed their dissatisfaction of their current networks and the expectations of improving the quality and quantity of the networks:

> "Only in the church, Chinese church. Our activities only take place within the Chinese church, because of language [barriers]…we can't communicate with foreigners (Canadians) and can only interact with people within the Chinese circle… I think it's sad. It's sad to Canada as well. These people are unable to integrate into the Canadian society; it's sad for them."

> "I think since we are living in Canada, we need to expand our social networks; then our lives can be happy. If [the people we can interact with] are confined in such as a small circle – although there are some advantages to a small circle, like one only needs to take care of oneself – but the circle is too small! I think we should integrate into the community, and into the Canadian society."

Social Participation

Quantitative Findings

Social participation was examined through asking respondents what social groups that they have been involved in and what volunteer work they had contributed to. Higher scores demonstrate the involvement in more social groups and volunteer activities for the respondents. Such groups include hobbies/social clubs, sports/exercises groups, community or neighbourhood groups, adult education groups, groups for older people, religious groups, environmental groups, etc.

The average score of the respondents is 5.4 with a standard deviation of 3.5, while the full score is 112. At least a quarter of the respondents reported no social participation at all, scoring 0. The majority (75%) obtained scores under 9. The distribution is positively skewed, as more cases are piled up at the left where lower scores fall; Kurtosis value 1.06 indicates a flat and heavy tailed distribution. The descriptive data show that overall the sample of seniors did not do so well in *social participation* in that they present evidence of *floor effect*, where most scores hit the bottom end of the distribution, which is due to the possibility of Chinese seniors' general unfamiliarity to these types of socialization groups in the Canadian context and the unavailability of such groups to the seniors. Analysis of the qualitative data in later sections will provide insights to this issue.

Table 7.6 Relationships between Social Participation and Health of the Respondents

	Physical Component Summary (PCS)						**Mental Component Summary (MCS)**					
	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75	Overall	Male	Female	Age <65	Age 65 – 74	Age > 75
Social Participation	τ = -.13 *p* <.05	τ = -.32 *p* <.05	-	-	τ = -.32 *p* <.05	-	-	-	-	-	-	-

The distribution of *social participation* did not represent a normal curve. Therefore, non-parametric statistics were applied to explore the relationships between social participation and the health status of the respondents. For the overall sample, social participation showed a small negative correlation with physical health (PCS), Kendall's correlation coefficient, $\tau = -.13$, *p* (one-tailed) <.05; but no relationship with mental health (MCS) for the seniors (Table 7.2 or 7.6).

The cases then were split by gender. For older Chinese women, no significant relationship between social participation and their health status was found. For older Chinese men (n = 30), the level of social participation was significantly negatively correlated with their overall physical

health (PCS), but not mental health (MCS), $\tau = -.32$, p (one-tailed) <.05; $r_s = -.40$, p (one-tailed) <.05 (Table 7.2 or 7.6).

Then the cases were split by age. For seniors who were younger than 65 or older than 74, no significant relationship was found between social participation and neither of the health summary scales. For the age group of 65 to 74 year olds (n = 30), social participation was again negatively correlated with physical health (PCS), $\tau = -.32$, p (one-tailed) <.05; $r_s = -.43$, p (one-tailed) <.05.

Qualitative Findings

Social participation is indicated by individuals' involvement in groups, clubs, or organizations. These could be formally organized groups or just groups of people who get together to do an activity or talk about topics of mutual interest. The interviewed seniors reported a few group activities they had taken part in. About one out five respondents (20%) had participated in one or more English as Additional Language (EAL) classes for seniors organized by the largest senior centre in Winnipeg. Five percent of the seniors had played ping-pong once a week; one senior had volunteered to run a dance class for fellow residents in the same apartment building. Approximately 30% of the focus group seniors mentioned that they played mah-jong with friends from time to time. The above-described group activities were either conducted on an irregular basis or only a few individuals were involved, having no interest to most of the seniors. The social participation activities involving the most seniors (approximately 40% of focus group respondents) were those organized or related to churches, such as Bible studies or senior fellowship groups. No other group activities had been organized specifically for Chinese seniors, either those living with children or by themselves in the community.

The level of seniors' social participation presented a similar pattern as that of their social networks and support. The seniors living in separate households expressed higher motivation to partake in social group activities than those co-residing with adult children, as one senior said: "…and I don't have the intention to communicate with (people in) the mainstream society… So I am not thinking of integrating into the society or the like; I just want to integrate into my family, and serve my family." Conversely, the focus group respondents who lived in retirement buildings generally indicated an interest in participating in social activities. Actually many of them complained that there had been too few available, affordable, and accessible activities in their current lives:

> Interviewer: Do you want to have more activities?
> Mrs. P: Of course!
> Mrs. Q: That's why we want to re-establish our Tenant Club. And we can organize some activities with the Club.
> Other respondents: Yes. This is what we have been hoping to do.

One senior volunteered to run a dance class once a week for the seniors living in the same building to be able to have a chance to do some exercises; some older seniors, even though they did not join the dancing, enjoyed watching others doing it. However, the on-site manager did not support this free activity and did not show up even once. After about six months, when the volunteer senior discussed with some friends and fellow residents about whether she should continue organizing the dance group without the support of the management, they said: "That's like making a fool of yourself." Thus she stopped volunteering, ending the only group activity for the seniors in that building.

Many interview respondents pointed out that potential costs could be a concern for accessibility of group activities. For example, an adult child of a senior resident in the Chinese retirement building donated a ping-pong table to the building so that seniors could play the game

at their convenience. The board decided to place the table in a community centre close to the retirement building. Every time the seniors wanted to play ping-pong, they had to pay to rent the room in which the ping-pong table was located. The rental fees were not much, but for seniors who were living on pensions and government supplements who had to count every penny they spent, it was one more expense. Not only was the use of ping-pong room charged to seniors every time they used it in the past ten years, but all other activities available at the community centre, such as Tai-chi exercises and dance classes, required fees:

> Interviewer: So seniors cannot afford the fees [for activities]?
> Mrs. P: That's right. So many rooms [for such activities] were empty.

Summary

Social participation was represented by the lowest scores of all social capital dimensions. Not only did the survey data indicate largely disengagement in various types of social groups and activities, but the focus groups' participants described minimal involvement in social participation-related activities. EAL classes for seniors, an adult learning group, appeared to be the most "popular" social engagement endeavour, as approximately 20% of sampled seniors had taken part at certain times. A few seniors initiated several types of indoor recreational activities on their own such as mah-jong, ping-pong, or dancing; some others joined Chinese church activities. Nevertheless, none of these activities appeared to have generated significant impact on the majority of seniors studied. Causes for such low involvement in social participation include lack of systematic support, formal organization, financial costs, and low motivation.

Social activity availability and accessibility seemed to have contributed to the low levels of social participation of Chinese seniors, besides language barriers, as the cross-cutting reason for other aspects of seniors' lives. The challenges faced by Chinese seniors in social participation were similar to those in social networks and social support, while social participation indicates

an individual's involvement in group activities, *social networks and support* focuses on the connections in a personal sphere, such as friends or relatives. It is not surprising that the seniors with fewer social networks had also acquired a lower level of social participation.

Relationships between Social Capital Factors

The social capital factors presented certain correlations among themselves (Table 7.7). All significant relationships were statistically positive and weak. *Social networks and social support, views of community,* and *civil participation* are all positively correlated with *trust and reciprocity*; *Social networks and social support* and *civil participation* are correlated with *social participation;* and *civil participation* with *social networks and social support*. Most social capital factors were related, but measured different aspects of seniors' social lives. Some factors might have a positive impact on others, but the relationships were generally weak. Obtaining a higher score for one factor did not contribute greatly to the possibility of scoring higher for another factor. For example, *trust and reciprocity* only explained 7.4% (effect size = $.272^2$) of the variance in *social networks and social support*, and 4% (effect size = $.200^2$) in *views of community*.

Table 7.7 Correlations between Social Capital Factors (Pearson's *r*)

	Trust & Reciprocity	Social Participation	Social networks	Views of community	Civil Participation
Trust & Reciprocity	1	.163	.272**	.200*	.358**
Social Participation	.163	1	.351**	-.032	.366**
Social networks	.272**	.351**	1	.121	.282**
Views of community	.200*	-.032	.121	1	.089
Civil Participation	.358**	.366**	.282**	.089	1

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Summary

Both quantitative and qualitative data demonstrate the possession of low social capital among Chinese seniors in Winnipeg. The quantitative data revealed some correlations between social capital factors and Chinese seniors' health conditions. Although the statistical relationships were not all significant or strong, the major relationships provided an overview of how social capital might have influenced Chinese seniors' health. Firstly, no social capital factors were found to be related to older Chinese women's physical health or older Chinese men's mental health. However, the findings demonstrate some effect that social capital had on female Chinese seniors' mental health and male Chinese seniors' physical health. Social capital appeared to be related to Chinese seniors' health, but differently for females and males. Secondly, *social networks and social support* was positively correlated with the mental health status for female Chinese seniors, Chinese seniors under 75, and Chinese seniors in general. The more social networks and support Chinese seniors had, the better mental health they enjoyed. Social networks and social support seemed to be the most influential factor among all on Chinese seniors' health, particularly mental health. Thirdly, *social participation*, presented negative relationships with Chinese seniors' physical health. Having not been identified in the literature and contradictory to the general understanding of the positive relationship between social participation and seniors' health, the results about social participation are confusing. However, taking into account the floor effect of the data which was represented by extremely low scores overall of social participation indicators, it was possible that the survey items regarding social participation did not effectively reflect the research participants' social participation activities or involvement. The reliability issues of research instruments will be discussed in the limitations section.

The seniors revealed multiple issues related to their communities, trust, civil participation, social networks and support, and social participation in focus group interviews that have offered plausible explanations to their limited social capital. The five dimensions of social capital interacte to cause negative or positive impact on each other. The interactions between social capital variables and their effects on Chinese seniors, and the relationships between social capital and Chinese seniors' health will be interpreted and further analyzed in Chapter Nine.

Chapter Eight

RESIDENTIAL ENVIRONMENT

Residential environment was described by research participants as a complex concept in relation to social capital, use of supportive social services for seniors, cultural values on social support, and seniors' expectations for elder care and the environment. This chapter presents the findings regarding aforementioned elements in a residential environment for Chinese seniors.

Cultural Values and Identity

Quantitative Findings

Chinese *cultural values and identity* was measured with Likert-scale questions such as the extent to which the respondents agreed with statements on interracial marriage, maintenance of Chinese language(s) by offspring, female and male roles in a family, ethnic diet, access to ethnic media, number of friends from the same cultural group, and perception of the importance of Chinese culture. Higher scores denote higher allegiance to Chinese cultural values and higher inclination to Chinese identity, as opposed to Canadian culture and identity.

The full score of *cultural values and identity* is 82. Forty-five cases contained missing data, leaving 56 cases of complete valid information. Because all the items regarding Chinese cultural values and identity were supposed to be familiar to the respondents who had grown up in Chinese culture(s), their choices of not providing statistically useful answers should be acknowledged as valid, although the reasons are unknown. Therefore, missing data were not replaced with any other values.

Among the valid cases, the mean is 56.9 with a standard deviation of 7.3. The lowest observed value is 35, and highest 71. The 25^{th}, 50^{th}, and 75^{th} percentiles are 55, 58, and 61 respectively. The skewness value -.94 and kurtosis value 1.35 indicate that the distribution is negatively skewed, relatively flat, and with heavy tails.

The five social capital factors were analyzed to identify whether they presented a signification relationship with the seniors' Chinese cultural values and identity. Only *social participation* was negatively correlated with cultural values and identity. It was a weak correlation since the seniors' self-identification as Chinese only explained 9.3% ($.305^2$) of the variance in the level of social participation among the seniors (Table 8.1).

Table 8.1 Bi-variate correlations between Social Capital Factors, Use of Services, and Cultural Values and Identity (Pearson's *r*)

	Trust & Reciprocity	Social Participation	Social networks	Views of community	Civil Participation	Use of services	Cultural Identity
Use of services	.152	.110	-.063	.123	.253*	1	-.097
Cultural Identity	.061	-.305*	.074	.100	-.194	-.097	1

*. Correlation is significant at the 0.05 level (2-tailed).

A plausible explanation for this relationship in this study is that only one item in the cultural identity and value scale - *number of friends from the same cultural group* – is related to the measurement of social capital factors, while other questions are focused on an individual's self-perception of cultural beliefs. The statistically significant relationship indicates that the more friends from the Chinese community that a senior had, the less likely he/she would not be involved in social participation, which was mainly denoted by numbers of social groups at different geographical levels. It seems reasonable that Chinese seniors decrease their participation in social groups in the general community if they had acquired friendship and socialization from within their own cultural circle. Due to language barriers and transportation difficulties in accessing the social groups or activities in the community, Chinese seniors were

"forced" to develop connections with others who spoke the same language and who shared the same culture. Nevertheless, *cultural identity and values* only explains a small portion (effect size = $-.305^2$, less than 10%) of the variance in the seniors' levels of *social participation*, which is only one dimension of the social capital.

Qualitative Findings

How seniors considered the role of children in the traditional notion of filial piety profoundly affected their perceptions and expectations of the elderly care they themselves would like to receive. The seniors discussed how they had perceived filial responsibility from their children's and their own perspectives.

Elderly care, or eldercare, is a broad concept that includes a variety of services for senior citizens, such as assisted living, adult day care, nursing homes, and home care. It is often divided into two different but related categories: medical care and social (non-medical) care. The focus group respondents generally were satisfied with the quality of medical care they had received from the local health care professionals, despite certain systematic issues like long waiting lists and out-dated equipment. The social aspects of elderly care, however, were one of the most concerning issues for the seniors. The seniors described the decline of their functional capacities in taking care of themselves and their spouses. Though the majority of them were still capable of self-care up to the point when the research was being conducted, they realized that they would need assistance in their lives in the foreseeable future. Not seeing evidence of any plausible facilities or services that were easily accessible to them (details discussed in previous sections), the seniors were deeply stressed by worrying about lack of care to maintain their quality of life, as they described:

> "At the end, we have to face the trial of aging and sickness and we hope [to get some help]. Because the elderly usually have chronic conditions or different diseases consecutively, and our energy is declining as well, how can we live our lives?"
>
> "The primary problem is that we are aging. [To use] walking [as an analogy], the path we are walking down is a 'sand road' which is impossible to walk. There is no way we can finish walking down the path, and it is getting harder and harder to walk."
>
> "We moved here from China, hoping to have a comfortable old age life and a peaceful ending."

The seniors believed that their adult children still maintain the Chinese tradition of filial piety and implemented it in everyday life. Children respected their parents, and carried the responsibility of taking care of the elderly. This did not necessarily mean that parents and children must co-reside in the same household. As revealed in the interviews, some seniors lived in separate households from their children. But adult children usually visited parents in retirement buildings on a regular basis: "The next generation, except those exceptional cases, most of our children carried the filial responsibility. It's very rare that someone doesn't take care of his parents at all. They generally do. It's very rare that they don't come to visit you if you live in a senior home." As described in preceding sections, adult children had provided a tremendous amount of assistance and support to their elderly parents or family members in their everyday lives, such as driving them to, and translating for them at, doctor's appointments, or helping out in emergency situations.

Nevertheless, the seniors were unsure about how the third generation – grandchildren – perceived the notion of filial piety. Regarding the younger generations, sentimental bonding seemed more important than fulfillment of filial responsibility to the seniors, not only because most grandchildren were still minors and unable to carry out practical tasks, but because the seniors were also uncertain about the level of acceptance of traditional concepts by younger

family members. The seniors reported more emotional benefits than tangible ones from the interactions with them:

> "The third generation [grandchildren] love to visit us grandparents, as they can have a free delicious meal at the grandparents'. Offering such a free meal will make grandparents so happy that their life spans would be extended for one more year. It (the intergenerational interactions) seems to represent a positive cycle in Chinese families."

An interesting mentality shift in the perception of elder care responsibilities from "Chinese" to "Canadian" was demonstrated in the interviews. As *caring for elderly family members* has been a legal obligation for the citizens in mainland China (Central People's Government of the People's Republic of China, 1996) but not in Canadian laws, some seniors seemed to have decreased expectations of their children for elder care:

> "In Canada, elder care is a responsibility of the society, rather than of the family. Children do not have such huge responsibilities of taking care of parents in Canada. It's good that the society takes care of the elderly. If children like to do something to care for parents, that's fine; if they don't want to do anything, that's fine, too. It's not like in China that children are [legally] obligated to care for parents. There is no such a law in Canada. Talking about the issues of elder care, I think the responsibilities of elder care are on the society, since we've moved to Canada and we're seniors."

The seniors who did not have children living in Winnipeg (30% of seniors in one focus group) explained their acceptance of the fact that they could not benefit from their children's support and care: "The more capable the children are, the less likely they would stay with the parents. Only those who are unable to accomplish anything would stay with the parents because they are not wanted by anyone else." After trying to justify the absence or insufficiency of elder care by their children (or family), the feeling of entitlement to social support was naturally expressed:

> "I think since we Chinese seniors have come here, to this society, we are part of Canada. Regardless of Permanent Resident's status or citizenship, we are a member of Canada; therefore we should enjoy the elder care [provided] by the society."

Use of Health Support Services

Quantitative Findings

The five social capital factors and *cultural values and identity* were also examined in terms of their relationships with seniors' use of services (Table 8.1). The only factor that demonstrated a significantly correlative relationship with the level of use of services was *civil participant*. The positive relationship was weak as civil participation explained only 6.4% ($.253^2$) of the variance in the use of services. It is possible that seniors who had the motivation to conduct or be involved in civil activities, such as organizing residents' clubs or appealing to social organizations, also acquired more awareness of social or health support services available in the community. With familiarity of community resources, including service providers and procedures for obtaining services, these seniors who were more active in *civil participation* were more likely than others to seek the use of social or health support services.

Qualitative Findings

The seniors did not mention much about participation in health support or social services in the focus group interviews due to a general lack of experience in this area. However, when they described some practical considerations of elder care in daily life and the services they did use, the interviewed participants revealed both direct and indirect reasons for not using most services.

All the seniors being interviewed, despite the fact that many of them were suffering from chronic diseases such as diabetes or cancer, were capable of caring for themselves in terms of daily activities like bathing or dressing themselves. A few of them were receiving home care services for light household work including cleaning the kitchen, vacuuming, or warming up prepared food. Thus, what they most needed assistance in were activities outside their homes, such as going to doctors' appointments and medical check-ups, getting groceries, or buying items that they needed or wanted in a timely manner, or activities related to establishing social capital. Adult children, and sometimes grandchildren, were the primary support to seniors in these areas. As all the tasks had to be carried out on an on-going and regular basis, adult children's involvement had to be constant.

When describing their adult children caring for them, the interview respondents frequently expressed the feelings of "owing children" or "guilty about burdening children". As one senior stated: "Our children here [in Canada] have to work very hard. They feel that they have not fulfilled the filial responsibility if they don't take care of us; but caring for us affects their work [in terms of time and energy]. We often feel we can't stand [watching them having to do so much]."

When the seniors needed to go to the hospital or clinic, their children usually had to arrange time off from work in order to provide transportation and translation in the process. Unlike their Canadian-born counterparts, many Chinese seniors did not have the language proficiency to arrange their transportation through public transit or taxicabs, which required certain reading, speaking, and listening skills. Winter was particularly difficult for seniors to go out alone, given slippery sidewalks and roads and severe weather conditions; a few who were able to take buses would also stop using public transit for the same reasons. The seniors' children needed to arrange a schedule of parents' medical appointments in coordination with their own

work hours, which could be challenging if a parent's condition demanded more than one or two appointments. Translation was another essential factor that demanded the presence of adult children. Without sufficient English skills, the seniors were incapable of finding out where to go or how to communicate with health care professionals. As most doctors' appointments would require at least half a work day, and more than once in many cases, one senior said: "They (adult children) are very busy at work, and they have their children to raise and educate. It's hard for them to ask for days off every so often." One senior woman's ultra-sound check had to be postponed for three times because her daughter could not get away from work every time. In the end, the granddaughter who had just received her valid driver's license offered to drive the senior to the appointment at an unfamiliar location, a forty-minute drive away. Another stated:

> "I feel I owe my children. It is pretty bad that I have to make them ask for time off so often. They need to go to school or work. [My daughter's] work is done on the Internet. She won't pick up my phone [when she's busy at work]. I called my daughter, and she didn't pick it up because she was working on a program on the Internet. I had no choice but gave up, as she was busy. Later I tried to call again; she picked that up because she had time then. Their work was really, really busy. I think this is a big problem."

Another senior mentioned a similar situation with her children:

> "For example, it'd be a big convenience if we could book a transportation service for doctors' appointments. It's difficult to require children to serve us all the time. They may be at work; and they are not obligated to do so. And sometimes they are not willing to do so; in another word, they may be unhappy to do so. They have their families, and their work. Combining of these two duties, and they don't have [legal] obligations to serve us, what can we do?"

Some seniors had attended EAL classes for seniors. They were those who lived within walking distance of the classes; some who took advantage of the free shuttle bus between the class venue and their certain pick-up location stopped attending once the shuttle service was discontinued due to lack of funding. Others, who needed to travel far, had never attended

because they could not arrange transportation since those classes took place during regular office hours when all their adult children were at work. Adult children, no matter how much they might like their elderly parents to socialize with other people, instead of staying home, could not afford to drive them around during work hours on a regular basis. One senior recalled what her daughter had told her in a joking manner: "Forget it (learning English). It's good enough that you can speak Chinese." The seniors living in the Chinese retirement building were in need of English support for preparation of documents for legal and civil procedures and for interpretation in meetings with individuals outside of the Chinese community. Although the adult children of some of the seniors had helped at different times, the demand for support was constant. Because, as one senior stated: "We all have children [in Winnipeg]; but not all children can be available every time we ask for help; they have their own children to look after". The seniors felt they could not demand their children's time for regular commitments of their civil participation activities.

Sometimes it was small practical issues that seniors felt in need of help for, but they felt guilty to ask children for assistance. One senior noted a situation she recalled from the year before: "It was so hot in July and August (the interview was taking place in early June). We older people sometimes just wanted to have a watermelon. But we couldn't go out to buy and carry one home [because it's heavy]. We could have asked our children [to do this]; but we didn't want to bother children." Other seniors mentioned their need for outings and trips: "I think it's good to organize older people to travel or have some activities. We'd like to go out with children, but they are so busy. Even if they could have some time off, it is always too short to arrange any outings."

Again, absence of accessible and affordable transportation means and insufficient English skills, appeared the major causes for seniors' low use of available services. It was also evident

that adult children's commitment was the Chinese seniors' primary source of support for transportation, language services, and activities related to improvement of social capital; however, it was not as consistent and reliable as the seniors wanted, due to their adult children's multiple responsibilities in life and at work. Moreover, the seniors were apologetic to their children about having to request help for life issues, which implies that they had minimized their demands for social activities and use of services, and will likely continue to do so before alternative solutions become identified.

Expectations of Living Arrangement of the Sample

Quantitative Findings

Expectation of living arrangement was measured by a single question in the survey: If you could have it the way you want, which of the following living arrangements would you like: living with children in the same household; living nearby to your children but in separate household; living as far as possible from your children; or other. Table 8.4 indicates a high percentage of seniors (60.4%) did not necessarily want to live with their adult children in the same household, while about one out of four (28%) would still do. Although fewer Chinese seniors in Winnipeg stated that they would like to live in separate households from their adult children than the figures (84% - 90%) shown in other Canadian cities or Western countries (Chappell, 2003), those who wanted to live independently were more than twice as many as those who wanted to live with children. The reasons for the preference of living in separate households will be articulated in the analysis of the interview data in the next section.

Table 8.4 Description of Expectations of Living Arrangement of Respondents

Expectation of Living Arrangement	Frequency	Percent	Cumulative Percent
Live with Children	28	27.7	29.2
Living Nearby Children	58	57.4	89.6
Live Far from Children	3	3	92.7
Other	7	6.9	100
Total	96	95	
Missing	5		

Qualitative Findings

When asked whether they would like to live with their children if they could choose, the majority of focus group respondents replied with *No*, which was consistent with the survey results for various reasons as described below - not necessarily in the order of importance.

First, the seniors and their children had different lifestyles that might create potential conflicts in the long term for the family. Some seniors noted that they had different daily schedules than their children's, and that they tended to get up earlier than the younger generations in the morning. One senior described the situation in his family:

> "We older people have our own activities and habits. Canadian house structure, any movement can cause noise [that can be heard in other parts of the house]. Older people like to get up early in the morning, very early. I like to get up early to go fishing. Everyone has different hobbies. Thus, [my getting up early] affected my children's and grandchildren's sleep. If they couldn't sleep well, they couldn't work well. And the grandchildren couldn't perform well at school."

The Chinese seniors generally preferred simple meals of relatively small amounts of soft, well-cooked food like congee (rice soup) or noodle soup in everyday life, while, on the other hand, their children and grandchildren demanded complex meals composed of multiple dishes or courses that included larger amounts of meat and vegetables; sometimes the younger generations

would enjoy foods other than Chinese, which was usually less acceptable to the elderly. Certainly, different kinds of food could be prepared for the needs of different family members. But who was one to cook most of time at home? It was the elderly parents who did not work outside the family who did.

The seniors who lived with their children undertook most of the housework, including cooking everyday of their own initiative because they wanted relationships with their children to be reciprocal. However, they found their energy did not always allow them to perform as much work as they wanted. This was another reason that the seniors to consider living in a separate household from their children. For instance, preparing a meal for a family of five or six adults and children could be physically demanding, especially if it was a daily task. One senior explained her perception of housework duties in the following way: "For example cooking. If only I or my husband and I eat, it's simple [to cook]. [Living with children], we need to wait for them to come home to eat together. Of course they haven't demanded us doing this for them, but we feel not right [if we don't cook and wait for them to have the meal together]. There are many other [similar] things, too. If we don't live with them, everything will be out of sight, out of mind."

The third reason was in relation to the apologetic attitude of the seniors toward their children which was described earlier. Seniors, either living with children or not, frequently referred to themselves as being a "burden" to their children once they were unable to continue their daily functions. As most of them were still capable of self-care and even of doing housework for their children, they believed they were currently in a reciprocal relationship with the younger generation(s). While the younger generation(s) provided the elderly with transportation, translation, handling mail and necessary paperwork, the seniors were able to reciprocate with cooking, housekeeping, and sometimes emotional support. They did not feel it

was right to receive help from their children who were already extremely busy and not able to be helpful themselves. The seniors were deeply stressed by the thought of having to depend on someone else to care for them when they would no long be able to. Their children's availability was often inconsistent even in present situations where the seniors were still capable of self care; their future commitment would be highly questionable, according to the seniors. Many a senior presented the considerations in a similar manner:

> "I am considering an issue. I can still feed myself, and work and walk now; so it's alright to live with my son [and his family]. But if I cannot walk and move any longer, then it's not good to live with them. They have work and their children to look after; it's impossible for them [to have time] to look after me."
>
> "When I will be older, and unable to care for myself, I'm not sure if they will have the filial conscience. But they won't be able to [look after me] in practice, because they need to live their lives, and work. And they have their children, too. I can't bear to increase their burden."
>
> "We live with him, but there are many differences [between us] which can generate conflicts. But what's more important is that he has to take care of us. Taking care of us increase his burden and pressure. It's not economic burden, but a burden to energy and mind."
>
> "What should I do when I can't care for myself any longer? I hope to have somewhere to settle down. I don't want to live with any of my children, although they will all accept me to their households if I want to – I trust my children have the filial conscience. But I can't stand it, the idea of burdening them."

Based on the ideological shift of elder care responsibilities from the family to society, and a variety of practical considerations of elder care, many focus group respondents explicitly expressed their expectations of how elder care should be conducted when they would need assistance in their daily functions, which was a senior home funded and operated by the government and community. One of the many statements by the interview seniors was: "In general, establishing a Chinese senior home is the best support from the government. The elderly will have a reliable and comfortable place to live in, with some assistance in daily function

activities." The following section will described in detail Chinese seniors' expectations of how such a residential environment should be built, operated, and managed.

Expectations of a Residential Environment

The focus group respondents presented and proposed many ideas on the design, implementation, and management of a residential environment that could better serve Chinese seniors than the existing services. Their proposal of a multi-level, multi-functional structure of a senior home would include health care and home care services, transportation and translation services, food and grocery services, activities and programs, community resource management, self-management, and affordable fees.

Multi-Level Structure and Services of a Senior Home

Co-residing with other seniors who spoke the same language(s) would automatically remove the language barriers that hindered Chinese seniors from socializing and communicating with neighbours, which would in turn improve their social capital by enabling interactions. A senior home for older Chinese immigrants should be designed for seniors with different levels of functionality. The seniors' comments included: "We need a senior home with diverse services for different levels of demands [of seniors]"; "If we have a Chinese senior home, we'd like it to provide multiple levels or types of services", and "The senior home needs to provide customized services and multiple types of services depending on each senior's requirements." There should be various types of units, to accommodate the different needs of seniors. Most of the

interviewees were capable of self-care; thus they preferred units with kitchens where they could make their own meals. But kitchens might not be necessary for those who did not want to cook or were incapable of managing kitchen safety. Bathrooms, especially with bathtubs or shower units, should be designed for easy access for those whose balance and mobility were declining. Certain types of units could be arranged together on a separate floor or mixed with other kinds at each floor in the same building. Units designed to accommodate seniors' levels of functionality would also encourage capable seniors to conduct their daily activities which would help maintain their cognitive and physical abilities, as indicated by one senior:

> "The facilities of the units shouldn't be all the same. For paralyzed people, they won't need a kitchen. But for those who can still take care of themselves and like to cook their preferred food, they need a kitchen; otherwise they can't cook, right? Some seniors may not be used to having all three meals at the cafeteria everyday. Some like to cook a bit. Therefore diverse services are appreciated. Those who are capable of self-care need to be encouraged to do some work – some exercises can help maintain their health. So the units need to be designed differently."

The focus group seniors expressed diverse attitudes toward older people with significantly declined functionality. Some did not want to associate with seniors who suffered more functional loss: "[The senior home] shouldn't accept those with senile dementia; or [we] who are normal will become demented." However others pointed out that those suffered from physical and/or cognitive deterioration were in greater need of care, and therefore, should not be excluded from the senior home. One senior explained her opinion of the inclusivity of the institute:

> "Listen to me, you can't exclude those [disabled or demented] people. They can move in, too… There are just so many Chinese people [in Winnipeg]. Those who lost parts of their bodies, old and disabled, you can't ignore them; it's impossible. They are in a worse situation. They need to be included; but they have to be better [than losing all functionality]. The definition of a Chinese senior home should not be as strict as a Western senior home."

Seniors of different ages expressed different demands of services as well; some stated a preference for an arrangement of recreational activities and programs, while others focused on services that aimed to improve comfort and convenience in daily life. Recent immigrant seniors complained that they had not received the information of various activities within the Chinese community or the broader society. They highly appreciated receiving information to promote the awareness of activities, like community parties or free festivals in the city, and to be organized arrangements made to be able to partake in those events. The seniors who had been living in Winnipeg more than seven years did not indicate the need for information of and facilitation to attending social or recreational activities. Moreover, those who had been in Canada longer also tended to be older than recent older immigrants. The old-olds, middle-olds, and young-olds clearly had varied focuses in the efforts to improve their quality of life. While the younger and newer immigrants were excited about attending social events, older and longer-term seniors stated: "Let me tell you, when you are my age, you won't feel like going (to those events) even if you were paid to go." It was not surprising to hear divided opinions about the services that should be provided by the Chinese senior home:

> "[The activities] you just mentioned are needed by seniors at your age. At our age… we are aware of all those activities since we have been here for so many years. The activities on July 1st and other days, we know about them. But in terms of attending … sometimes [we don't attend the activities] because of health reasons. As older people, [our energy] is declining, and our interest in those activities is getting lower. What we want is the comfort and happiness in our everyday life. This is our request at this point. I am going to be 80; an 80-year-old's [demand] is different from a 70-year-old's or a 60-year-old's."

Health Care and Home Care Services

The seniors proposed several options to solve the challenges that had been facing them, such as language barriers, shortage of health care professionals, and unavailability of transportation to access health care services, as indicated in preceding sections. A few seniors

mentioned the option to establish a coordinator office where seniors could call to book and pay for a vehicle with a driver who could also serve as an interpreter for medical appointments.

Many seniors preferred a second option, which was once a Chinese senior home was established, to arrange for a doctor with Chinese proficiency to have regular office hours onsite. The doctor could come one or two days per week to provide regular check-ups, follow up with seniors' medication and treatment, answer seniors' inquiries regarding minor health issues, and refer them to specialists in case of further intervention required. Chinese seniors would not need to worry about transportation and translation issues if such an arrangement could be made, by receiving "health care onsite, and medication onsite".

Another option was to establish a health care facility (e.g., a clinic) within or near the Chinese seniors' home. The respondents pointed out the fact that the Chinese population in Winnipeg had been growing rapidly in recent years; more and more seniors were demanding that health care services be delivered, and medical terminology explained, in a language that they could understand. Although many clinics were available in the community city-wide, none of them were able to provide services in a manner easily accessible to Chinese seniors who did not have sufficient English skills to communicate effectively.

To solve the problem caused by a shortage of medical professionals, some seniors suggested that a Chinese health care facility could take advantage of having doctors or specialists who were immigrants by including them as volunteers to assist licensed professionals. For example, these volunteers could offer advice on everyday self-care to seniors or provide first aid before paramedics or medical professionals arrive. The interviewees also mentioned about that professionals from China should be hired to serve the Chinese community - but without knowing the complex and lengthy recognition process for health care professionals in Canada.

Nevertheless, with positive intentions, they believed the hiring of professionals speaking the same language would be an effective solution to the problem of a shortage of doctors in Canada and the challenges in health care for Chinese seniors.

The seniors presented similar concerns about home care services as those of health care. Home care service providers who could speak the same language(s) were in high demand as they needed to communicate details of housework. Flexibility about the levels and types of housework or personal care would be appreciated as well because the assistance seniors needed could vary day by day. The notion of payment was acceptable to the seniors, but they should not be excessive, as the seniors would not be able to afford it, living on pensions and government supplements. A coordinator or a coordination centre within the housing complex that provided services in Chinese would be helpful for seniors, to enable them to inquire, request, or arrange for temporary or long-term home care support. Several interview respondents suggested that the Chinese senior home could arrange for such services through its management, especially if some tenants did not meet the strict qualifications for home care services operated by the Winnipeg Regional Health Authority. The Chinese senior home management could establish its own policies for the provision of home care services and a pool of service providers, preferably Chinese speakers. However, fees must be reasonable or seniors would not be able to afford the costs as most of them lived on pensions and government supplements.

Transportation and Translation Services

The interviewed seniors all seemed to agree on a solution to the transportation difficulties they had experienced. As they didn't have driving skills that local-born seniors had acquired from a young age, the Chinese seniors expected the Chinese seniors' home to have transportation

services available through the provision of one or two vehicles with available drivers. The transportation services were most needed for medical appointments, as mentioned above, but also for other activities in everyday life. The seniors were willing to pay some fees for booking and using the service, as long as they could receive timely assistance without burdening their busy children.

The seniors advised that the transportation service should be incorporated with other social activities, such as outings to a park in the summer, or city events like the annual Santa Claus Parade. As well, the seniors were open to a collective fee for transportation for such outings, if they could be arranged.

Translation services could be arranged in a similar manner as transportation. A coordination office could provide a pool of translators and interpreters who could be assigned to work with seniors who would call to book the service. If the Chinese seniors' home did not have the funding to operate such a service, a city-wide agency could collaborate with other organizations in the same field to coordinate the resources. Students at universities or colleges who were looking for experience could be recruited as volunteer translators for the seniors, particularly students in health care disciplines, social work, education, and others who would like to contribute to the community.

Several seniors reported that they had used the translation services available at hospitals, but which were only available upon that request of their family doctors. The seniors were satisfied with the translation services and found them extremely helpful, but the services were not available and accessible to individual patients every time they needed to see a doctor or get a check-up. The majority of the focus group interviewees were unaware of such translation

services that they could request through their family doctors, and further, if they were aware, the senior did not know how to request such services on their own.

Dietary and Grocery Services

Dietary services were another important area where seniors requested assistance. The seniors noted that although they appreciated the availability of a kitchen in their units, they might not make their own meals three times a day, as their energy and physical dexterity declined. Several respondents mentioned that they had had or were about to have surgery, and therefore were in great need of post-operation care, including dietary services. Getting groceries for cooking was another challenge for seniors if they had to carry heavy items like milk or rice themselves; it became particularly difficult during Winnipeg's long winters with harsh road and weather conditions.

The proposed dietary service could be run following a similar model as that in most Canadian retirement buildings. It should be on a not-for-profit basis so that fees would not be charged beyond seniors' financial capacity. Residents in the facility could pre-order meals from a weekly menu displayed in the dining room and pay before or after use of the service. Ordering food from the service should not be mandatory, but depend on an individual's needs. They might order all three meals or just one per day. The respondents who lived in the retirement buildings with seniors of various cultural backgrounds indicated explicitly that the food should be prepared to fit Chinese seniors' diet customs. After having tried Western food, the seniors believed that Chinese food with good nutritious balance was their "comfort" food. Thus, the core requirement for the dietary service in the Chinese senior home would be the provision of good quality authentic Chinese food at an affordable cost.

Services to facilitate seniors in getting groceries were desired as well, because some seniors still preferred to make their own meals at times. Some respondents suggested an arrangement of weekly grocery delivery from grocery stores to residents, which had been a common practice in many general senior buildings in the city. Grocery delivery should include items for daily dietary needs, such as milk, fresh fruit, vegetables, and bread. One senior noted that watermelons had been a rare treat for the seniors in her building on hot summer days. It was difficult for a senior to travel to a store and carry a heavy watermelon home in the summer. In an effort to avoid bothering their busy children from driving to a grocery store for them, the seniors would choose to not have watermelons. As the senior described it:

> "When it's hot in July or August, we older people wanted a watermelon so much. But we couldn't buy one. We could have asked our children to buy one for us, but we didn't want to bother them. … if you could help them buy one, they would be so happy to divide it to have just one slice. … when the van comes, it can bring some good quality fruits, especially watermelons. We can buy them here. If a watermelon is too big, we can share with neighbours. It'd be good. When it's hot, even a slice of watermelon means a lot to the seniors."

Another proposal made as an alternative to grocery delivery was to transport the seniors to a grocery store once a month. The way that this would work is that residents could book a spot in a van arranged by the building management to take seniors to the store on a particular day. This service could be a supplement to the weekly grocery delivery, or could be expanded to be an independent service.

Social and Recreational Activities

The seniors expected the Chinese senior home could arrange activities and programs for the purposes of socialization and recreation. These activities could be on-site or could be outings to different locations outside the building.

Many recreational programs could be arranged at the senior building, for example, fitness exercises that were modified for seniors, dance classes that would teach moderate movements, or tai-ji classes. Seniors could also enjoy the traditional game mah-jong with others. Several younger seniors mentioned the idea of founding of a choir in which they could apply their talents and fulfill their interests in music. The respondents would like to be able to coordinate some tea parties or dinner parties among residents as well, because they could socialize with others and share their finest cooking.

The seniors also suggested several outreach ideas to incorporate the existing resources in the community. For instance, A & O: Support Services for Older Adults, a city-wide senior agency, coordinates English as Additional Language (EAL) classes for seniors in various locations in Winnipeg. The agency is willing to offer a new English language class in a venue with a minimum of twelve immigrant seniors. The Chinese senior home would be an ideal venue for such a class as participants would not need to travel (therefore no need of additional arrangements for transportation) in order to attend the class; since classes would be free of charge, there should not be great difficulty to recruit more than a dozen seniors interested in improving their English skills. To many older adults, socializing with fellow seniors in class and during breaks was more attractive than learning a new language per se, although there were always several seniors who were serious about increasing their English proficiency in order to be able to handle their own social affairs without assistance. Another idea was to invite professionals from health associations or agencies to deliver recreational or therapeutic exercises and programs. Specific associations had developed various types of exercises for different age

groups within the community; and they would often organize free workshops for community participants. Either professional therapists could be invited to deliver workshops and demonstrations of exercises to the residents in the seniors' home or a few representatives from the seniors could be sent to learn the exercises and then teach them to other seniors.

Trips to special attractions or to social events outside the senior home would be desirable activities for the respondents. Recently arrived older immigrants were curious about different places in and around the city but had not had many chances to travel and visit those places which include museums or Gimli, a town on Lake Winnipeg. Other seniors would also appreciate opportunities for outings as a change from their daily routines. The seniors noted that they would need assistance in transportation and translation for such outings; otherwise they might get lost or not know where to go. It requires physical mobility, English proficiency, and knowledge of the city for seniors to be able to travel to and from a place other than their residence. In the summer, Assiniboine Park, the beaches close to Winnipeg, or any of the street festivals, such as Canada Day events or activities at the Forks Market, would be great options; watching the annual Santa Claus Parade or visiting museums would be an alternative outing in the winter.

The interview participants strongly agreed that a variety of activities and programs, including physical exercises, would help increase the quality and quantity of seniors' socialization, for the betterment of their physical and mental health, which, in turn, would help lessen health care costs and reduce the burden to their families.

Operational Issues (Self-Management Mechanism; fees)

The seniors contributed a number of suggestions of how to manage a senior home open to all Chinese seniors in the city. Some were similar to those offered by management of mainstream retirement buildings, while others were unique because of the characteristics of this particular group of seniors. The suggestions offered can be organized into three categories: management issues, self-management mechanism, and considerations of fees.

The respondents living in both a Chinese retirement building and one for older adults of all cultural backgrounds had experienced numerous difficulties with the management, and suggestions were offered to improve services. First, the management would be expected to create and facilitate as many communication channels as possible with the residents, such as general meetings, additional meetings, or posters in the language understood by Chinese seniors. Management also needs to hear residents' concerns, to address issues of abuse or mismanagement, so as to maintain the quality of services. Allowing resident representatives to report at general meetings would be one of the means to ensure a two-way communication pattern between the management and the residents. Management issues concerning the seniors included financial management and the hiring of building maintenance staff who would take residents' well-being seriously and who would be able to communicate with Chinese seniors in a common language on a day-to-day basis.

Second, besides the higher expectations of management, the seniors would like to establish and run their own Tenant Club to present the concerns and interests of the residents. The Club should include all residents who wished to participate, and the executive committee must be elected by all members through a democratic process. Any decisions of the Club should be made collectively. The executive committee should represent the residents at board meetings, general meetings, and other management meetings to express the residents' opinions and advocate for them, serving as one component of the two-way communication between service providers and

users. Another expectation for the Tenant Club was to initiate and organize the activities and programs described above, including on-site exercises and classes and outings in or around the city. As well, the management of the Tenant Club should be transparent and separate from either the management or the board of the senior home. The Club and its executive committee would assure the mechanism of self-management of the residents in order to voice their concerns and protect their interests. Collaborating with the management, especially on financial and material support (e.g., provision of transportation) and outreach for resources (e.g., existing community programs, volunteers), the Tenant Club should be able to coordinate activities and programs to improve seniors' health and social involvement.

Third, all fees, including accommodation costs and charges of different services, need to be within the affordable range of the seniors. Most services should be optional and paid separately from general housing costs, as older adults have varied levels of functionality and require diverse types of assistance services. Additional costs, such as booking a van for a trip to a picnic in a park would be acceptable, as long as they would not be at commercial rates like taxicabs. The respondents suggested that fees could be determined by comparing to current policies of charging in mainstream senior homes, which are likely through a combination of personal contributions and government subsidies. All fees should be charged at a not-for-profit basis or seniors would not be able to afford living there.

Summary

With the change in physical living environment and social and cultural context as a result of their immigration, the majority of Chinese seniors have experienced a notable shift in their perceptions and expectations of elder care from the traditional concept of filial piety which

involved adult children's full responsibilities of caring for elderly parents. Based on practical considerations for the benefit of both their families and themselves, many seniors expressed their wish to live in separate households from their children, and they provided sound suggestions on the development of a residential environment for Chinese seniors in Winnipeg, including the design of a multi-level senior home, accessibility to health care and home care services, provision of transportation and translation services, arrangement for dietary and grocery services, organization of social and recreation activities, affordability for seniors, and sustainable management of the residential environment.

Chapter Nine

DISCUSSIONS OF RESEARCH FINDINGS

Older Chinese immigrants expressed general contentment with their retirement life in Winnipeg, which is consistent with the findings in recent research on Chinese ethnic seniors in Canada (Li, 2009; Luo, 2011). Many older Chinese immigrants report a positive migrating and aging experience in the Canadian context, including being in a clean natural environment, friendly citizens or service providers, strong social assistance for seniors, and older immigrants' sense of belonging and commitment to Canada.

Immigrants and senior citizens are two major demographic factors which are shaping the composition of Canada's population. The combination of the two factors has profound impact on the labour market and economics, the health care system, the welfare system, and Canadian culture(s). As service providers, policy decision-makers, or citizens of the Canadian society, we need to sensitize ourselves to the changes in order to improve the support of society to individuals for the purpose of collective well-being. Discussing implications of the findings for the theoretical tools articulated in Chapter 1 and 2, this chapter attempts to promote a better understanding, coming from the research, of the interactions between seniors, as individuals in the environment, and the environment in which they reside.

Social Capital

Social capital is the key concept connecting seniors' health outcomes and their residential environment, among the three concepts in this study - healthy aging, social capital, and residential environment. Chinese seniors in Winnipeg presented an overall low attainment of social capital in all of its aspects – views of community, trust, civil participation, social

networks, and social participation. Social capital, or more precisely insufficiency of social capital, appeared to have substantial influence in Chinese seniors' lives.

The social capital that the Chinese seniors demonstrated in this study illustrates in particular two of the three types of social capital: *bonding* individuals within a group or between those who share similar traits; and *linking* individuals belonging to different societal levels that allow for access to particular resources, such as wealth or power, while a third type - *bridging* individuals in various groups of the same level – did not take place frequently enough to make a difference in seniors' lives (Bryant & Norris, 2002; Harper, 2002; Foxton & Jones, 2011).

Bonding Social Capital

The bonding effects were quite obviously present in seniors' networks and social support. *Social networks and social support* includes family members, friends, neighbours, and other individuals in seniors' daily life. This social capital factor seems to be the most influential among all, considering that most other factors presented a weak to moderate connection with Chinese seniors' health status. Social networks and support was in particular positively correlated with seniors' mental health across several sub-groups. The results are consistent with those found in the literature where the greater the number of social networks a senior has usually leads to a more optimistic mental health outcome (Health Canada, 2006; Campbell, 2000; Franke, 2006). In this study, social networks and social support was especially important to older Chinese women. Through socializing with relatives, friends, and neighbours, they were able to better cope with life adversities and negative emotions, and, in turn, were able to reach a happier mental state.

Emotional support offered by seniors' *social networks and support* was foremost beneficial in Chinese seniors' lives. Although some seniors did not want to live with their younger family members as reported in Chapter Eight, emotional intimacy with family members through physical connection (e.g., frequent visits, family dinners, and phone calls) was the core of seniors' lives, keeping them energetic and hopeful everyday. However in many cases, insufficient or a lack of physical or emotional connection with family members resulted in feelings of loneliness and emotional vulnerability.

Another bonding function of seniors' *social networks and support* was to provide tangible assistance, such as transportation to health care or social activities, translation and/or communication, and advice on life issues. It was notable that seniors usually received tangible help from younger individuals in their networks, including adult children, grandchildren, or younger friends (e.g., fishing buddies). As for friends or neighbours of the same age, seniors found that their advice, rather than their physical capacities, was valuable. Indeed, seniors started to identify and utilize informational resources among themselves to handle problems or questions, as many seniors possessed extensive knowledge from their previous professional or personal experience. For example, a retired gynaecologic doctor volunteered as a consultant to older Chinese women who were suffering from women's diseases, helping them understand Canadian doctors' treatment and instructions. It is not surprising that social networks and social support were positively related to the seniors' mental health, as it served a critical role in diverse aspects of their lives, especially for older women.

Linking Social Capital

Chinese seniors who were active in *civil participation* took the initiative to reach out for assistance in solving the conflicts within their residential environment. The resources they had obtained varied from community leaders, social service workers or volunteers at different agencies, officials in governmental sectors, politicians, and legal professionals. Although not all of these individuals and organizations were able to provide assistance to Chinese seniors' expectations or satisfaction, they contributed to resolve of issues from different perspectives. Having their own policy limits or professional boundaries, these resource people or organizations introduced Chinese seniors to other resources from within their networks: while they might not be able to help the seniors resolve the problems, they knew someone who might be able to help.

Many of the above-mentioned social capital resources, such as lawyers or MLAs, are not commonly encountered by Chinese seniors in their everyday living environment. It was due to a special circumstance that certain seniors started their tireless request for help from individuals at different societal levels. The circumstance impact on seniors' social capital will be further discussed later in this chapter. It suffices to point out that the bridging function of social capital has played an important role for Chinese seniors when some were facing life adversities, and helped solve serious issues.

Bridging Social Capital

If the overall social capital was low for Chinese seniors, then the social capital to help them bridge with other social groups was hardly there. For example, as indicated by the low scores of *social participation,* which emphasizes involvement in social groups such as hobby groups, adult learning activities, or other groups formed on common interests of multiple individuals, the

seniors in this study reported extremely low levels of participation in group activities organized by senior houses, senior centres, community centres, or various organizations in the city.

Some seniors were aware of these social or group activities that could increase their *social participation,* as well as bridging with other community groups or senior citizens of different backgrounds, such as street festivals in the summer or free events in various parks. Other seniors might not be aware of many social groups, organizations, or programs available in the community, as a result of limited networks (e.g., the family or a few friends speaking the same language) and low-level English skills. Neither they nor members in their networks were able to access relevant information for social participation. Some of their family members possessed the language ability to acquire information, but if they did not know how to, or lacked the interest to search and require information, family members would not obtain the information either.

Few seniors reported friendships with individuals outside the Chinese community or membership with social groups other than a building tenants' club or a seniors' fellowship group at a church. Although a number of seniors indicated their interest in expanding their friend circles to include individuals from other cultural groups, they found their English skills did not allow them to conduct meaningful conversations on topics of life issues. As a result, establishing and maintaining reliable friendships with people who do not speak the same language does not seem feasible for them currently.

Social Capital and Health and Health Care Services

Winnipeg Chinese Seniors' Health

Previous research shows that older Chinese-Canadians report similar to better physical health but poorer mental health than the general population of the same age group in Canada (Lai, 2004a, 2004b). Compared to the Chinese senior population in Canada, most of Winnipeg Chinese seniors in the study seemed to have worse physical health, especially those aged 65 or older (n = 88, 87%). The youngest group, seniors between 60 and 65 (representing approximately only 13% of the sample), demonstrated a similar health level as that of the national Chinese seniors. It is possible that Winnipeg Chinese seniors' physical health, including physical functioning, level of bodily pain, and how physical health has interfered with their social activities, is poorer than that of the general Chinese senior population in Canada.

Winnipeg Chinese seniors' mental health, on the other hand, appeared similar to, or even slightly better than, the mental health conditions of the overall older Chinese population in Canada, across all age groups (Table 9.1). Moreover, while the mean score of mental health for each age group remains similar, the physical health status seems to decline with advanced age. This is not surprising because individuals' physical conditions tend to deteriorate with age, but mental health is not necessary associated with one's physical health but with other factors such as social support or self-perception.

The data also showed that a senior's physical health and mental health were worse if she or he had lived in Canada a longer period of time. This is understandable because those who have been living in Canada for longer are often older than seniors who are newer immigrants. Moreover, long-term immigrant seniors demonstrate a lower level of English proficiency than recent immigrants. As English is one of the most critical factors affecting seniors' lives, particular their accessibility to health care and social services, language support to older and long-term immigrants is a pressing demand.

The seniors' physical health was negatively correlated with their use of health support services, such as fitness programs, senior centre programs, home care, and senior housing. The poorer seniors' health was, the more likely they were clients of some of these services. Although health conditions cannot be interpreted as the cause for use of health and social support services, it is sensible for individuals with physical and/or mental morbidity or deterioration to seek assistance from professional helpers.

The findings indicate that social capital affected Chinese seniors' health conditions to certain degrees, but were different for men than for women. While older Chinese women were commonly affected in their mental health, older Chinese men were only impacted in their physical health. It is likely that when social capital is at an unsatisfactory level for Chinese seniors, women may present more mental health issues, whereas men may report more complaints of physical problems.

It is also worth noting that *social networks and support* and mental health have a moderate positive correlation for the Winnipeg Chinese seniors across all age groups, especially for older Chinese women. In other words, older Chinese who do not have sufficient interactions with other people in their family and community at an individual level will likely suffer from some mental health difficulties. Mental health issues can also be accentuated by lack of *trust* in the environment, demonstrated at, but not restricted to, the mezzo and micro levels. Chinese seniors reported tremendous stress, frustration, feelings of segregation, and even a sense of insecurity due to the prevalent managerial problems which occurred at a particular retirement building and the ineffective actions of people in authority, social organizations, or governmental sectors.

Lack of Support to Access Health Care Services

A major difficulty in their access to health care or support services, as reported by Chinese seniors, was a lack of practical assistance of transportation and translation/interpretation. No affordable and accessible transportation seemed to be apparent to Chinese seniors, besides regular public transit. A few seniors had used buses for outings, including visiting a doctor's office; however, the majority were reluctant to go out by bus because they did not have the language skills to navigate the information of bus routes, stops, connections, and schedules. Taking a taxi was considered too costly by seniors (49.8% of the sampled seniors had a monthly income under $1,000), and their language skills to use the services were in question; thus taxicabs were not considered an option by Chinese seniors. Even for the few seniors who were able to take advantage of public transit, travelling by bus in the winter was practically impossible because of harsh weather and slippery icy roads. Interviewed Chinese seniors did not seem to be aware of the supplementary Handi-Transit option offered by the city public transit department. It is likely, though, many of the seniors would not be qualified for Handi-Transit, whose eligibility is merely assessed by an applicant's physical abilities, such as the inability to walk 175 meters. For Chinese seniors, it is the language barrier that prevents them from using affordable public transit.

Relying on family members, and having no other resources available within the seniors' social capital to provide transportation, not only increases the difficulty of time allocation with commitments and multiple roles of family members, including younger family members, but seniors' flexibility for doctor check-ups or specialist appointments is severely reduced. Given the long wait periods for specialists or particular medical tests, some seniors did not receive medical diagnoses and treatment in a timely manner, which resulted in worsening of their health conditions and intensifying of their worries about health.

Language barriers and inaccessibility to existing translation services are another reason restricting seniors from using health care and support services. The majority of the interviewed seniors did not seem to be aware of interpretation/translation services available in the community, such as the Language Access Interpreter Service at Winnipeg Regional Health Authority (WRHA). Again, who seniors depend on are their family members. The disadvantages of having family members as interpreters include inflexibility of appointment scheduling due to family members' non-availability, and presentation of incomplete and/or inaccurate information of descriptions of symptoms and medical treatment due to inadequate training of nonprofessional translators/interpreters in medical settings. On occasions with no interpretation/translation assistance, seniors can only communicate with health care or service providers through non-verbal approaches. The quality of the services that Chinese seniors receive can be unsatisfactory and inconsistent.

Environment and Social Capital

The reasons for Chinese seniors' insufficient social capital were related significantly to the environment in which they lived their everyday lives. From family members, residential buildings or neighbourhoods, to the social environment, obstacles were evident at every level.

Obstacles in the Environment for Social Capital Development (Trust)

Not all seniors were able to acquire the quantity and quality of social capital they would like. Firstly, an unsupportive environment encumbered seniors from befriending with each other or improve their friendships. One circumstance that segregated individuals even turning them

into opponents further isolated the seniors who were already experiencing diminished connections with others, who were retiring or moving to new residential environments. Secondly, language barriers restricted many seniors from attending activities organized by mainstream services for seniors, despite their willingness or eagerness to take part in socialization. This can be regarded as an environmental factor as well because some programs/activities should be organized in a language understandable to the seniors who wish to participate.

It is interesting to notice that language and cultural sameness or similarities do not guarantee trust-building and nurturing of social capital for Chinese seniors, as illustrated by problems that had been seriously affecting seniors' collective and individual well-being. The interviewed seniors could be divided roughly into two groups that presented different opinions toward *trust*. Those who were from Mainland China and were currently living in a residential environment of cultural heterogeneity seemed to express a higher level of trust of different levels of government and the community than the other group. The seniors enjoyed trustful interactions with not only fellow Chinese-Canadians but also individuals who did not speak the Chinese language. In contrast, the other group of seniors living in an environment in which all residents were ethnic Chinese, who spoke and understood each other's language and culture, actually reported multiple problems in trust issues with the community and even governmental departments. A lack of trust and doubt about individuals/organizations in authority (e.g., managers, politicians, or officials) hinders Chinese seniors from expanding and improving their social networks in the mezzo environment.

Some of the seniors who demonstrated higher trust levels lived with their children's families. They were not exposed to everyday situations with different levels of governance in the society, from local community clubs, organizations, to governmental offices. Other seniors with higher trust levels resided in culturally heterogeneous retirement buildings which were operated

through mainstream management style or organizations. Those Chinese seniors had not been involved extensively in management of the mezzo-level environment, such as financial management, voting for tenant representatives, or hiring of building maintenance staff. These seniors had not been involved in many civil participation activities or social groups/programs except within their churches. These seniors' higher level of trust could be a result of their lack of knowledge of the conflicts in management at different levels of mezzo- or macro-environments.

The seniors in the Chinese retirement building, on the other hand, due to their extended periods of living in the building and the convenience of speaking the same languages, were much more involved in higher levels of management within the residential environment. Aware of the history of the building and stories of most past and present tenants, they demonstrated a much stronger sense of ownership in how the building should be managed. Recognizing mismanagement behaviours that had caused negativity in their lives, the seniors developed great distrust of individuals, organizations, and/or governments. In the issue of trust, language or cultural convenience seems secondary to the importance of healthy and transparent management of the residential environment.

Adversities in the Environment Trigger Seniors' Motivation to Increase Social Capital

A linguistically and culturally homogeneous environment does not automatically provide a better or easier living situation to seniors. While the seniors were struggling to protect their own rights, they manifested incredible inner strength in searching and gaining recourse to help them achieve their goals. It seems that the hardships in the environment triggered and fueled their eagerness to practise civil actions, despite the language barriers and lack of social networks that each of them experienced. The active seniors were motivated by the desire to correct the

unfairness in the residential environment which had significantly affected the quality of life for them. It is a common goal for every senior citizen to have a comfortable retirement life; those who cannot obtain it due to reasons in the living environment often seek solutions to overcome obstacles to achieve that goal. This motivation is likely the major attribution to the seniors' civil participation.

Motivation to build and expand social networks is important to create satisfactory social networks. Some seniors were not motivated to seek networks outside of family because they did not see the need as their families took care of most issues. The seniors who did not have family members to handle the problems seniors were facing (e.g., conflicts in the retirement building) demonstrated high motivation to reach out to different resources in the community; in other words, they were "forced" by the environment to expand their networks. A few interviewed seniors did not have adult children living in Winnipeg or nearby. They reported more frequently on taking advantage of public transit, home care services, or interpretation assistance in hospitals. Absence of social capital in the micro environment, the immediate circle of individuals who are usually composed of family members, leaves Chinese seniors no choice but to seek help in the bigger environment, from neighbours, community leaders, volunteers, and social agencies, to governmental or legal figures.

Physical Environment

Chinese seniors' *views of community* was presented by moderate scores across all age groups and genders, indicating a satisfactory but not excellent evaluation of the general living environments. Several potential explanations can be considered from age-related activities to immigration experience. As one of the questions regarding views of community was about the

number of years one had been living in the community, younger seniors who were under 65 might be newer immigrants who had just moved into the area. As for older seniors who were 75 years and over, they might not have been going out often due to declining physical health conditions, and, in turn, have not opportunities to observe whether there were gang, drug, or drinking problems in the neighbourhood. If a senior did not have sufficient experience of the physical and social environments of the community, he or she might have unrealistically either overestimated or underestimated the issues in most of the survey items. This might have affected the homogeneity of the scores of related items and weakened the possible association between the social capital variable and health outcomes. Several other variables present similar problems, which will be discussed in upcoming sections.

The seniors between 65 and 74 years old might have been the most active in the community through participation in physical, social, and political events. They were comfortable going out to partake in various activities, such as grocery shopping and exercises, given their familiarity with the streets, amenities and facilities in the neighbourhood due to extended periods of living in the same or nearby areas since immigration. The seniors' physical and mental health might have benefited from their interactions with the community.

The comfort that the immediate residential environment could offer was of great importance to Chinese seniors. The structural design of a seniors' building should be considered from the view of seniors' health conditions and needs. For example, installment of a sufficient number of windows that are easy and safe to open will allow for fresh air to come in if senior residents are house-bound due to physical health reasons or harsh weather conditions.

Based on the comparison of the general views of Chinese seniors living in a cultural- and linguistic-homogeneous environment and those in residential areas or retirement buildings of

mixed cultures, it is noticeable that the former group did enjoy the convenience in practical aspects such as understanding management notices or making friends easily in the immediate environment. However, negativity demonstrated in other social capital variables of the seniors (i.e., low trust level and destructive social network) strongly decreased the comfort and convenience that a culturally homogeneous environment would have contributed to. Seniors' views about a community are a combination of their experience with the livability of the immediate environment (e.g., cleanness, facilities), support to social and physical activities, practice of rights, neighbour relationships, and community governance.

Expectations of Living Arrangement: Emerging Cultural Norms

Though a common belief in the Western society is that Chinese families provide more support and care for elderly members with declining health, there has been no empirical evidence to support this belief (Chappell, 2003; Chappell & Kusch, 2007; Liu 1994). It is not surprising for this study to conclude that the majority of Chinese seniors prefer living apart from their adult children and their families - many of them were even co-residing with offspring at the time of the study - consistent with the findings in the academic literature (Chappell, 2003). It has been questioned whether the practice of familial care is because of Chinese cultural norm or caused by tangible obstacles, including lack of information of available services, financial insufficiency, language barriers, or discomfort with different culture(s).

Chinese seniors in the present research and a related study (Luo, 2011) stated practical considerations for independent living arrangements. Firstly, seniors and younger generations have different life styles. Most seniors are used to going to bed early and rise early, but adult children and grandchildren prefer sleeping in when time permits. Getting up early to do morning

exercises or go fishing are routine activities seniors enjoy, but this may cause noise that wakes up other people in the household. Luo (2011) reported about an instance where an elderly couple, according to Chinese custom, went into their daughter and husband's bedroom in the morning to help get the granddaughter ready for daycare. The son-in-law, a Canadian man, was offended by such behaviour which was actually considered doing a favour in Chinese culture. After several other similar incidents, also due to cultural differences, the elderly couple moved into an apartment to avoid further conflicts. Secondly, seniors and younger family members have different food and dietary preferences – it is part of lifestyle; however, it has implications to housework management. Younger people prefer a greater variety and amounts of food, while older people like smaller amounts of soft light food that is easy to digest. Most seniors prepare their own food, such as rice soup or soft noodles, but they may also cook for the whole family as well if living in the same household, with the feeling that they may be a burden to their children if they are not able to contribute to the family. Cooking may become physically demanding work as seniors get older, although many of them came to Canada to help adult children with child care and homemaking.

The practice of familial care for the elderly is rooted in the traditional cultural norm – filial piety. Filial piety, as a complex concept in the Chinese culture, was embodied in *san-gang* (Three-Guide) where "an official must die if his ruler tells him so, and a son must die if his father tells him so, and a woman must die if her husband tells her so" (Li, 2010). The transformation of the discourse of filial piety from ethical to constitutional, and from familial to political, played a critical role in strengthening Chinese feudalist authorities through funneling individual minds into one voice of the ruler. Many Chinese seniors and most of their offspring have been living in Canada for an extended period of time, which leads to subtle, but significant, shifts in their adherence to traditional norms, beliefs, and practices. Common traditional filial acts, such as

unconditional obedience to parents and multi-generational living arrangements, are no longer fully accepted by both Chinese seniors and younger generations. Separate residences for elderly parents and adult children, institutionalization of seniors with declined daily functional abilities for better professional care, and provision of financial instead of instrumental support, are new patterns of fulfilling filial responsibilities for many Chinese families, without stigma, shame, or loss of face (Zhan et al., 2008; Zhan, Feng, Chen, & Feng, 2011).

Chinese culture has provided individuals with guidance throughout their lives into old age, in all perspectives including personal behaviours, interpersonal relationships, social structure, health beliefs, and medical practice. Cultural context has changed and will continue to emerge with time and geography. Therefore, when working with seniors of various cultural and/or social backgrounds, we should avoid over-generalization of cultural-specific concepts, behaviours, and beliefs.

Implications to Social Work Practice

Contemporary social work conducts its helping endeavours through thorough understanding and improving the dynamic interactions between human agency and its environment (Miley et al., 2011; Payne, 2005). The ecosystems perspective emphasizes the goodness of fit between individuals and their surroundings to achieve optimal holistic well-being for people, instead of focusing on separately on individual's problems or on environmental issues (de Hoyos, 1989; Miley et al., 2011). Has the relationship between Chinese seniors in Winnipeg and their residential environments reached a satisfactory goodness-of-fit? Heinonen and Spearman (2001) remind us that when individuals experience difficulties and challenges living in an environment, it is a sign that this goodness of fit is lacking.

It has been demonstrated that older Chinese in Winnipeg have been experiencing numerous challenges and obstacles in physical, social, and cultural aspects of the environment in which they live their retirement lives. Individuals and the environment will continue to change based on positive or negative reactions from each other until a goodness-of-fit is achieved. So will Chinese seniors faced by various difficulties within the environment. They have tried in their way to voice their needs and wants with regard to the quality of their lives, including actively participating in the present research. It had been planned to set aside up to two months to collect a certain number of responses for both quantitative and qualitative data; however, it took no more than three weeks to complete the data collection due to the prompt engagement of many members of the targeted population. The participants seemed strongly motivated by the goal of establishing a supportive environment for Chinese immigrants who are aging in a cultural context unfamiliar to many of them. Participation in the current study appeared to be an important step to fulfill that goal. Social workers can play a crucial role in assisting seniors to reach that goal.

Changing the Environment

The section *Expectations of a Residential Environment* in Chapter Eight presents in detail an ideal environment as depicted by Chinese seniors collectively. In summary, Chinese seniors would like to live in a residential community or building that:

1) Is Chinese language- and culture-oriented. Most staff should speak Chinese language(s) and share similar cultural backgrounds with the residents, older Chinese immigrants.

2) Provides multi-level assistance to seniors' later lives. As individuals experience varied stages of aging and health conditions, they require different levels of support to function daily in their activities.

3) Offers a variety of services for minimal fees or free of charge, including basic medical check-up services, home care, transportation, translation, food and grocery shopping programs, document handling services (e.g., paying bills, filling tax return), recreational activities, and socializing programs. The residence needs to be inclusive to all sub-groups in the community. The residential community/building can serve as a hub to many services that are open not only to residents but to all Chinese seniors in the city.

4) Operates under healthy and transparent management.

Besides the aforementioned changes that the Chinese seniors in this study propose to social service providers and decision-makers to consider, several seemingly ordinary issues demand us re-visit the purposes and outcomes as well.

Integrating Services and Programs

Services and programs for seniors need to be designed to achieve multiple outcomes because their demands often are multi-dimensional, and feasible solutions can come from multiple resources. For example, with regard to accessibility problems in the health care field, due to language barriers and transportation difficulties, many research participants suggested agencies recruit medical students, Chinese students at universities/colleges, or individuals who were health care professionals back in China to be volunteers, under proper supervision, to assist in providing required services. On the one hand, students in the process of obtaining medical designations will acquire community work experience and professional experience; on the other

hand, seniors will be able to receive the services they may have long requested. Social workers, using their skills for community development, can identify and mobilize the resources which are available but may be undiscovered in the community. Through collaboration with other volunteer organizations and existing services, social workers could apply their expertise to coordinate better and more services for seniors.

English as an Additional Language (EAL) programs for seniors were originally developed to help improve immigrant seniors' English skills in order for them to integrate into Canadian society. Because of personal and contextual factors described by seniors, such as declining of memory and lack of suitable environment for practice after class, it is challenging for seniors to make noticeable and sustainable progress in English learning with those classes. Many seniors, however, were fond of those classes, and were upset about being unable to continue to attend classes due to the discontinuation of the free shuttle bus, the result of termination of funding. Learning and improving English seems a secondary goal for Chinese seniors in attending EAL classes; rather, it is the opportunity to socialize with people of similar age from diverse cultures that attracted them the most. They enjoyed interacting with others, even those who did not speak a common language, by the use of body language or other non-verbal communicative approaches, during breaks or potluck parties. When designing and modifying EAL curricula for seniors, adult educators and social workers could work together to integrate elements for enhancing social participation for seniors, such as light recreational activities like stretching, socializing interactions that encourage taking individual initiative to expand friend circles, and built-in mechanisms for receiving seniors' feedback on improving the program. Social workers could help facilitate classes and enhance them from simply English learning to social capital building opportunities mutually appreciated by all involved parties.

Chinese seniors are willing and open to befriend others from other cultural groups, living in a multicultural society. Linguistic diversity creates practical obstacles in seniors' pursuit of upgrading their social networks; but seniors can be creative in communicating and understanding one another in certain circumstances. At a relaxing and encouraging gathering such as a potluck dinner or tea party, seniors can manage fundamental information exchanges through body language or use of objects such as pictures, along with basic English skills. Facilitators of EAL classes could organize activities for English-speaking seniors to be able to socialize with those who are learning the language, while minority seniors could be invited to volunteer as facilitators at programs such as ethnic cooking workshops, dancing clubs, or tai-ji classes. Activities like these not only increase Chinese seniors' social networks and participation, as well as their English proficiency, but also help establish reciprocity for seniors to be able to contribute to the community, and, in turn, strengthen their self-esteem and their sense of self-value.

When designing and developing programs for seniors of diverse cultural backgrounds, it is important to keep in mind that multi-purpose and multi-function programs can likely support seniors more effectively in building their social capital and improving their mental and physical health. Integrative-minded social workers focus on mobilizing open and hidden resources in the community, engaging seniors and other individuals in various programs/services and operating programs that meet a variety of needs. A program that is designed to enhance seniors' levels of recreational exercise can include network-building elements; English learning programs can incorporate and promote information about availability and accessible methods of health care and support services. In addition, seniors can receive services from volunteers, but also be volunteers themselves, depending on their capacities and interests. Programs integrating multiple purposes deliver quality care and services to seniors in a holistic manner.

Educating to Promote Awareness to Seniors, Families, Individuals, and Agencies

The present research results reveal that Chinese seniors seem to have been "forced" by challenges or adversities in life to improve their social capital. For instance, the seniors who did not have adult children living close by and had to deal with practical issues, such as visiting a doctor's office or paying bills, expressed a much higher demand for translation/interpretation services and/or English learning opportunities. Those who lived in retirement buildings, in separate households from their children, indicated a stronger need to expand their friend circles to include seniors from other cultures, although language differences do present as a barrier. The seniors who were active in *civil participation* activities did not possess better English skills, higher education levels, or any characteristics that were significantly different from those who were not. The major explanation for the difference between the active and inactive seniors was related to their residential environments. As the management of the seniors' building had caused many adversities in their personal lives and collective benefits (e.g., financial abuse, segregation, and lack of social and recreational programs), some of the seniors had decided to work together to remedy the mismanagement. After fruitless efforts to solve these problems internally, the seniors reached out to the community for assistance. They approached any resources they could, from social agencies and legal professionals to individuals who could potentially provide translation assistance on a voluntary basis. As a result, this group of seniors' engagement in *civil participation* was significantly higher than others who had not experienced such environmental problems.

It should not be necessary for seniors to go through difficulties as described above in order to obtain and increase their social capital. From a social work perspective, promoting the benefits of effective social capital building should be the focus in the process of physical and social environmental development. Chinese seniors, as well their family members who have not had

educational and work experience in the Canadian context, may not be aware of the nature of social capital and its positive outcomes to seniors' quality of life. Social workers can design and develop educational activities to promote an understanding of the importance of social capital, with manifestation of social capital elements and potential benefits to seniors and their families. For instance, information on civil participation, such as taking initiative in local management issues or expressing other concerns in local community meetings can be integrated into EAL classes for seniors. The material could include examples of how individuals have influenced decision-making in local and national issues. For many older Chinese immigrants who were originally from mainland China, civil participation or civil society were foreign concepts, let alone how to implement these concepts.

In this study, the measurement of *social participation* (i.e., participation in social groups such as hobby clubs or adult education groups) resulted in floor effect in scoring, partially because Chinese seniors were unfamiliar with the term. *Social group* may evoke negative connotations as this term has been used in the Communist government's propaganda to describe and criticize groups who follow different ideologies from the government's. It is not uncommon that social/cultural/religious dissidents, activists, lawyers with conscience, or individuals who have been treated with injustice and want to appeal to higher levels of government are named "some social groups" in propaganda discourse to segregate people with different opinions from the "majority", or the Communist government. Imbedded in the social system in contemporary Mainland China, the power of meta-narrative through propaganda has allowed the government to manipulate people's minds and thoughts, which includes how people understand various forms of social groups.

Social workers, while helping Chinese seniors in Canada build and enhance their social capital, need to understand that reluctance to social activities not only comes from practical

obstacles, but also is caused by different mentality and social norms. Educational programs that deliver information to debunk misconceptions and clarify the nature and benefits of social capital will greatly promote Chinese seniors' motivation in social capital development, as well as their families' support to seniors' pursuit.

From the perspective of service providers and policy makers, it is vital to increase seniors' interest and motivation in civil participation in order to acquire extended social support and advocacy for issues of concern. However, we do not want to create intentional or unintentional hardships for seniors. Therefore, we need to be creative in promoting the benefits of taking part in civil actions. One of the approaches would be to offer relevant information through public education, such as thematic workshops in different cultural communities, public awareness programs in social events or festivals, or flyers printed in seniors' first languages distributed to community centres, senior centres, or even residential homes. Another potentially effective method would be to deliver information of promoting civil participation to adult children for them to pass on to their elderly parents. As seniors trust and depend greatly on their adult children, convincing the children of the benefits of civil participation will smooth the communication channel to reach immigrant seniors who have limited access to the information concerning their rights and well-being.

With the same logic, promotion of awareness of other topics concerning seniors, such as educational programs or activities, should include their family members, particularly adult children. Topics may cover how to establish and strengthen new social networks to provide support for Chinese seniors with physical or mental health problems. Adult children not only would be able to explain and translate relevant information to their elderly parents, but they are often the primary advice-givers to seniors.

Considerations for Social Policy

Due to their unfamiliarity of Canadian social welfare and health systems and Canadian cultural values, many older Chinese-Canadians and their families may not be fully aware of their rights, means of practising their rights, and available services and benefits. One important mission of the social work profession is to advocate for less powerful groups whose discourses are often disregarded in social policy-making, and to raise public awareness of rights and benefits for seniors. Durst (2005, 2010a) and Hohart (2002) urge for empowerment of immigrant seniors by involving them in policy decision-making and volunteerism, while Lavoie, Guberman, & Brotman (2010) point out a series of structural problems in the host society that delay or restrict older immigrants' access to services, such as the 10-year residency requirement for the Old Age Security Pension. Scholars consider that cultural differentiations are less influential than the structural context with respect to social inequality. Therefore, it is essential to develop a policy model that takes into account cultural differences without implying that they explain everything (Lavoie et al., 2010).

Despite the fact that multi-generational co-residence is still prevalent among Chinese families in the West, seniors and their families can appreciate and enjoy independent living as long as crucial pre-conditions, such as assistance services, economic independence, or removal of language barriers, are met (Chappell & Kusch, 2007). Cultural involvement (e.g., attending functions or seeing friends), rather than traditional cultural values, is found to be positively related to older Chinese-Canadians' life satisfaction (Chappell, 2005). It would be most effective if social services and programs focus on teaching and facilitating access to cultural activities (e.g., qi-gong exercise, mah-jong playing) without emphasis on ethnocentric beliefs. In the health care domain, mental health services are promoted as part of the current health care

system in Canada, and this is due to the biomedical orientation of mental health in Western medicine and health insurance programs. Older Chinese adults may find it hard to convince themselves to go to a clinic just because they exhibit some depressive symptoms but are otherwise healthy. Chen et al. (2009) recommend that mental health services extend beyond formal sectors to "involve education, social and community services, and perhaps the complementary health practice sectors so that intervention for psychological difficulties can be provided early and in a milieu and manner acceptable to the individuals involved" (p. 637).

Social workers can also collaborate with grass-roots cultural organizations to provide the information and access to existing programs and services for seniors. Many Chinese seniors are unclear about universal health coverage, including annual physical examinations (Lai & Kalyniak, 2005), home care services, senior center activities, or interpretation services in medical or legal settings, the information of which is available upon request (Lavoie et al., 2010; Luo, 2011).

Considerations for Cultural Competence and Cultural Sensitivity

Cultural competence and cultural sensitivity are the most frequently used terms in the cross-cultural counselling literature (Whaley, 2008). Many writers treat these terms as interchangeable and synonymous, but they are essentially different although semantically connected (Whaley, 2008). While cultural sensitivity usually indicates knowledge and awareness, culture competence means skills in the cross-cultural clinical context (Whaley, 2008), and knowledge and awareness do not guarantee proficiency in providing cultural-appropriate services. The association between cultural sensitivity and cultural competence suggests that both

are needed in cross-cultural training and practice, whereby sensitivity is established first, and then competence is addressed on the basis of sensitivity.

Dean (2001) and Johnson & Munch (2009) criticize the mainstream promotion of cultural competence, arguing that it will lead to a "know-how" attitude which is "consistent with the belief that knowledge brings control and effectiveness" (Dean, 2001, p. 624). They question the idea that a clinician can become competent in one culture or another. Therefore, it is more beneficial in cross-cultural work to develop the ability to understand, rather than to know how. Acknowledgement of "lack of competence" should be an attribute of cultural competence. Knowledge of cultures often is insufficient (or impossible) to acquire in cross-cultural work. For example, Wong, Cheng, Choi, Ky, LeBa, Tsang, & Yoo (2003) demystify the common belief that practitioners with minority cultural backgrounds are capable of working culturally competently with clients from the same cultural group. Lee (2010) argues that cultural competence is a reciprocal concept and the practitioner's competence level can be severely affected by that of the client.

Social workers, when working with Chinese seniors, need to integrate cultural competence into services or programs provided. Cultural norms are ever-shifting and contextualized by specific time, location, social circumstance, and personal life course stages. Equipped with the sensitivity to targeted groups' culture through professional development training and/or life experience, social workers should not forget that seniors are the experts of their lives and the ultimate decision-makers for themselves.

In cross-cultural studies, acculturation theory emphasizes a bilateral relation between minority and dominant cultures where members of both groups can move to or away from both culture of origin and culture of the other (Berry, 1980, 2005). Compared to earlier cross-cultural

theories, such as assimilation, that indicates members of the minority culture lose their original cultural identity and fully adopt the dominant culture, acculturation theory is more comprehensive and inclusive as it stresses the multi-dimensional and relative characteristics of intercultural relations; it promotes the idea of creating new trans-national identities by blending the two cultures (Berry, 1980; Lai & Leonenko, 2007). "While assimilationists implicitly assume that the dominant culture is superior and pluralists argue for the coexistence of many different groups, a model of bi-culturalism or a hybridizing of the donor culture and the receiving culture is garnering more attention recently" (Chappell & Kusch, 2007, p.42). Studies of Chinese seniors in Canada have revealed optimistic evidence of acculturation theory (e.g., Casado & Leung, 2001; Lam, Pacala, & Smith,1997; Lai & Leonenko, 2007; Tsang, Liamputtong, & Pierson, 2004). Liu and colleagues (2000) find that the support of the traditional value of filial piety is related to both Chinese and Western identities. It suggests that Western identity "contributes to filial piety by facilitating regular positive communication between generations (e.g., contact with respect), whereas Chinese identity contributes more to material obligations (e.g., financial assistance)" (Liu et al., 2000, p. 221).

While practitioners strive to understand seniors' thoughts and behaviours based on their culture(s), Chinese seniors may appreciate introduction and guidance to the host culture as well. As indicated in the findings, some seniors expressed the intention to expand their social connections to non-Chinese communities for higher engagement in social participation, civil participation, social networks and support, and other social capital elements. Assisting Chinese seniors in improving their competence of Canadian culture(s) should be an importance aspect of cultural competence in social work with cultural minority seniors.

Summary

The overall low possession of social capital among Chinese seniors in Winnipeg has a substantial impact on their health and use of health care and support services. Insufficient social capital is related to a series of obstacles and nonavailability of support in the physical, social and cultural environments in which seniors live their retirement lives. Chinese seniors and their residential environment(s) do not present goodness-of-fit based on the ecosystems perspective; therefore, social workers need to play a leading role in providing culturally competent services, integrative programs, advocacy and awareness promotion, and other activities to meet the emergent needs of the targeted population, to build a supportive residential environment for the betterment of quality of life for Chinese seniors.

Chapter Ten

CONCLUSION

Summary of the Research Study

Using an ecosystems perspective, this study has focused on the role of social capital in the community residential environment to promote healthy aging for Chinese seniors in a Canadian city. The issues faced by Chinese seniors have been examined through understanding seniors' perceptions and statistically analyzing the impact of social capital on health and well-being for this population. The findings, in turn, provide immediate and practical information to policy-makers and service providers for proper design of supportive environments and services.

The prospective audience and beneficiaries of the study are people who develop, influence, and implement programs and practices that affect the well-being of Chinese-Canadians aged 60 and over. These include all levels of funders of community support for ethnic minority seniors: government decision-makers in a variety of sectors; nongovernmental sectors, including seniors' groups and community organizations; service providers in health, social work, recreation, and housing; and older Chinese-Canadians themselves and their families.

The role of social work in meeting the needs of the target group has been discussed with respect to the findings, because social work is often called upon to provide vital contributions to build and strengthen social capital to promote health among people of all ages. Aiming for simultaneous growth in individual, community, and society at present and in the future, social workers may use the research findings at all levels: individual practitioner, organization, and policy. With enhanced knowledge of the health and social issues faced by older immigrants, social workers will be able to serve Chinese seniors in the community with greater cultural

competence in both social and health aspects. At the organizational and institutional level, social services can develop appropriate environmental programs demanded by the target population or integrate their needs into existing services to be cost-effective. Program design and management should be conducted to serve Chinese seniors' needs and preferences, such as building an environment that can sustain the quality of Chinese seniors' lives or hiring of staff who possess good comprehension of the seniors' culture and are able to deliver culturally competent services. At the policy and social levels, social workers will also help ensure older immigrants' voices are heard while designing social programs for their benefits. Not only does government funding need to be allocated properly for services and programs for immigrant seniors, but various stakeholders in the community should also be mobilized to work together to develop a social-capital-enabling environment for everyone - current and future seniors.

The findings can be utilized as solid evidence to support community initiatives of new programs or modification of existing services. Research data of this study can also serve as a baseline to evaluate current and future intervention programs to identify their effectiveness and gaps. Although this study targets Chinese seniors in a Canadian urban context and there are cultural or contextual differences between this group of seniors and others from other cultural backgrounds, the barriers faced by other elderly immigrants and related demands of services could be similar (Makwarimba et al., 2010). Thus, the findings from this study could offer a reference to researchers to develop strategies to assessing challenges and needs of other senior immigrant groups.

Limitations

This completed study is subject to several limitations. The first concern lies in the ecosystems perspectives used as an overarching theoretical framework for the study. Ecosystems is not a theory that carries explanatory power (Heinonen & Spearman, 2001); thus, it does not help explain and illustrate interrelational transactions between an individual and particular existing elements within a system. For example, cultures are an influencing factor for an individual's behaviour; but how exactly cultures can impact Chinese seniors' lives in a Canadian context needs to be explored beyond ecosystems perspectives. Acculturation theory assists in interpreting some seniors' motivation to extend their social circles to non-Chinese communities; proper understanding of cultural fluidity also helps explain Chinese seniors' demand for an independent living arrangement that is different from that in the traditional Chinese culture.

The second concern is related to the manner in which the findings have been presented: qualitative results have been demonstrated in parallel with the quantitative data. Both types of data were organized in the theoretical framework which was composed of three major concepts – healthy aging, social capital, and residential environment – under the overarching ecosystems perspective. Survey items and focus group interview questions were designed based on these constructs and respective measures from the literature; once data had been collected, it was analyzed within the same framework as well.

The advantage of organizing findings based on proposed theoretical structure is that data is theme-oriented and able to illustrate major aspects of the concepts that a researcher sets off to study. Findings from both types of data complement one another in depicting a fuller picture of the studied phenomenon. For example, the survey results indicated that the majority of Chinese seniors were uninterested in co-residing with their adult children, consistent with the findings in the literature. What has not been revealed in previous research is the reasons that seniors prefer independent living arrangements. The qualitative findings from the focus group interviews offer

several plausible explanations, based on both practical considerations and shifted cultural norms on roles of family members. The disadvantage, however, is also obvious as data seems to be "forced" into pre-set categories, such as each of the five different components of social capital, which is one of many existing approaches to study social capital, or the social aspects of individuals' lives in general. The qualitative data might have suffered more than the quantitative data from artificial divisions of information based on a pre-set theoretical framework, because qualitative research values and emphasizes the congruent meaning that flows naturally from the narratives of research participants and the reflexivity of the interactions between the researcher and the researched. Fixing qualitative data into a proposed structure does not provide much room for a natural flow of meaning emerging from the data.

The second limitation is about construct validity and measurement. When studying seniors of different cultural backgrounds, researchers are faced with ontological and epistemological challenges where the conceptions of aging and related issues vary in different cultures. Gerontology is a Western science, and many theories have been developed on the basis of observations and investigations of Western social phenomena. The applicability of Western gerontological concepts and theories to older people with Chinese cultural backgrounds is thus questionable (Chappell, 2005). *Social capital* is not a commonly used term in everyday language, let alone being translated and used in another language and cultural context. Among the five components of social capital in the present study, *social participation*, which involves attendance in social groups, hobby clubs, or adult education or recreational groups, seems to be the least understood and practised by Chinese seniors (i.e., floor effect), according to the survey results. It is possible, though, that the sampled seniors' actual *social participation* levels were low and were captured by the data accurately. But it is also possible that the term was unfamiliar or misunderstood by the research respondents, as some of them might have interpreted the

concept in a political sense due to the social and cultural environment in which they had been raised.

Thirdly, it is also challenging to obtain measurable variables that are meaningful to seniors of non-Western cultural groups, given that most measuring instruments have been developed from Western perspectives and in Western language(s). Conventional depression scales often generate low scores indicating absence or low levels of depression among non-Western seniors, but this does not mean those seniors are free of depression (Parker, Cheah, & Roy, 2001; Chi, 2011). Likewise, the low scoring of *social participation* does not necessarily mean that Chinese seniors do not take part in group activities for socializing or recreational purposes. They might have organized, coordinated, and/or attended different forms of *social* participation without realizing it or connecting their activities with the concept, such as informal and irregular gatherings of friends or like-minded individuals for continuous learning or leisure. Focusing on inapplicable variables could result in misunderstanding of certain phenomena in a cultural context unfamiliar to a researcher, which, in turn, may lead to inappropriate interventions and policies.

Fourthly, other challenges in measurement of cross-cultural research include method bias and translation problems (Vijver & Leung, 1997; Chi, 2011). Method bias occurs when scores are affected by certain traits of a measure or the administration of the study itself. For instance, participants tend to choose middle scores based on the mentality of not going extreme (Chi, 2011). Language also contributes to methodology difficulties. Despite that the researcher employed a substantial number of items in the survey that had been tested and applied in previous successful research projects and operated pre-tests of the questionnaire to enhance reliability, it is difficult to determine whether respondents actually understand the meaning of the original questions. Chi (2011) presents an example of translating the term “self-respect” in a life

satisfaction scale from English to Chinese, and the final product was so repugnant to Chinese seniors that most of them refused to respond, even though all five principal investigators were of various degrees of Chinese cultural background. Although the instruments applied in the current study were presented and the data collection was conducted in the first language for the researcher and most respondents, misunderstanding and loss of meaning cannot be guaranteed to be fully removed in the research process, and, in turn, from the findings.

As the fifth limitation, due to various conditions, the study applied nonprobability sampling strategies to recruit research participants and collect data; the results, therefore, cannot be generalized to a broader population. Nevertheless, the data have illustrated to a degree the relationship between health and social capital among some Chinese seniors in Winnipeg, and have been examined in comparison with the findings of the older Chinese population in Canada to identify the similarities and differences between the two samples. Furthermore, themes that emerge from seniors' collective interviews have provided valuable recommendations for decision-makers to consider.

The sixth limitation regards the construct of social capital, a concept with diverse versions of interpretation. The measurement framework conceptualized by the UK ONS (Foxton & Jones, 2011) is only one of them. Social capital is a relatively new and constantly evolving concept. One should expect to find other variables and indicators, like public good or self-efficacy, in different studies based on their authors' conceptualization of social capital.

Due to limited time, resources, and the focus of the research, this study has explored only the relationships between the key concepts: social capital, residential environment, and health. Some moderating factors, such as dynamics within a cultural group, health beliefs, health behaviours, and socioeconomic factors, although important, have not been examined in-depth.

Recommendations for Future Research

Social capital is a construct that has been conceptualized and oriented in the Western culture. Existing definitions and measures do not seem to have effectively reflected the understanding of social involvement or social participation of Chinese seniors, nor are they able to accurately present the level of seniors' social capital and their endeavours to achieve it. For instance, the actual scores of Chinese seniors' *social participation* might have been hindered by their misunderstanding or lack of understanding of the concept, even though it was translated into and explained in two common Chinese languages (Mandarin and Cantonese). A major improvement in the research area of social capital and immigrant seniors will be to acquire the perceptions of the targeted group(s) on *social capital*: how they define the issues which scholars call *social capital*; what the important elements there or should be included in *social capital* construct and measurement; and how individuals of targeted groups view the relevance or importance of social capital in various aspects of their lives. Studies based on targeted groups' understanding of social capital will greatly enhance the comprehensiveness of the concept and related measuring instruments, especially in a cultural context. Integration of cross-cultural theories and studies of social capital should benefit both areas through broadening topics for investigation and deepening the comprehension of research outcomes.

The dynamics within a particular cultural group to support or impede individuals developing social capital is another interesting topic for future research. As indicated in the findings of this study, a cultural- and/or linguistic-homogeneous environment does not necessarily provide positive social interactions to nurture seniors' social capital. In case of disagreement on resource sharing, members of a cultural group with stronger personal

competencies (e.g., English proficiency, interpersonal skills, or managerial skills) may take advantage of those with fewer competencies, resulting in segregation of certain sub-groups, collective or individual abuse in various forms (e.g., financial, physical, or emotional), and, in turn, declining mental and physical health of those affected. Social work practitioners and researchers acknowledge that it is beneficial for seniors to age in a familiar cultural and social community and strive to build such communities to facilitate healthy aging; however, some issues that have been commonly identified in the general aging population, such as elder abuse or neglect, cannot be considered buffered or overridden by a familiar cultural environment. Research on within-group dynamics will enrich social service providers' knowledge of cultural sensitivity and enhance their cultural competence in service provision.

It will also be helpful to apply advanced quantitative analysis methods in future studies of Chinese seniors' social capital and health. As the present research attempted to examine the interactions among three major concepts – health, social capital, and residential environment – all of which consisted of multiple sub-concepts and categories of measures and information, conducting more advanced tests than bi-variate statistics was more time- and resource-demanding than the conditions permitted. In order to achieve in-depth understanding of the relationships between social capital elements and health indicators for Chinese seniors in Canada, future research can narrow investigation areas and conduct advanced tests and statistics, focusing on analyzing one or several categories of information more thoroughly and in greater depth.

In spite of its limitations, the current research is the first study that focuses on analyzing Chinese seniors' social capital, how it has impacted their health, and how it has been influenced by their residential environments. Hybridizing first-hand quantitative and qualitative data, the study also breaks new ground by applying mixed-methods research approaches to studying

cross-cultural aging issues, particularly with older Chinese immigrants in Canada. With a comprehensive review of existing research on health, social capital, and environment for immigrant seniors, the study has contributed to recommendations for social work with Chinese seniors, such as implications to policy and culturally competent services. The findings have provided a rich foundation for research possibilities and direction, as well as recommendations, for further studies that will help enhance our understanding of Chinese seniors and older adults of diverse cultural groups.

REFERENCES

Abdulahad, R. (2010). *Social capital: An investment in understanding and addressing acculturative stress in the Canadian Iraqi-Christian community.* (Doctoral thesis). Calgary: University of Calgary.

Adler, P. S, & Kwon, S. (2002). Social capital: Prospects for a new concept. *The Academy of Management Review, 27*(17), 4.

Assisted living quality coalition (1998). *Assisted living quality initiative: Building a structure that promotes quality.*

Berry, J. W. (1980). Acculturation as varieties of adaptation. In A. M. Pailla (Ed.), *Acculturation: Theory, model, and some new findings*. Boulder, CO: Westview.

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*, 697-712.

Bouchard, L., Roy, J., & van Kemenade, S. (2006a). Research traditions: An overview. *Social Capital and Health: Maximizing the Benefits. Health policy research bulletin, 12,* 10-12.Health Canada.

Bouchard, L., Roy, J., & van Kemenade, S. (2006b). Developing an operational model based on networks. *Social Capital and Health: Maximizing the Benefits. Health policy research bulletin, 12,* 13-15.Health Canada.

Canadian Association of Social Workers (2013). *What is social work?* Retrieved from http://www.casw-acts.ca/en/what-social-work

Canadian Institute for Health Information (2005). National Health Expenditure Trends 1975–2005. Retrieved from https://secure.cihi.ca/free_products/nhex_trends_report_2011_en.pdf

Cannuscio, C., Block, J., & Kawachi, I. (2003). Social capital and successful aging: The role of senior housing. *Annals of Internal Medicine, 139*(5), 395-399.

Central People's Government of the People's Republic of China. (1996). *Protection of the Rights and Interests of The Elderly* (中华人民共和国老年人权益保障法). Retrieved from http://www.gov.cn/banshi/2005-08/04/content_20203.htm

Centre on Aging (2010). *Profile of Manitoba's Seniors 2010.* Winnipeg: University of Manitoba.

Chappell, N. (2003). Correcting cross-cultural stereotypes: Aging in Shanghai and Canada. *Journal of Cross-Cultural Gerontology*, 18, 127 – 147.

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

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

Chappell, N. & Lai, D. C. Y. (2001). Social support of the elderly Chinese: Comparison between China and Canada. In I. Chi, N. L. Chappell, & J. Lubben (Eds.), *Elderly Chinese in Pacific Rim Countries: Social Support and Integration*. Hong Kong: Hong Kong University Press. 2001

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

Chappell, N., McDonald, L, & Stones, M. (2008). *Aging in contemporary Canada*, second edition. Toronto: Pearson.

Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research, the third edition.* Thousand Oaks: Sage Publications.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage.

Chen, A. W., Kazanjian, A., & Wong, H. (2009). Why do Chinese Canadians not consult mental health services: Health status, language or culture? *Transcultural Psychiatry,* 46(4), 623-641.

Chi, I. (2011). Cross-cultural gerontology research methods: challenges and solutions. *Ageing & Society, 31*, 371-385.

Chow, H. P. H. (2000). *The health needs of the Chinese seniors in Calgary: A community survey*. Alberta, Canada: Chinese Christian Wing Kei Nursing Home Association.

Chow, H. P. H. (2010). Growing old in Canada: physical and psychological well-being among elderly Chinese immigrants. *Ethnicity and Health*, 15(1), 61-72.

Citizenship and Immigration Canada. (2009). *Facts and figures 2005: Immigration overview: Permanent and temporary residents*. Ottawa, ON: Citizenship and Immigration Canada. Retrieved October 2, 2010, from, http://www.cic.gc.ca/english//resources/statistics/facts2009

Claridge, T. (2004a). *Is social capital really capital.* Retrieved from http://www.socialcapitalresearch.com/literature/capital-debate.html

Claridge, T. (2004b). *Dimensions of social capital theory.* Retrieved from http://www.socialcapitalresearch.com/literature/theory/dimensions.html

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting Mixed methods research*. Thousand Oaks: Sage.

De Hoyos, G. (1989). Person-in-Environment: A tri-level practice model. *Social Casework: The Journal of Contemporary Social Work, March 1989,* 131-139.

Dean, R. G. (2001). The myth of cross-cultural competence. *Families in society: The Journal of Contemporary Social Services, 82*(6), 623-630.

Driedger, L. & Chappell, N. (1987). *Aging and ethnicity: Toward an interface.* Toronto and Vancover: Butterworths.

Durst, D. (2005) *Aging Amongst Immigrant In Canada: Policy and Planning Implications.* 12th Biennial Canadian Social Welfare Policy Conference: "Forging Social Futures".

Durst, D. (2010a). Elderly immigrants in Canada: Changing faces and greying temples. In D. Durst & M. MacLean (Eds.), *Diversity and Aging among Immigrant Seniors in Canada: Changing Faces and Greying Temples.* Calgary: Detselig Enterprises Ltd.

Durst, D. (2010b). Cultural diversity in long-term care: Confusion with cultural tensions. In D. Durst & M. MacLean (Eds.), *Diversity and Aging among Immigrant Seniors in Canada: Changing Faces and Greying Temples.* Calgary: Detselig Enterprises Ltd.

Evans. S. (2009). 'That lot up there and us down here': Social interaction and a sense of community in a mixed tenure UK retirement village. *Ageing & Society, 29,* 199-216.

Federal, Provincial and Territorial Committee of Officials (Seniors), 2006. *Healthy aging in Canada: a new vision, a vital investment from evidence to action*. Ottawa: Public Health Agency of Canada. Retrieved from http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/pro/healthy-sante/haging_newvision/vision-rpt_e.pdf

Foxton, F. & Jones, R. (2011). *Social capital indicators review.* London: Office for National Statistics.

Franke, S. (2006). What is social capital and why is it important to health research and policy? Health Canada. (2006). Building social capital: A role for public health policy? *Social Capital and Health: Maximizing the Benefits. Health policy research bulletin, 12.* Ottawa: Health Canada.

Franke, S. (2005). *Measurement of social capital: Reference document for public policy research, development, and evaluation.* Ottawa: Policy Research Initiative.

Fry, C. (2003). The life course as a cultural construct. In Settersten, R. A. (Ed.), *Invitation to the life course: Toward new understandings of later life.* New York: Baywood Publishing Company.

Galo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. *Integrative Psychological & Behavioral Science,42,* 266-290.

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

Gelfand, D. E. (2003). *Aging and ethnicity: Knowledge and services,* second edition. New York:

Harper, R. (2002). *The measurement of social capital in the United Kingdom.* Office for National Statistics.

Health Canada. (2006). Building social capital: A role for public health policy? *Social Capital and Health: Maximizing the Benefits. Health policy research bulletin, 12.*Health Canada.

Health Canada for the Federal, Provincial, Territorial Ministers Responsible for Seniors (1998). *National Framework on Aging*. Retrieved from http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/pro/healthy-sante/nfa-cnv/aging_e.pdf

Heinonen, T. & Spearman, L. (2001). *Social work practice: problem solving and beyond.* Toronto: Irwin.

Hohart, K. R. (2002). Death and dying and the social work role. *Journal of Gerontological Social Work, 36*(3), 181-192.

Hoyle, R. H., Harris, M. J., & Judd, C. M. (2002). *Research methods in social relations, seventh edition*. Belmont Drive: Wadsworth Cengage Learning.

Ikels, C. (1998). The experience of dementia in China. *Culture, Medicine and Psychiatry*, 22, 257-283.

Ingersoll-Dayton, B. (2011). The development of culturally-sensitive measures for research on ageing. *Ageing & Society*, *31,* 355-370.

Jang, Y., Mortimer, J., Haley, W., & Graves, A. (2004). The role of social engagement in life satisfaction: Its significance among older individuals with disease and disability. *Journal of Applied Gerontology, 23,* 266-278.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33*, 14-26.

Johnson, Y. M. & Munch, S. (2009). Fundamental contradictions in cultural competence. *Social Work, 54*(3), 220-231.

Karls, J. M., Lowery, C. T., Mattaini, M. A., & Wandrei, K. E. (1997). The use of the PIE (person-in-environment) system in social work education. *Journal of Social Work Education, 33*(1), 49-58.

Karls, J. M. & Wandrei, K. E. (1992). PIE: A new language for social work. *Social Work, 37*(1), 80-85.

Kemper, E. A., Stringfield, S., & Teddlie, C. (2003). Mixed methods sampling strategies in social science research. In A. Tashakkori & C. Teddlie (Eds.), *Sage Handbook of mixed methods in social and behavioral research* (pp. 351-383). Thousand Oaks, CA: Sage.

Knight, T. & Ricciardelli, L. (2003). Successful aging: Perceptions of adults aged between 70 and 101 years. *International Journal of Aging and Human Development, 56*, 223-245.

Laditka, J. (2001). Providing behavioral incentives for improved health in aging and medicare cost control: A policy proposal for universal medical savings accounts. *Journal of Health and Social Policy, 13*(4), 75-90.

Lai, D. W. L. (2012). Ethnic identity of older Chinese in Canada. *Journal of Cross-Cultural Gerontology, 27*(2), 103-117.

Lai, D. W. L. (2004a). Depression among elderly Chinese-Canadian immigrants from Mainland China. *Chinese Medical Journal*, 117(5), 677 – 683.

Lai, D. W. L. (2004b). Health status of older Chinese in Canada: Findings from the SF-36 Health Survey. *Canadian Journal of Public Health*, 95(3), 193 – 197.

Lai, D. W. L. & Chappell, N. (2006). Use of traditional Chinese medicine by older Chinese immigrants in Canada. *Family Practice,* 24, 56 - 64.

Lai, D. & Chau, S. (2010). Social capital, health and well-being of elderly Chinese immigrants in Canada. In D. Durst & M. MacLean (Eds.), *Diversity and Aging among Immigrant Seniors in Canada: Changing Faces and Greying Temples.* Calgary: Detselig Enterprises Ltd.

Lai, D. W. L. & Chau, S. B. Y. (2007). Predictors of health services barriers for older Chinese immigrants in Canada. *National Association of Social Workers,* 57 – 65.

Lai, D. W. L. & Hui, N. T. A. (2007). Use of dental care by elderly Chinese immigrants in Canada. *Journal of Public Health Dentistry,* 67(1), 55 - 59.

Lai, D. W. L. & Kalyniak, S. (2005). Use of annual physical examinations by aging Chinese Canadians. *Journal of Aging and Health*, 17(5), 573-591.

Lai, D. W. L. & Leonenko, W. L. (2007). Correlation of living alone among single elderly Chinese immigrants in Canada. *International Journal of Aging and Development,* 65(2), 121 – 148.

Lai, D. W. L. & McDonald, J. R. (1995). Life Satisfaction of Chinese Elderly Immigrants in Calgary. *Canadian Journal on Aging*, 14(3), 536-552.

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

Lai, D. W. L., Tsang, K. T., Chappell, N., Lai, D. C. Y., & Chau, S. B. Y., (2007). Relationships between Culture and health status: A multi-site study of the older Chinese in Canada. *Canadian Journal on Aging, 26(3),* 171-184.

Lavoie, J., Guberman, N, & Brotman, S. (2010). Service use by immigrant families caring for an older relative: A question of culture or structure? In D. Durst & M. MacLean (Eds.), *Diversity and Aging among Immigrant Seniors in Canada: Changing Faces and Greying Temples.* Calgary: Detselig Enterprises Ltd.

Lee, E. (2010). Revisioning cultural competencies in clinical social work practice. *Families in society: The Journal of Contemporary Social Services, 91*(3), 272-279.

Levin, J., Fox, J. A., & Forde, D. R. (2010). *Elementary statistics in social research, eleventh edition.* Boston: Allyn & Bacon.

Li, B. K. (2010). *中華孝道的承傳* (The Chinese Tradition of Filial Piety). Retrieved from http://www.for99.com.cn/default.asp?id=553

Li, K. M. (2009). *Transnationalism, citizenship and sense of belonging among elderly Hong Kong immigrants in Canada.* Kingston: Queen's University. Unpublished thesis.

Li, P. S. (2009). Thorny questions and conceptual biases. In M. Wallis & A. Fleras (Eds.), *The politics of race in Canada: Reading in historical perspectives, contemporary realities, and future possibilities.* Don Mills: Oxford University Press.

Liu, R. (1994). *Baseline Survey Data of Beijing Multidimentional Longitudinal Study of Aging.* Beijing: Weijin Publishing House.

Liu, J. H., Ng, S. H., Weatherall, A., & Loong, C. (2000). Filial piety, acculturation, and intergenerational communication among New Zealand Chinese. *Basic and Applied Social Psychology, 22*(3), 213-223.

Litwin, H. (1998). The provision of informal support by elderly people residing in assisted living facilities. *The Gerontologist, 38*(2), 239 – 246.

Longman Dictionary of Contemporary English (2010). http://www.ldoceonline.com/dictionary/narrative

Luo, H. (2011). *A new home in old age: The Role of Culture in the Aging Experience of Chinese Immigrants in a Cross-Cultural Context.* University of Manitoba. Unpublished manuscript.

MacKinnon, M. E., Gien, L., & Durst, D. (2001). Silent Pain: Social Isolation of the elderly Chinese in Canada. In I. Chi, N. L. Chappell, & J. Lubben (Eds.), *Elderly Chinese in Pacific rim countries: social support and integration.* Hong Kong: Hong Kong University Press.

Makwarimba, E., Stewart, M., Jones, Z., Makumbe, K., Shizha, E., & Spitzer, D. (2010). Senior immigrants' support needs and preferences of support intervention programs. In D. Durst & M. MacLean (Eds.), *Diversity and Aging among Immigrant Seniors in Canada: Changing Faces and Greying Temples.* Calgary: Detselig Enterprises Ltd.

Manitoba Health (2012). *Aging in place.* Retrieved from http://www.gov.mb.ca/health/aginginplace/docs/aging_in_place.pdf

Mattaini, M. A. & Meyer, C. H. (2002). The ecosystems perspective: Implications for practice. In M. A. Mattaini, C. T. Lowery, & C. H. Meyer (Eds.), *Foundations of social work practice: A graduate text, 3rd edition.* Washington, DC: NASW Press.

McDonald, L. (2010). Theorizing about aging and immigration. In D. Durst & M. MacLean (Eds.), *Diversity and Aging Among Immigrant Seniors in Canada.* Calgary: Detselig Enterprises.

McDonald, L., George, U., Daviuk, J., Yan, M. C., & Rowan, H. (2001). *A study on the settlement related needs of newly arrived immigrant seniors in Ontario.* University of Toronto: Centre for Applied Social Research.

Mellor, M. J. (2009). Social work with older immigrants and their families. *Journal of*

Miley, K. K., O'Melia, M., & DuBois, B. (2011). *Generalist social work practice: An empowering approach, 6th edition.* Boston: Allyn & Bacon.

Minuchin, P., Colapinto, J., & Minuchin, S. (2006). *Working with families of the poor, 2nd edition.* New York: Guilford Press.

Moore, S., Shiell, A., Haines, V., Riley, T., & Collier, C. (2005). Contextualizing and assessing the social capital of seniors in congregate housing residences: Study design and methods. *BMC Public Health, 5*(38). Available from: http://www.biomedcentral.com/1471-2458/5/38

National Advisory Council on Aging (2006). *Seniors in Canada: 2006 Report Card*. Minister of Public Works and Government Services Canada.

Nakhair, M., Smylie, L., & Arnold, R. (2007). Social inequalities, social capital, and health of Canadians. *Review of Radical Political Economics, 39,* 562-585.

Northcott, H. C. & Northcott, J. L. (2010). Integration outcomes for immigrant seniors in Canada: A review of literature 2000-2007. In D. Durst & M. MacLean (Eds.), *Diversity*

and Aging among Immigrant Seniors in Canada: Changing Faces and Greying Temples. Calgary: Detselig Enterprises Ltd.

Onwuegbuzie, A.J. & Teddlie, C. (2003). A framework for analyzing data in mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Sage Handbook of mixed methods in social and behavioral research* (pp. 351-383). Thousand Oaks, CA: Sage.

Oxford Dictionary (2010). http://oxforddictionaries.com/view/entry/m_en_gb0548370#m_en_gb0548370

Park, N. S., Jang, Y., Lee, B. S., Schonfelf, L., & Molinari, V. (2012). Willingness to use mental health services among older residents in assisted living. *Journal of Applied Gerontology, 31*(4), 562 – 579.

Payne, M. (2005). *Modern social work theory, 3rd edition.* Chicago: Lyceum.

Portes, A. (1998). Social capital: its origins and applications in modern sociology. *Annual Review of Sociology*, 24, 1-25.

Public Health Agency of Canada. (2012). *Age-Friendly Communities*. Retrieved from http://www.phac-aspc.gc.ca/seniors-aines/afc-caa-eng.php

Pushkar, D & Arbuckle, T. (2002). Positive Mental Health in Aging: Challenges and Resources. In *Writings in Gerontology: Mental Health and Aging*, 18. Ottawa: National Advisory Council on Aging. http://www.naca-ccnta.ca/writings_gerontology

Putnam R. D. & Goss, K. A. (2002). Introduction. In R. D. Putnam (Ed.), Democracies in Flux: *The evolution of social capital in contemporary society.* Cary, NC: Oxford University Press.

Ren, X., Ameick, B., Zhou, L., & Gandek, B. (1998). Translation and psychometric evaluation of a Chinese version of the SF-36 Health Survey in the United States. *Journal of Clinical Epidemiology, 51,* 1129-1138.

Shields, M. & Martel, L. (2006). Healthy Living among seniors. *Supplement to Health Reports*, 16, 7-20. Statistics Canada, Catalogue 82-003. Retrieved from http://www.statcan.gc.ca/pub/82-003-s/2005000/pdf/9086-eng.pdf

Shiner, D. V., Stadnyk, R., daSilva, Y., & Cruttenden, K. (2010). *Seniors' housing: Challenges, issues, and possible solutions for Atlantic Canada. Final report of the Atlantic Seniors Housing Research Alliance.* Halifax: Mount Saint Vincent University.

Special Senate Committee on Aging (2008) *Second Interim Report: Issues and Options for an Aging Population.* Statistics Canada.

Special Senate Committee on Aging (2007) *First Interim Report: Embracing the Challenge of Aging.* Statistics Canada.

Statistics Canada (2010). *Projections of the diversity of the Canadian population: 2006 - 2031.* (Catalogue No. 91-551-X). Statistics Canada.

Statistics Canada (2003). *Ethnic diversity survey: Portrait of a multicultural society*. (Catalogue No. 98-593-XIE). Ottawa: Minister of Industry.

Statistics Canada (2006). *Immigration and citizenship.* Retrieved from http://www12.statcan.ca/census-recensement/2006/dp-pd/hlt/97-557/T404-eng.cfm?Lang=E&T=404&GH=4&GF=1&G5=0&SC=1&RPP=100&SR=1&S=1&O=D&D1=1#FN1

Statistics Canada (2010). Canadian Community Health Survey (CCHS) – Healthy Aging Questionnaire.

Tabachnick, B. G. & Fidell, L. S. (2007). *Using multivariate statistics, fifth edition.* Boston: Pearson.

Tashakkori, A. & Teddlie, C. (2003). The past and the future of mixed methods research: From data triangulation to mixed model designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research*, 671-701. Thousand Oaks: Sage.

Tjam, E. Y. & Hirdes, J. P. (2001). Social support and medication use: A cross-cultural comparison. In I. Chi, N. L. Chappell, & J. Lubben (Eds.), *Elderly Chinese in Pacific Rim Countries: Social Support and Integration*. Hong Kong: Hong Kong University Press.

United Nations (2002). Madrid International Plan of Action on Ageing. Madrid. Retrieved from http://www.un.org/ageing/documents/building_natl_capacity/guiding.pdf

Van Kemenade, S. (2003). *Social capital as a health determinant: How is it measured?* Catalogue No. H13-5/02-8E. Health Canada.

van Kemenade, S., Roy, J., & Bouchard, L. (2006). Social networks and vulnerable populations: Findings from the GSS. *Social Capital and Health: Maximizing the Benefits. Health policy research bulletin, 12.*Health Canada.

Veninga, J. (2006). Social capital and healthy aging. *Social Capital and Health: Maximizing the Benefits. Health policy research bulletin, 12.*Health Canada.

Vijver, F. V. D. & Leung, K. (1997). *Methods and data analysis for cross-cultural research.* Thousand Oaks: Sage.

Vijver, F. V. D. & Leung, K. (2011). Equivalence and bias: A review of concepts, models, and data analytic procedures. In D. Matsumoto & F. V. D., Vijver (Eds.), *Cross-cultural research methods in psychology*, 17-45. New York: Cambridge University Press.

Ware, J. E., Kosinski, M., Bayliss, M. S., McHorney, C. A., Rogers, W. H., & Raczek, A. (1995). Comparison of methods for the scoring and statistical analysis of SF-36 health profile and summary measures: Summary of results from the medical outcomes study. *Medical Care, 33*(4), AS264-279, *Supplement.*

Ware, J., Kosinski, M., & Keller, S. (1994). *SF-36 physical & mental health summary scales: A user's manual.* Boston: The Health Institute, New England Medical Centre.

Wasserman, S. & Faust, K. (1994). *Social network analysis: Methods and applications.* Cambridge: Cambridge University Press.

Whaley, A. L. (2008). Cultural sensitivity and cultural competence: toward clarify of definitions in cross-cultural counselling and psychotherapy. *Counselling Psychology Quarterly, 21*(3), 215-222.

Wiles, J. L., Allen, R. E. S., Palmer, A. J., Hayman, K. J., Keeling, S., & Kerse, N. (2009). Older people and their social spaces: A study of well-being and attachment to place in Aotearoa New Zealand. *Social Science & Medicine, 68,* 664 – 671.

Wong, Y. R., Cheng, S., Choi, S., Ky, K., LeBa, S., Tsang, K., & Yoo, L. (2003). Deconstructing culture in cultural competence: Dissenting voice from Asian-Canadian practitioners. *Canadian Social Work Review, 20*(2), 149-167.

World Health Organization. (2011). *Definition of an older or elderly person: Proposed working definition of an older person in Africa for the MDS project.* Retrieved from http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.html

World Health Organization. (2002). *Active Ageing: A Policy Framework.* Madrid, Spain: Second United Nations World Assembly on Ageing.

World Health Organization. (1946). *Constitution of the World Health Organization* as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July, 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April, 1948. Retrieved from http://whqlibdoc.who.int/hist/official_records/constitution.pdf

Yu, J., Coons, S. J., Draugalis, J. R., Ren, X. S., & Hays, R. D. (2003). Equivalence of Chinese and US-English versions of the SF-36 health survey. *Quality of Life Research, 12*, 449-457.

Zhan, H. J., Feng, Z., Chen, Z., & Feng, X. (2011). The role of the family in institutional long-term care: cultural management of filial piety in China. *International Journal of Social Welfare, 20*, 121-134.

Zhan, H. J., Feng, X., & Luo, B. (2008). Placing elderly parents in institutions in urban China: A reinterpretation of filial piety. *Research on Aging, 30*(5), 543-571.

Zimmerman, S., Scott, A. C., Park, N. S., Hall, S. A., Wetherby, M. M., Gruber-Baldini, A. L., & Morgan, L. A. (2003). Social engagement and its relationship to service provision in residential care and assisted living. *Social Work Research, 27*(1), 6 – 18.

Online Resources

Active Ageing. (2010). http://www.who.int/hpr/ageing

Citizenship and Immigration Canada. (2010). http://www.cic.gc.ca

The Free Dictionary. (2011). http://www.thefreedictionary.com/aging

Merriam-Webster Dictionary. (2011). http://www.merriam-webster.com/dictionary/aging

National Improving the Quality of Life of Canadian Seniors Project. (2010). http://www.yorku.ca/ychs/

Office for National Statistics: http://www.statistics.gov.uk/hub/index.html

Oxford Dictionary. (2011). http://oxforddictionaries.com/definition/age

Quality of Life Project. (2010). http://www.utoronto.ca/qol

Parliamentary Information and Research Service. (2010). http://www2.parl.gc.ca/Content/LOP/ResearchPublications/prb0745-e.htm

Raosoft, Inc. (2012). http://www.raosoft.com/samplesize.html

Seniors Quality of Life. (2010). http://www.utoronto.ca/seniors/natProject2.htm

Service Canada. (2011). http://www.servicecanada.gc.ca/eng

Social Capital Research: http://www.socialcapitalresearch.com

Wikipedia. (2011). http://en.wikipedia.org/wiki

Appendix I Survey Questionnaire

Strengthening Social Capital through Residential Environment Development to Support Healthy Aging: A Mixed Methods Study of Chinese-Canadian Seniors in Winnipeg

QUESTIONNAIRE

- This questionnaire is part of a project that investigates housing needs of Chinese seniors in Winnipeg.
- Your answers to the questions will help us understand your health and social network that are affected by community residential environments.
- You are free to refuse to answer specific questions by leaving them blank.
- All responses will be kept confidential.

Thank you for choosing to participate in the survey!

UNIVERSITY OF MANITOBA | Faculty of Social Work

521 Tier Building
Winnipeg, Manitoba
Canada R3T 2N2
Telephone (204) 474-7050
Fax (204) 474-7594
Social_Work@UManitoba.CA

LETTER OF INFORMED CONSENT

(FOR QUESTIONNAIRE PRETEST)

Research Project Title: Strengthening Social Capital through Residential Environment Development to Support Healthy Aging: A Mixed Methods Study of Chinese-Canadian Seniors in Winnipeg

Researcher: **Hai Luo**, PhD Candidate
Faculty of Social Work, University of Manitoba
Ph: 204-xxx-xxxx Email: xxxxxx@cc.umanitoba.ca

Advisory Committee: **Dr. Don Fuchs**
Professor, Faculty of Social Work, University of Manitoba
Ph: 204-xxx-xxxx Email: xxxxxxx@ad.umanitoba.ca

Dr. Len Spearman
Senior Scholar, Faculty of Social Work, University of Manitoba
Email: xxxxxx@cc.umanitoba.ca

Dr. Verena Menec
Director, Centre on Aging; Professor, Community Health Science
Ph: 204-xxx-xxxx Email: xxxxxxx@med.umanitoba.ca

Dear Research Participant:

This consent form, a copy of which will be left with you for your records and reference, is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more information about

something mentioned here, or not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

What is the project about?

This project aims to find out Chinese seniors' needs and wants from their living environments. I would like to know the general health, social support, and living environment that seniors like you have. It is important for people who work with seniors to understand how social support and housing can affect health, and how practitioners can help. This research has been approved by the Psychology/Sociology Research Ethics Board at the University of Manitoba.

What are you requested to do?

You are requested to provide an answer to each of the questions in this questionnaire. An interviewer will be reading you these questions aloud. You are free to refuse to answer any specific questions by simply leaving them blank. It may take 30 – 40 minutes to complete the questionnaire.

How is your privacy protected?

We are not asking for or recording your name for filling out this questionnaire and the following discussion. Your answers will be analyzed with those of other respondents in a collective manner. The way the survey is designed will not allow anyone to be able to identify your particular answers to the questions. All responses will be kept strictly confidential and can be accessed only by the researcher.

What are your rights as a survey participant?

Agreeing to fill out this questionnaire does not waive your legal rights nor release the researcher or involved institutions from their legal and professional responsibilities. You are free to stop filling out the questionnaire at any time, or refuse to answer any specific question by simply leaving it blank, without any consequence. Please feel free to ask the researcher for clarification or new information throughout your participation. If you have any questions or concerns, please contact the researcher or the Coordinator of Human Ethics of the U of M below:

Hai Luo, PhD Candidate — Email: xxxxxx@cc.umanitoba.ca
Faculty of Social Work, University of Manitoba — Ph: 204-xxx-xxxx

Margaret Bowman, Coordinator of Human Ethics — xxxxxxxx@ad.umanitoba.ca
Office of Research Services, University of Manitoba — Ph: 204-xxx-xxxx

What are the benefits for you?

The information you provide us will help me better understand the needs of Chinese seniors in Winnipeg, which will, in turn, inform policy-makers and service providers to design and develop programs and services to improve the living environment for Chinese seniors.

What may be the risks for you?

We do not anticipate any risk for you to take part in the research. However, if you have any upset feelings after filling out the questionnaire due to recall of emotional moments or experiences, you may contact any of the following counselling agencies for help.

A & O Elder Abuse……...…….204-956-6440, 1-888-333-3121
Seniors' Abuse Line……...204-945-1884, 1-888-896-7183
Manitoba Interfaith Immigration Council……..204-977-1000
Immigrant Women's Counselling Services……204-940-2127

You can choose or reject to participate in the project.

You do not have to take part in this research and fill out this questionnaire. There will absolutely be no repercussions for you. However, your contributions to the research are highly appreciated.

How can you access the research findings?

The final report will be submitted to the researcher's Advisory Committee at the University of Manitoba and to the Winnipeg Chinese Cultural and Community Centre (WCCCC). A presentation of major findings will be given to the WCCCC Executive Committee and interested individuals. Copies of the summary of the research findings can be obtained upon request to WCCCC at 204-xxx-xxxx/204- xxx-xxxx or the researcher at 204- xxx-xxxx or xxxxxx@cc.umanitoba.ca.

Please check one of the options below.

[ ] ***I want to fill out the questionnaire and participate in the following discussion to provide my comments on the questionnaire. 我要填写这份问卷, 并提供意见和反馈。***

(By checking this option, you have indicated that you agree to participate in the research and that you understand the nature of the project, your rights in the project, and potential benefits and risks of your participation.)
（选择此项表示您：同意参加问卷调查，明白问卷调查的目的，了解您的权益及参加问卷调查的利害。）

[ ] ***I do not want to fill out the questionnaire and participate in the following discussion. 我不要填写这份问卷，也不提供意见和反馈。***

Participant's Signature _____ Date _____
受访人签字 日期

Interviewer's Signature _____ Date _____
研究员签字 日期

A. Demographics I

First of all, I would like to ask you some questions related to your personal background.

A1. Your gender [ ] 1. Male [ ] 2. Female

A2. What is your year of birth? _____

A3. What is your current marital status?
- [ ] 1. Married or living common-law
- [ ] 2. Separated
- [ ] 3. Divorced
- [ ] 4. Single (never married)
- [ ] 5. Widowed

A4. Are you a ……?
- [ ] 1. Canadian citizen by birth
- [ ] 2. Naturalized Canadian citizen
- [ ] 3. Landed immigrant
- [ ] 4. Visitor
- [ ] 5. Others (Specify)_____

A5. How long have you been living in Canada? _____Years

A6. Which country/city did you live before migrating to Canada?
- [ ] 1. Mainland China
- [ ] 2. Hong Kong
- [ ] 3. Taiwan
- [ ] 4. Vietnam
- [ ] 5. Born in Canada
- [ ] 6. Other (specify) _____
- [ ] 99. No answer

A7. Do you speak Chinese (any Chinese dialects)?
- [ ] 1. Yes, I speak well
- [ ] 2. Yes, I speak a little
- [ ] 3. No, not at all

A8. What language(s) or Chinese dialect(s) do you speak at home? (Check all answers that apply)

[ ] a. Cantonese
[ ] b. Toishan
[ ] c. Mandarin
[ ] d. Chiu Chow
[ ] e. Fujian
[ ] f. Taiwanese
[ ] g. Shanghai
[ ] h. Vietnamese
[ ] i. English
[ ] j. Other (specify) _____

A9. Do you comprehend English?

[ ] 1. Yes, I understand well.
[ ] 2. Yes, I understand a little.
[ ] 3. No, not at all.

A10. Do you speak English?

[ ] 1. Yes, I speak well.
[ ] 2. Yes, I speak a little.
[ ] 3. No, not at all.

A11. Who are you living with now? (Check all items that apply)

	Yes	Speak your Chinese dialect? (Check if yes)
A/Spouse/Partner	[ ]	[ ]
B/Sibling	[ ]	[ ]
C/Son	[ ]	[ ]
D/Daughter	[ ]	[ ]
E/Son-in-law	[ ]	[ ]
F/Daughter-in-law	[ ]	[ ]
G/Grandchild	[ ]	[ ]
H/Other relative	[ ]	[ ]
I/Friend	[ ]	[ ]
J/Alone	[ ]	Not applicable
K/Other (Specify) _____	[ ]	[ ]

A12. If you could have it the way you want, which of the following living arrangement(s) would you like?

[ ] 1. Live with your children in the same household (including in-law suites)
[ ] 2. Live nearby your children but in separate household
[ ] 3. Live as far away as possible from your children
[ ] 4. Other (specify) _____

B. General Health

B1. In general, would you say your health is: (Check one answer only)

[ ] 1. Excellent
[ ] 2. Very good
[ ] 3. Good
[ ] 4. Fair
[ ] 5. Poor

B2. Compared to one year ago, how would you rate your health in general now? (Check one answer only)

[ ] 1. Much better now than one year ago
[ ] 2. Somewhat better now than one year ago
[ ] 3. About the same as one year ago
[ ] 4. Somewhat worse now than one year ago
[ ] 5. Much worse now than one year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Check one item on each line only)

	1. Yes, limited a lot	2.Yes, limited a little	3.No, not limited at all
B3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	[ ]	[ ]	[ ]
B4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	[ ]	[ ]	[ ]
B5. Lifting or carrying groceries	[ ]	[ ]	[ ]
B6. Climbing several flights of stairs	[ ]	[ ]	[ ]
B7. Climbing one flight of stairs	[ ]	[ ]	[ ]
B8. Bending, kneeling, or stooping	[ ]	[ ]	[ ]
B9. Walking more than a mile	[ ]	[ ]	[ ]
B10. Walking several blocks	[ ]	[ ]	[ ]
B11. Walking one block	[ ]	[ ]	[ ]
B12. Bathing or dressing yourself	[ ]	[ ]	[ ]

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (check one item on each line only)

	1.Yes	2.No
B13. Cut down on the amount of time you spent on work or other activities	[ ]	[ ]
B14. Accomplished less than you would like	[ ]	[ ]
B15. Were limited in the kind of work or other activities	[ ]	[ ]
B16. Had difficulty performing the work or other activities (for example, it took extra time)	[ ]	[ ]

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	1.Yes	2.No

B17. Cut down on the amount of time you spent on work or other activities	[ ]	[ ]
B18. Accomplished less than you would like	[ ]	[ ]
B19. Didn't do work or other activities as carefully as usual	[ ]	[ ]

B20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

[ ] 1. Not at all
[ ] 2. Slightly
[ ] 3. Moderately
[ ] 4. Quite a bit
[ ] 5. Extremely

B21. How much bodily pain have you had during the past 4 weeks?

[ ] 1. None
[ ] 2. Very mild
[ ] 3. Mild
[ ] 4. Moderate
[ ] 5. Severe
[ ] 6. Very severe

B22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework?)

[ ] 1. Not at all
[ ] 2. A little bit
[ ] 3. Moderately
[ ] 4. Quite a bit
[ ] 5. Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks……?

	1.All of the time	2.Most of the time	3.A good bit of the time	4.Some of the time	5.A little of the time	6.None of the time
B23. Did you feel full of pep?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B24. Have you been a very nervous person?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B25. Have you felt so down in the dumps nothing could cheer you up?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B26. Have you felt calm and peaceful?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B27. Did you have a lot of energy?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B28. Have you felt downhearted and blue?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B29. Did you feel worn out?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

B30. Have you been a happy person?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B31. Did you feel tired?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

B32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc .)?

[ ] 1. All of the time
[ ] 2. Most of the time
[ ] 3. Some of the time
[ ] 4. A little of the time
[ ] 5. None of the time

How true or false is each of the following statements for you?

	1.Definitely true	2.Mostly true	3.Don't know	4.Mostly false	5.Definitely false
B33. I seem to get sick a little easier than other people.	[ ]	[ ]	[ ]	[ ]	[ ]
B34. I am as healthy as anybody I know.	[ ]	[ ]	[ ]	[ ]	[ ]
B35. I expect my health to get Worse.	[ ]	[ ]	[ ]	[ ]	[ ]
B36. My health is excellent.	[ ]	[ ]	[ ]	[ ]	[ ]

C. Social Capital

C1. Views of community

C1.1 How long have you lived in this area?

[ ] 1. Less than 12 months
[ ] 2. 12 months but less than 2 years
[ ] 3. 2 years but less than 3 years
[ ] 4. 3 years but less than 5 years
[ ] 5. 5 years but less than 10 years
[ ] 6. 10 years but less than 20 years
[ ] 7. 20 years or longer
[ ] 98. Don't know

C1.2 How satisfied are you with this area as a place to live?

[ ] 1. Very satisfied
[ ] 2. Fairly satisfied
[ ] 3. Neither satisfied nor dissatisfied
[ ] 4. Slightly dissatisfied
[ ] 5. Very dissatisfied
[ ] 98. Don't know

Now I'd like to ask you a few questions about your ***immediate neighbourhood***, by which I mean your street, block, or apartment building.

C1.3 I am going to read out a list of problems which some people face in their neighbourhood. For each one, please can you tell me how much of a problem it is?

	1.Very big problem	2.Fairly big problem	3.Not a very big problem	4.Not a problem at all	5.It happens but it's not a problem	6.Don't know
A. How much of a problem are people being drunk or rowdy in public places?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B. How much of a problem is rubbish or litter lying around?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
C. How much of a problem are vandalism, graffiti and other deliberate damage to property or vehicles?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
D. How much of a problem are people using or dealing drugs?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E. How much of a problem is people being attacked or harassed because of their skin colour, ethnic origin or religion?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
F. How much of a problem are teenagers hanging around on the street?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
G. How much of a problem are troublesome neighbours?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

C2. Reciprocity and Trust

C2.1 Would you say that

[ ] 1. Most of the people in your neighbourhood can be trusted
[ ] 2. Some can be trusted.
[ ] 3. A few can be trusted.
[ ] 4. No one can be trusted.
[ ] 5. Just moved here.
[ ] 98. Don't know

C2.2 Suppose you lost your (purse/wallet) containing your address details, and it was found in the street by someone living in this neighbourhood. How likely is it that it would be returned to you with nothing missing?

[ ] 1. Very likely

[ ] 2. Quite likely
[ ] 3. Not very likely
[ ] 4. Not at all likely
[ ] 98. Don't know

C2.3. In general, what kind of neighbourhood would you say you live in – would you say it is a neighbourhood in which people do things together and try to help each other, or one in which people mostly go their own way?

[ ] 1. Help each other
[ ] 2. Go own way
[ ] 3. Mixture
[ ] 98. Don't know

C2.4 To what extent do you agree or disagree that this neighbourhood is a place where people from different backgrounds get on well together?

[ ] 1. Definitely agree
[ ] 2. Tend to agree
[ ] 3. Tend to disagree
[ ] 4. Definitely disagree
[ ] 5. Don't know
[ ] 6. Too few people in neighbourhood
[ ] 7. All same backgrounds

C2.5 Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?

[ ] 1. Most people can be trusted
[ ] 2. Can't be too careful in dealing with people
[ ] 3. It depends on people/circumstances
[ ] 98. Don't know

C2.6 For the following, please can you tell me how much trust them.

	1.A lot	2.A fair amount	3.Not very much	4.Not at all	5.No experience	6.Don't know
A. Police	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B. The courts	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
C. Government of Canada	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
C. Government of Manitoba	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
D. Winnipeg City Council	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

C3. Civil participation

To what extent do you agree or disagree with the following statements regarding **participation in local issues?**

C3.1 I can influence decisions affecting my local area.

[ ] 1. Strongly agree

[ ] 2. Agree
[ ] 3. Neither agree nor disagree
[ ] 4. Disagree
[ ] 5. Strongly disagree
[ ] 98. Don't know

C3.2 By working together, people in my area can influence decisions that affect the local area.
[ ] 1. Strongly agree
[ ] 2. Agree
[ ] 3. Neither agree nor disagree
[ ] 4. Disagree
[ ] 5. Strongly disagree
[ ] 98. Don't know

C3.3 In the last 12 months have you taken any of the following actions in an attempt to solve a problem affecting people in your local area?
[ ] 1. Contacted a local radio station, television station or a newspaper
[ ] 2. Contacted the appropriate organization to deal with the problem
[ ] 3. Contacted a local councillor or MP
[ ] 4. Attended a public meeting or neighbourhood forum to discuss local issues
[ ] 5. Attended a tenants' or local residents' group
[ ] 6. Attended a protest meeting or joined an action group
[ ] 7. Helped organize a petition on a local issue
[ ] 8. No local problems
[ ] 9. None of the above
[ ] 98. Don't know

C3.4 In the last 12 months have your taken any of the following actions to show your concern over a national issue?
[ ] 1. Contacted a radio station, television station or a newspaper
[ ] 2. Contacted the appropriate organization to deal with the problem
[ ] 3. Contacted an MP
[ ] 4. Attended a public meeting
[ ] 5. Attended a protest meeting or joined an action group
[ ] 6. Helped organize a petition
[ ] 7. None of these
[ ] 98. Don't know

C3.5 Can I check, did you vote…
[ ] 1. … in the last national election?
[ ] 2. … in the last local council election?
[ ] 3. Did not vote in either election
[ ] 4. Not eligible to vote in either
[ ] 98. Don't know

C4. Social networks and social support

C4.1 The next few questions are about how often you personally contact your relatives, friends and neighbours. Not counting the people you live with, how often do you do any of the following?

	1.On most days	2.Once or twice a week	3.Once or twice a month	4.Less often than once a month	5.Ne-ver	6.Don't know
A. Speak to relative on the phone	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B. Write a letter or note to relatives	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
C. Text or email relatives, or use chatrooms on the internet to talk to relatives	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
D. Speak to friends on the phone	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E. Write a letter or note to friends	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
F. Text or email friends or use chatrooms on the internet to talk to friends	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
G. Speak to neighbours	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
H. Meet up with relatives who are not living with you	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
I. Meet up with friends?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

I am going to describe two situations where people might need help. For each one, could you tell me if there is anyone you could ask for help? (If more than one person in household, add: Please include people living with you and people outside the household.)

C4.2 You are ill in bed and need help at home. Is there anyone you could ask for help?

[ ] 1. Yes [ ] 2. No

C4.3 If so, who provides the help?

[ ] 1. Husband/wife/partner
[ ] 2. Other household member
[ ] 3. Relative (outside household)
[ ] 4. Friend
[ ] 5. Neighbour
[ ] 6. Work colleague
[ ] 7. Voluntary or other organization
[ ] 8. Other
[ ] 9. Would prefer not to ask for help
[ ] 10. Don't know

C4.4 You are in financial difficulty and need to borrow some money to see you through the next few days. Is there anyone you could ask for help?

[ ] 1. Yes [ ] 2. No

C4.5 If so, who provides the help?

[ ] 1. Husband/wife/partner
[ ] 2. Other household member
[ ] 3. Relative (outside household)
[ ] 4. Friend
[ ] 5. Neighbour
[ ] 6. Work colleague
[ ] 7. Volunteer or other organization
[ ] 8. Other
[ ] 9. Would prefer not to ask for help
[ ] 98. Don't know

C4.6 If you have a serious personal crisis, how many people, if any, do you feel you could turn to for comfort and support?

[ ] _____ (0-15)
[ ] 15 (if more than 15)
[ ] Don't know

C4.7 Some people have extra responsibilities because they look after someone who has long-term physical or mental ill health or disability, or problems due to old age.
May I check, is there anyone living with you who is sick, disabled or elderly whom you look after or give special help to, other than in a professional capacity. (For example, a sick or disabled relative/husband/wife/child/friend/parent, etc.)

[ ] 1. Yes
[ ] 2. No

C4.8 Now I'd like to talk about any unpaid help you may have given people who do not live with you. In the past month, have you given any unpaid help in any of the ways shown below? Please do not count any help you gave through a group, club or organization.

[ ] 1. Domestic work, home maintenance or gardening
[ ] 2. Provision of transportation or running errands
[ ] 3. Help with child care or babysitting
[ ] 4. Teaching, coaching, or giving practical advice
[ ] 5. Giving emotional support
[ ] 6. Other
[ ] 7. None of the above
[ ] 98. Don't know

C4.9 Now I'd like to talk about any unpaid help you may have received. In the past month have you received any unpaid help in any of the ways shown below? Please do not count help from people who live with you or from an organization or group.

[ ] 1. Domestic work, home maintenance or gardening
[ ] 2. Provision of transportation or running errands
[ ] 3. Help with child care or babysitting
[ ] 4. Teaching, coaching or giving practical advice
[ ] 5. Giving emotional support

[ ] 6. Other
[ ] 7. None of the above
[ ] 98. Don't know

C5. Social participation

The next questions are about involvement in groups, clubs, and organizations. These could be formally organized groups or just groups of people who get together to do an activity or talk about things. Please exclude just paying a subscription, giving money, and anything that was a requirement of your job.

I am going to ask about three different types of groups:

C5.1 First, in the last 12 months, have you been involved with any (neighbourhood) groups of people who get together to do an activity or to talk about things? These could include evening classes, support groups, slimming clubs, keep-fit classes, pub teams and so on.

Which of the following best describe the groups you have taken part in?

[ ] 1. Hobbies/social clubs
[ ] 2. Sports/exercise groups, including taking part, coaching or going to watch
[ ] 3. Local community or neighbourhood groups
[ ] 4. Groups for children or young people
[ ] 5. Adult education groups
[ ] 6. Groups for older people
[ ] 7. Environmental groups
[ ] 8. Health, disability and welfare groups
[ ] 9. Political groups
[ ] 10. Trade union groups
[ ] 11. Religious groups, including going to a place of worship or belonging to a religious based group
[ ] 12. Cultural groups
[ ] 13. Other group _____
[ ] 14. None of the above
[ ] 98. Don't know

C5.2 In the last 12 months, have you taken part in any (other) group activities as part of a **local or community** group, club, or organization? These could include residents' associations, sports groups, parent-teacher associations, school or religious groups and so on.

Which of the following best describe the groups you have taken part in?

[ ] 1. Hobbies/social clubs
[ ] 2. Sports/exercise groups, including taking part, coaching, or going to watch
[ ] 3. Local community or neighbourhood groups
[ ] 4. Groups for children or young people
[ ] 5. Adult education groups
[ ] 6. Groups for older people
[ ] 7. Environmental groups
[ ] 8. Health, disability, and welfare groups

[ ] 9. Political groups
[ ] 10. Trade union groups
[ ] 11. Religious groups, including going to a place of worship or belonging to a religious based group
[ ] 12. Cultural groups
[ ] 13. Other group _____
[ ] 14. None of the above
[ ] 98. Don't know

C5.3 In the last 12 months, have you taken part in any (other) group activities as part of a national group, club, or organization? These could include pressure groups, charities, political groups, environmental groups and so on.

Which of the following best describe the groups you have taken part in?

[ ] 1. Hobbies/social clubs
[ ] 2. Sports/exercise groups, including taking part, coaching or going to watch
[ ] 3. Local community or neighbourhood groups
[ ] 4. Groups for children or young people
[ ] 5. Adult education groups
[ ] 6. Groups for older people
[ ] 7. Environmental groups
[ ] 8. Health, disability, and welfare groups
[ ] 9. Political groups
[ ] 10. Trade union groups
[ ] 11. Religious groups, including going to a place of worship or belonging to a religious based group
[ ] 12. Cultural groups
[ ] 13. Other group _____
[ ] 14. None of the above
[ ] 98. Don't know

C5.4 During the last 12 months have you given any unpaid help to any groups, clubs, or organizations in any of the ways shown below?

[ ] 1. Raising or handling money/taking part in sponsored events
[ ] 2. Leading the group/member of a committee
[ ] 3. Organizing or helping to run an activity or event
[ ] 4. Visiting people
[ ] 5. Befriending or mentoring people
[ ] 6. Giving advice/information/counselling
[ ] 7. Secretarial, administrative or clerical work
[ ] 8. Providing transportation/driving
[ ] 9. Representing
[ ] 10. Campaigning
[ ] 11. Other practical help (e.g., helping out at school, religious group, shopping)
[ ] 12. Any other help _____
[ ] 13. None of the above
[ ] 98. Don't know

C5.5 Think about the unpaid help you have mentioned. Would you say you give this kind of help …

[ ] 1. At least once a week
[ ] 2. At least once a month
[ ] 3. At least once every three months
[ ] 4. Or less often?
[ ] 5. Other

C5.6 About how many times in the last 12 months have you given unpaid help through a group, club or organization?

_____

D. Use of Health Support Services

In the last year, have you used the following community health support services?

	1.Yes	0.No
D1. Services from senior centre	[ ]	[ ]
D2. Adult day program	[ ]	[ ]
D3. Fitness program	[ ]	[ ]
D4. Community nurse/health care worker	[ ]	[ ]
D5. Counselling	[ ]	[ ]
D6. Home support services (i.e. household chores, meal preparation)	[ ]	[ ]
D7. Personal care services (i.e. bath/shampoo, supervised medication)	[ ]	[ ]
D8. Meals-on-wheels	[ ]	[ ]
D9. Senior housing	[ ]	[ ]
D10. Other, please specify: _____	[ ]	[ ]

E. Cultural Values and Identity

E1. Beliefs in Chinese Culture and Values

How much do you agree or disagree with the following ideas?	1.Strongly disagree	2.Disagree	3.Neither disagree or agree	4.Agree	5.Strongly agree	99. No Answer
E1. 1It should be better for my offspring to be married with Chinese people.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

E1.2 Chinese children should maintain their Chinese language(s) (either speak, write or read).	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.3 It should be the responsibility of adult children to take care of aging parents.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.4 Even for adult children, parents' decisions should still be followed.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.5. Taking care of children's daily routines should be women's major responsibility at home.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.6. Men are better than women to be the head of the family.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.7. A Chinese person should show more appreciation to Chinese food than to Western food.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.8. I am a very "Chinese" person.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.9. As a Chinese person, one should vote for Chinese political candidates.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.10. As a Chinese person, one should care about issues happening in the Chinese community.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E1.11. As a Chinese person, one should donate to Chinese charities.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

E1.12. How important is "having face" to you?

[ ] 1. Totally not important
[ ] 2. Not important
[ ] 3. Important
[ ] 4. Very important
[ ] 98. Don't know
[ ] 99. No answer (reason): _____

E1.13. Name three things that would make people feel having most face.

A _____ B _____
C _____

E1.14. Name three things that would make people feel losing face?

A _____ B _____
C _____

E2. Measure of Cultural Identity

How often do you do the following?	1.Never	2.Some-times	3.Frequ-ently	98.No answer
E2.1 Eat any food that is associated with Chinese holidays or special events				
E2.2 Listen to Chinese radio broadcasts or watch Chinese television programs				

E2.3 Read Chinese newspapers, magazines, or other periodicals				
E2.4 Attend Chinese social functions organized by the Chinese community				
E2.5 Go to visit your place of origin				
E2.6 Go to visit Asia				

E2. 7 How close are the ties which you maintain with the Chinese community in Winnipeg?

[ ] 1. Very close
[ ] 2. Moderately close
[ ] 3. Not very close
[ ] 4. Not close at all

E2.8. Do you usually think of yourself more (as a Chinese, a Chinese-Canadian or a Canadian)?

[ ] 1. Chinese
[ ] 2. Chinese-Canadian
[ ] 3. Canadian
[ ] 4. Some other groups (specify) _____
[ ] 98. Don't know
[ ] 99. No answer

E2.9. Is Chinese culture important to you?

[ ] 1. Very unimportant
[ ] 2. Somewhat unimportant
[ ] 3. Somewhat important
[ ] 4. Very important
[ ] 98. Don't know
[ ] 99. No answer

E2.10 I would like you to think about your three closest friends (in the city you live) who are not relatives. Of these three friends how many, if any, are Chinese?

[ ] 1. None
[ ] 2. One
[ ] 3. Two
[ ] 4. Three
[ ] 98. Don't know
[ ] 99. No answer

E2.10. What is your religion? (Check all that apply)

[ ] 1. None
[ ] 2. Catholic
[ ] 3. Protestant
[ ] 4. Taoist
[ ] 5. Buddhist
[ ] 6. Ancestor worship
[ ] 7. Muslim
[ ] 8. Other (specify) _____
[ ] 99. No answer

E2.11. How important is your religion to you?

[ ]1. Very unimportant
[ ] 2. Somewhat unimportant
[ ] 3. Moderate
[ ] 4. Somewhat important
[ ] 5. Very important
[ ] 97. Not applicable
[ ] 99. No answer

F. Demographics II

F1. What is your highest education level?

[ ] 1. No formal education
[ ] 2. Elementary school
[ ] 3. High school or technical/professional college
[ ] 4. Post-secondary school

F2. What is/was your major occupation in life? _____

F3. In general, how well does your income and investments currently satisfy your need?

[ ] 1. Very well
[ ] 2. Adequately
[ ] 3. Not very well
[ ] 4. Very inadequate
[ ] 98. Don't know
[ ] 99. No answer

F4. If 65 or older, are you receiving Old Age Security (O.A.S.)?

[ ] 1. Yes [ ] 2. No [ ] 98. Don't know [ ] 99. No answer

F5. Are you receiving Canada Pension Plan (C.P.P.)?

[ ] 1. Yes [ ] 2. No [ ] 98. Don't know [ ] 99. No answer

F6. Which of the following sources provide you with some income? (Check all that apply)

[ ] 1. Son/daughter in household
[ ] 2. Son/daughter not in household
[ ] 3. Daughter-in-law/son-in-law in household
[ ] 4. Daughter-in-law/son-in-law not in household
[ ] 5. Earnings from work
[ ] 6. Pension/Retirement
[ ] 7. Personal savings
[ ] 8. Investment (i.e., from renting, savings, or yield from stock or properties, from stock or estate)
[ ] 9. Social security/welfare/public assistance
[ ] 10. Old Age Security/Government Supplement
[ ] 11. Disability Allowance

[ ] 12. Other, please specify _____
[ ] 99. No answer

F7. Think of all your resources of income, which is your **MAJOR** source? (Choose ONLY ONE answer)

[ ] 1. Son/daughter in household
[ ] 2. Son/daughter not in household
[ ] 3. Daughter-in-law/son-in-law in household
[ ] 4. Daughter-in-law/son-in-law not in household
[ ] 5. Earnings from work
[ ] 6. Pension/Retirement
[ ] 7. Personal savings
[ ] 8. Investment (i.e., from renting, savings, or yield from stock or properties, from stock or estate exchange)
[ ] 9. Social security/welfare/public assistance
[ ] 10. Old Age Security/Government Supplement
[ ] 11. Disability Allowance
[ ] 12. Other, please specify _____
[ ] 99. No answer

F8. What is your personal average monthly income, including old age security payment?

[ ] 1. Less than $500
[ ] 2. $500 - $999
[ ] 3. $1000 - $1499
[ ] 4. $1500 - $1999
[ ] 5. $2000 - $2499
[ ] 6. $2500- $2999
[ ] 7. $3000 - $3499
[ ] 8. $3500 and over
[ ] 99. No answer

****

You have completed the questionnaire.

Thank you for your participation!