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MULTICULTURAL HEALTH DISCOURSES AND ELDERLY NEWCOMERS AGING IN WINNIPEG

BY

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Finally I dedicate this research to the memory of my loved father.

ABSTRACT

Multicultural Health Discourses and Elderly Newcomers Aging in Winnipeg

This exploratory and descriptive study is concerned with the discursive construction of ethnicity and aging in Canada and Manitoba. Based on Foucault's methodological principles and qualitative methods it focuses on three competing discourses labelled "official" , professional and "lay" respectively. A discourse analysis was implemented to study the official multicultural health discourse on aging . The textual analysis included policy documents, reports and related literature on multicultural health and aging. . The professional discourse was studied through semi-structured interviews to a non probabilistic sample of health and social service providers practicing in Winnipeg. The elderly newcomers discourse was re-constructed through focused life history narratives. Non participant observations were also implemented as part of the field work conducted in two seniors organizations where elderly newcomers congregated.

The implementation of a genealogical method led to the identification of the conditions for the emergence of the official multicultural discourse on aging, its main themes and constructs as well as its links with other discourses. Its institutional development following professional management and multicultural and health policies' guidelines is described. Foucault's notions of bio-power and power/

knowledge were related to the official multicultural health discourse action orientation. Themes were identified and described as being the constitutive elements of a process of differentiation and subsequent normalization of ethnic aging. Particularities of that process in Manitoba were highlighted. This process included proposals for "aging well" and the "multiculturalization" of the mainstream health and social services. Barriers to access, cross cultural health care, organizational change and professional roles were among the core constructs and themes used by the official discourse to legitimize its existence. The professional discourse specified elderly newcomers' differences in terms of dependency, cultural and language barriers. It shared with the official texts the definition of immigration and resettlement as risk factors for the development of physical and mental health problems. Difficulties for the delivery of culturally sensitive programs were related to newcomer's characteristics, lack of political will and on-going funding. Documents and professionals' perspectives constituted the ethnic elderly newcomers' world as problematic and deserving professional intervention.

While the official discourse seems to ensure the professional management of the normalization of ethnic aging, the benefits for the integration of the elderly newcomers into a barrier free health care system remain uncertain. Internal dissent within the official discourse revealed potential sources of change. Some voices inside that discourse drew attention on the social determinants of health and the political nature of the construct of ethnicity.

Elderly newcomers constituted their experiences of immigration and resettlement in terms of intergenerational reciprocity and visions and experiences of Canada as a caring and peaceful country. Their positive aging was constructed around family relationships and their participation in religious and social activities within their ethnic communities and peer groups. They also defined their health status in positive terms and opted for seeking services which were provided in their mother tongues. Their participation in the multicultural programs helped them in the adaptation to the new environment. They constructed their needs in terms of income, language proficiency, skills upgrading and job finding. Worries about the future included fear of physical and financial dependency. After comparing these discourses, research limitations and insights are discussed. Finally, recommendations and topics for future research suggested by the study findings are proposed.

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CHAPTER 1

1. Introduction

Four years after arriving in Canada and having experienced the transformation from newcomer to Canadian citizen, I felt the need to explore some issues related to the notion of ethnicity. After reviewing the available literature for academic purposes and having the personal experience of working in Winnipeg with elderly people who were born outside Canada, I increasingly began to realize what Disman (Ontario Advisory Council on Senior Citizens (OACSC), 1988-89, A: 4) has suggested:

> The notion of ethnicity is really a North American invention. The North American notion of ethnicity labels people who are blissfully unaware that they would become "ethnics" by virtue of immigrating to this continent.

The need to understand why now I might be labelled as an "ethnic person", and why elderly immigrants are named "multicultural seniors" (Ethos' Report, 1992) or "ethnocultural seniors" (OACSC, 1988-89) led me to the formulation of these questions:

1) how has the label "ethnic" been socially constructed and applied in the field of health care in general and of gerontological health care in particular?

2) do the individual perspectives of elderly immigrants and refugees as they are aging in a new environment coincide with that social construction ?

3) how do these multiple discourses and perceptions interact in a multicultural seniors' organization?

The literature on "ethnicity and aging" has been growing in Canada since the 1980's. Many issues apparently have been addressed, but a critical view of their theoretical constructions, their assumptions and their social and health policy implications still has to be developed.

While the professional and community leaders' perspectives on ethnic elderly needs have received considerable attention, (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988a; OACSC, 1988-89; Age and Opportunity Report, 1992; Nyman, 1992; Auger, 1993) the ethnic elderly's own definition of their needs, concerns and worries as they are aging have remained an underdeveloped research area in Manitoba.

The positive effects of membership in seniors' centres for the ethnic elderly have been demonstrated for specific ethnic groups (Cuellar, 1978; Holzberg, 1984; Myerhoff, 1978). However neither the peculiarities of a multicultural seniors' organization as a space where elderly newcomers with different ethnic backgrounds interact, nor the impact of multicultural discursive practices on their members' lives have yet been extensively studied.

2. Objectives

In order to contribute to the improvement of our knowledge in the areas mentioned above, my research objectives are:

(1) to analyze the multicultural health discourses on aging in order to describe the social construction of ethnicity and aging in Canada and Manitoba.

(2) to describe the needs, worries and concerns of the elderly immigrants as they age in Winnipeg from their own frame of reference in order to contrast their perceptions with the social construction of the "ethnic elder" world,

3) to explore the impact on the newcomers' perceptions of their needs of a program specifically devoted to "multicultural" seniors.

In the following section of this chapter a literature review on ethnicity and aging is presented with particular emphasis on Canadian studies. Chapter two is devoted to the description of the methodology implemented and the limits set to study the discourses on ethnicity and aging. In chapters three, four and five are described the main themes and constructs respectively identified in the official, professional and lay discourses. In chapter six, these discourses are compared, conclusions are presented, methodological limitations are acknowledged and some suggestions in terms of policy and future research are made.

3. Literature Review

This section intends to review the literature on ethnicity and aging to identify main trends and research findings. An overview of Canadian studies produced since the 198O's is presented. Their limitations have opened a space for the analysis of a discourse to which they have contributed.

3.1 Introduction

The field known as "Ethnicity and Aging" in Canada is the result of a multidisciplinary endeavour with studies mainly coming from the fields of Anthropology, Gerontology, Psychiatry, Sociology, Social Work and Nursing. Different paradigms and methodologies therefore have been adopted.

Research on the ethnic dimensions of aging acquired significant impetus in Canada since the 1980's. This may be interpreted as a response to the challenges posed by the aging of the population in general and new patterns of immigration in particular.

Canadian studies have been reflecting the impact of those changes following two major directions in terms of levels of analysis (Holzberg, 1982). The first, at a micro or small scale community level, has focused on old-age homes (MacLean and Bonar, 1983), seniors' centers (Holzberg, 1984) and community social service centers (MacLean et al., 1987).

In Manitoba, macro-level studies of the aged population have been developed since the 1970's (Chipperfield and Havens, 1992; Havens and Chappell, 1983; Manitoba Department of Health and Social Development, 1975; Mossey et al., 1981). This activity, however, has been constrained, not only by the use of concepts which were borrowed from conceptual frameworks constructed to study the dominant aging patterns but also by their transference from foreign experiences to the Canadian contexts. Examples of such practices in Canada are studies based on concepts such as life-satisfaction (Ujimoto et al., 1993), acculturation (Berry, 1987), well being (Wong and Recker, 1984; Blandford and Chappell, 1990; Singh and Kinsey, 1993) and the renowned "multiple jeopardy" hypothesis (Gerber, 1983; Havens and Chappell, 1983; Wong and Reker, 1984).

In the following paragraphs, the main topics addressed by the literature are discussed.

3.2 Ethnicity and the Aging Process

Two apparently contradictory views of the effects of ethnic lifestyles on the aging process have been identified in the literature (Sokolovsky, 1985).

3.2.1 Double and multiple jeopardy

One of these perspectives assumes that ethnic group membership in the context of structural inequality intensifies the problems of growing old. The "double jeopardy hypothesis " (Dowd and Bengston, 1978; Gibson, 1989) and the construct of

"minority" (Manuel, 1990) are some examples of elaborations along this line of thought. The direct policy implications are recommendations for the provision of social programs to help the ethnic elderly.

The "multiple jeopardy hypothesis" has been tested by several Canadian studies (Gerber, 1983; Havens and Chappell, 1983; Wong and Recker, 1983). It states that members of ethnic minority groups are negatively affected in their adjustment to aging by the combined and long term effect of their minority status, gender and old age.

The study by Havens and Chappell (1983) based on data of the Aging in Manitoba Study follows the framework already adopted on that occasion to identify the "unmet needs" of elderly Manitobans in nine areas. These were categorized as: psycho-social functioning, housing, household maintenance, ethnocultural participation, physical health, mental health, economic well-being, accessibility and availability of resources. The triple jeopardy hypothesis was confirmed at the objective level but not for the subjective measures of well being. Findings revealed that elderly members of each ethnic group had unmet needs in each of the areas mentioned above. It was also demonstrated the existence of triple jeopardy for elderly women of Polish, Russian and Ukrainian descent with reference to the mental health dimension. Intergroup and intragroup comparisons revealed that the old-elderly women of these ethnic groups were the worse off. Ethnicity was found to be the only significant predictor in terms of health perceptions.

3.2.2 As a Resource

The other view focuses on the benefits that those elderly can obtain when remaining attached to an ethnic identity and subculture (Simic, 1985). The roles of the ethnic community as a "mediator resource" to cope with the problems of acculturation (Aguirre and Bigelow, 1983; Baker, 1993; Breton, 1964), as well as the ethnic family supports to their elder members are underscored. Ethnic identification is conceptualized as giving the elderly a sense of communal belonging which improves their adjustment to aging (Cool, 1986).

A more eclectic perspective proposed by Sokolovsky (1985) pointed out that informal supports are adequate to deal with acute but not with long-term problems. He remarked that the myth of the ethnic family support could be used as an excuse to minimize social assistance or reduce funding to existing social programs.

3.3 Universal vs Specific Themes

By the end of the 1980's, anthropologists identified three major themes in the aging process of different cultural groups: the need and drive for spatial, social and cultural continuities, a gender dichotomy and aging as a "career" meaning that it is a process covering the entire life span. (Myerhoff and Simic, 1978).

In the 1990's, some "critical gerontologists" intended to advance in the direction of accepting that "there are not universal definitions for health, illness, ethnicity, family and self" (Luborsky and Sankar, 1993: 440). This approach received

support from cross societal studies which demonstrated that definitions of old age in terms of problems and opportunities vary across cultures (Fry and Keith, 1990).

3.4 Culture, Health Status and Practices

Another set of studies have been concerned with measuring the impact of cultural values and ethnic identity retention on health practices and help seeking behaviours (Wong and Becker, 1983, Chan, 1983, Strain, 1990). Wong and Becker found that Chinese elderly, when compared with Anglo of the same age, experienced aging as more stressful and adopted less effective coping strategies. Findings were interpreted as motivated by the Chinese elderly adherence to cultural values which promote group dependence for support and guidance. Their health practices were explained in terms of the existence of language barriers and their previous knowledge of herbal medicine.

Another study following a similar perspective arrived at different findings. It compared lay health care beliefs and practices of elderly residents of four different cultural settings in Canada and USA. It revealed that differences existed but cultural factors alone explained little of that variance (Singh and Kinsey, 1993).

Ujimoto, Nishio, Wong and Lam (1993) studied the level of satisfaction with their health status among the elderly of Chinese, Japanese and Korean origins including intergenerational variations. They found very positive self reported health status for all

the groups. Korean elderly and first generation immigrants of the other groups were those less satisfied.

Other studies analyzed ethnic group membership related to experiences of institutionalization. MacLean and Bonar (1983) were concerned with the effects on the physical and mental health status of ethnic minority elderly living in a long term facility organized according to mainstream cultural patterns. Findings revealed experiences of loss of family, culture and community in the cases studied.

Disman and Disman (1993) compared attitudes to institutionalization among members of different ethnic groups in Toronto. They found that although feelings of fear are shared by all, attitudes to institutionalization improved when a facility of their ethnic preferences was the alternative.

3.5 Barriers

"Barriers" to access health and social services is another topic which was addressed from different perspectives. MacLean, Siew, Fowler and Graham (1987) studying the provision of social services in three community centers in Montreal, found that the Chinese elderly were institutionally discriminated.

Saldow and Chow (1991) identified a high percentage of elderly affected by language barriers in several hospitals and nursing homes in Metro Toronto. The absence of professional interpreters was found to affect the quality of care provided.

3.6 Native Peoples

Although Native peoples constitute a very heterogeneous population, some studies were concerned with Native elderly similarities.

Frideres (1994: 20,24) characterized them as being affected by a "double alienation" which made them marginal to the Canadian society and their own communities. After analyzing the structural and individual factors which produced that marginalization, he concluded that the many psychological and physical needs that elderly Natives have, should receive culturally appropriate health and social services.

Without disregarding the importance of health related problems, Armstrong-Esther (1994: 45) suggested that one of the most critical problems which Native elderly are facing, is the "loss of continuity in their lives". She also reported that in Saskatchewan, a quarter of urban Native elderly live alone, isolated, and depending upon others to go out.

Two studies compared native and non native elderly residents of Manitoba. The study by Bienvenue and Havens (1986) confirmed previous information on the disadvantaged status of the native elderly. The relevance of their informal network was demonstrated and probably compensated for their underutilization of formal services. Blandford and Chappell (1990) compared the subjective well being of native and non native elderly residents of Winnipeg. Lower subjective well being reported by the native elderly was related to their worse health and social conditions.

3.7 Social Policy Impact

Outside Canada, researchers examined the dominant values, attitudes and practices towards the elderly, which contributed to the construction of old age either as a social problem (Holzberg, 1982) or as the result of an unjust economic system (Phillipson, 1982).

In Canada, from a political economy perspective, Wanner and McDonald (1986) draw attention to the impact of social policies on the life conditions of ethnic elderly. They found that elderly men belonging to African, Asian and Latin American groups, who immigrated to Canada after 1966, used to remain longer in the labour force and have lower incomes after retirement. They related these findings to changes introduced to the Canadian pension legislation in the 1960's and 1970's which reduced benefits to immigrants.

3.8 Ethnic Types

Driedger and Chappell (1987) intended to integrate ethnicity and aging based on a critical adaptation of modernization and assimilation theories .

Several ideal types of Canadian ethnic groups were constituted according to their levels of modernization and assimilation. Ethnic differences were demonstrated and then tied to a discourse on needs:

> Needs will vary depending on such factors as the extent of the person's ethnic identification, the prevalence of services that are ethnically congruent, the health of the individual, the social support available to the person, and the individual's ability and style of coping (Driedger and Chappell, 1987: 88).

The provision of flexible and varied programs to address these different needs was their main recommendation for policy makers.

3.9 Aging and Immigration

Another topic of interest identified in the literature is that of the effects of the process of immigration on elderly individuals. One dominant perspective presented them as a group at risk for mental health problems (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988a; Health and Welfare, 1988; Roskies, 1976; Salvendy, 1983).

Particularities of this approach will be consider with detail in chapter three when analyzing the "official" multicultural health discourse on aging.

Definitive "ruptures" such as separation from their place of birth and the culture in which they were socialized as well as the partial alienation within their present natural and cultural environment, have been interpreted as possible sources of mental health problems for elderly newcomers (Myerhoff and Simic, 1978; Salvendy, 1983).

A less pessimistic approach is provided by Aroian (1990) who found that migration and resettlement can present both opportunities and risks.

3.10 The Meanings of Ethnicity

The recognized difficulties in conceptualizing and operationalizing ethnicity in the social sciences (Singh and Kinsey, 1993) are reflected in different proposals. While some authors produced elaborate definitions of ethnicity (Cool, 1986; Isajiw, 1980) others alerted us to the "political' nature of this construct as it has been created as a label of difference and often prejudicial meanings are attached to it (Lock, 1993). It has also been critiqued as a "boxification" of culture, when it is applied as another epidemiological variable to explain health beliefs and behaviours (Kaufert, 1990).

Although we can agree with these critical commentaries, there is a generalized use of the concept in the literature. The latest studies operationalize it on the basis of mother tongue and official language proficiency (Auger, 1993: 156) with an increasing emphasis on the need to recognize the existence of intra and inter-ethnic group differences based on age, gender, rural /urban origin, social class, political affiliations and personal interests (Auger, 1993; Matsuoko and Sorensen, 1992; Masi, 1993; OACSC 1988-89).

3.11 Ethnicity and Social Class

Although there is an increasing acknowledgement that social class influences life course choices and opportunities and that the problematic aspects of aging are often concentrated among working class and poor individuals (Atchley, 1988: 288), it

has been difficult to distinguish the effect of ethnicity from that of social class (Cool, 1986).

3.12 Summary Table

The wide range of research interests, the methods and findings of the studies analyzed above, is summarized in Table 1.1.

3.13 Limitations of Previous Research

Some of the limitations of Canadian studies dealing with ethnicity and aging have already been identified by Driedger and Chappell (1987). They remarked that most studies tended to focus on one ethnic group, using for each of them different concepts and variables with cross- sectional designs which hinder comparisons between groups as well as over time.

Through a broad overview of the Canadian studies published since the 1980s, I have also identified substantial variance in the power of their respective designs.

Many studies have been conducted with rather small or otherwise idiosyncratic samples. In some cases the low response rates of the surveys have seriously limited the generalization of their findings (e.g., Age and Opportunity Report, 1992).

Discrepancies among service providers, community key informants and elderly newcomers in assessing the needs of the latter, have been acknowledged (Age and Opportunity Report, 1992). These facts were taken into consideration when I was

Table 1.1. Canadian Studies on Ethnicity and Aging

Author	Topic	Sample	Methods	Findings
Chan (1983)	Patterns of social life of aged Chinese women in Montreal	26 elderly widows	questionnaire, interviews, narratives participant observation	ethnicity can both hinder or facilitate adjustment to old age
Gerber (1983)	Multiple jeopardy hypothesis tested with 19 elderly ethnic groups in Ont.	8,400 elderly residents in Ont. in 1971	secondary data analysis: census data	differences in aging depend on institutional completeness of each ethnic group, socio-economic status, language use, length & urban/rural place of residence
Havens & Chappell (1983)	triple jeopardy hypothesis in Manitoba	4,505 elderly Manitobans	secondary data analysis; survey using life satisfaction index	triple jeopardy was confirmed; at objective but not subjective level
MacLean & Bonar (1983)	ethnic elderly in a dominant culture long-term care facility	three elderly residents in a long-term facility in Montreal	case study of 84 year old Italian woman, 84 year old Chinese man & 93 year old Greek female	experiences of loss of family, culture & community identified
Wong & Recker (1983)	double jeopardy hypothesis regarding stress coping & well-being in immigrant elderly Chinese & Anglo elderly groups	40 elderly Chinese & 40 elderly Anglos	interviews using perceived well-being scale & coping inventory	conform double jeopardy hypothesis in the Chinese group

Bienveneu & Havens (1986)	comparison of Native and non-Native elderly in Manitoba in terms of structural inequalities & informal networks	rural sub-sample of aging in Manitoba study, 110 of Native ancestry	interviews	confirmed disadvantaged status of Native elderly; relevance of informal network for assistance
MacLean et al. (1987)	institutional discrimination in service access & provision for Portuguese & Chinese elderly in Montreal	n/a of social & health service providers in 3 community centres of Montreal	semi-structured interviews	institutional discrimination confirmed in Chinese elderly
Ontario Advisory Council (1988/89)	attitudes toward aging in Ont.	98 elderly; 63 who arrived before 1969	standardized questionnaire	more women than men living alone & in institutions; not confirmed support of immigrant family; preference for ethno-specific housing; life satisfaction improved in general with exception of Vietnamese elderly; shared concerns with mainstream seniors; some still pulled by previous home countries
Redcliffe & Landringan (1988)	barriers to access health care services by immigrants in London, Ont.; depression in Vietnamese, Portuguese, Chinese & Spanish-speaking elderly	30 elderly aged 50+ years in each group	questionnaire, personal map, MacMillan Health opinion form, Canada health survey questionnaire, CES-D scale	ethnic elderly show higher levels of stress than general population

Blanford & Chappell (1990)	subjective well-being among Native and non-Native elderly persons in Winnipeg	193 Native aged 50+ years; 197 non-Native aged 60+ years	needs assessment questionnaire	Natives have significantly lower life satisfaction; lower quality of life explained by worse health & social conditions & not attributable to being Native, *per se*.
Strain (1990)	influence of health beliefs on the use of health services by the elderly applying Anderson-Newman framework	743 persons aged 60+, residents of Winnipeg	questionnaire with interviews conducted in the major language groups	need factors are strongly correlated with service use; strongest beliefs in the value of health maintenance activities are associated with greater use
Saldow & Chow (1991)	develop database in Metro Toronto; document communication barriers & strategies implemented	administration of 37 hospitals and 69 homes for aged	questionnaire	87% of elderly were reported to have language barriers; health care provided affected by lack of professional interpreters
Anderson (1991)	social construction of devalued self of immigrant women with chronic illness	15 Chinese and 15 Anglo females	ethnographic in depth interviews	feelings of being devalued arises from chronic illness experiences added to def'n. of self constructed in dealing with migration experiences; emotional support not provided by physicians; caring role of nurses should be recognized.
Villeneuve & Lambert (1992)	degree of association of selected psychosocial & health variables with psychological distress in elderly (Quebec)	French (57%), English (35%) and Others (8%)	multiple regression analysis of Quebec health survey data (1987)	psychological distress is significantly related to: interaction stress events x perceived social support; physical/functional health; & sex. Buffering effect of social support on stress is demonstrated.

Higgit & Greenslade (1992)	needs assessment of Asian elderly newcomers in Winnipeg	158 service providers; 48 ESL teachers; 60 key informants; 197 ethnic seniors	standardized questionnaire, focus group, interviews	def'n of problem areas: economic, transportation, housing, language; recommendations for overcoming barriers
Chipperfield & Havens (1992)	longitudinal analysis of perceived respect among elders; changing perceptions for some ethnic groups	n=776 elderly from 66-94 years, residents of Manitoba	secondary analysis data from Aging in Manitoba study, interviews, Lickert type rating scale	over the decade the social climate of the elderly population in Manitoba has improved for some ethnic groups (British, French & German) & evaluations have not increased for the rest
Disman & Disman (1993)	Attitudes towards institutionalization among elderly Canadians, Italian & Portuguese residents of Metro Toronto	104 English elderly; 109 Italian elderly; 94 Portuguese elderly	standardized questionnaire with face to face interviews in three 3 languages	fear as omnipresent feeling in all groups; better opinion of institutionalization when own ethnic home for the aged is involved & when the option seems to be the only available
Singh & Kinsey (1993)	lay health & health care beliefs & practices of elderly in 4 cultural settings in Canada & U.S.	100 elderly residents; 30 of whom lived in community A, Nfld., 37 in community B, Nfld., 50 in Oklahoma & 21 Filipinos in Toronto	standardized questionnaire	elderly do differ in their popular beliefs about health; scepticism about things doctors do was one of the best predictors for home remedies use & health maintenance beliefs; cultural factors alone explained little of the variance
Ujimoto et al. (1993)	Cultural factors affecting self-assessment of health satisfaction of Chinese, Japanese & Korean elderly living in urban areas	n=774; random sample from community agencies lists, 223 Chinese, 373 Japanese, 178 Korean	standardized questionnaire, Michalos life satisfaction scale & time budget form	self reported health status was very positive for all the ethnic groups; Koreans & 1st generation immigrants of the other ethnic groups were the most dissatisfied

designing my research and taking decisions on what would be an appropriate methodology to address the proposed objectives.

Most of the limitations mentioned above are probably the result, on one hand, of methodological procedures based on standardized questions and/or predetermined categories to be ranked by the respondents. On the other hand, they are in some cases also driven by professional agendas. These are based on a model which benefits the professional system more than its clientele (Dill, 1993). One of the recurrent topics which could be interpreted as one of the needs of the system is that of how to overcome the underutilization of health and social services by ethnic people.

Most of these studies have assumed that ethnicity is a given variable affecting the aging process, the impact of which should be measured. Studies based on census data analysis, for example, are affected by the way in which ethnicity has been constructed by that instrument. Instead of being a fixed and stable characteristic, ethnic identity should be considered as situational, emergent and changeable (Lock, 1990; Nagel, 1994).

Most of the studies reviewed share the assumption that ethnicity is a variable which differentiates between individuals and groups, affecting their sense of well being, beliefs and behaviours. However, they did not attempt to analyze the ways in which that differentiation is socially constructed and therefore it is susceptible to being contested and reformulated.

In sum, the literature reviewed above has been contributing to the discursive construction of ethnicity and aging in Canada without a critical reflection on the topics selected and the categories borrowed or originally constructed. This thesis intends to initiate that analysis with the methodology and assumptions described in the following chapter.

CHAPTER 2: METHODOLOGY

This chapter introduces the conceptual framework and rationale for both the implementation of discourse analysis and the selection of qualitative methods. It continues with an account of the theoretical assumptions and discourse analysis process. Then, it follows with the description of the samples, the field work contexts, data sources and analyses. Finally, the criteria and procedures adopted to ensure validity and reliability of the data as well as confidentiality to respondents are discussed.

1. Conceptual Framework

This research intends to describe some of the discourses involved in the construction of ethnicity and aging in Canada and Manitoba. As Satzewich suggested (1992) the considerable number of discourses produced in recent years on multiculturalism, immigration and race reveals the importance assigned to this topic in the Canadian context.

Contemporary society may be conceptualized as constituted by a plurality of power strategies, discourses and practices which produce different subject positions (Seidman, 1994). The guiding hypothesis for the research design has been that issues related to ethnicity and aging have been constructed through competing discourses. The description and comparison of two of them, which I labelled "official" and "lay"

respectively was the main focus of this study. The "official" discourse exists through texts and professional practices. The ethnic elderly subject as it has been constituted by this discourse, competes with other representations and meanings of being an elderly newcomer in Winnipeg. These may also be reconstructed in the form of a newcomers' discourse.

A genealogical method (Foucault, 1970, 1972, 1977, 1978, 1980; Armstrong, 1990) was adopted for the textual analysis of the official multicultural discourse on aging and qualitative methods for studying professional's and lay's perspectives.

2. Qualitative Methods

The selection of semi-structured interviews and life history narratives as methods to re-constsruct professional and lay perspectives respectively, was oriented by the exploratory and descriptive purposes of the research questions . These aim at interpreting meanings attached to experiences of aging in a new environment (Lincoln, 1992: 377). Based on a phenomenological and holistic paradigm they are appropriate to study individuals' perceptions, beliefs, feelings, experiences and behaviours (Denzin, 1989; Lord et al., 1987). They enhance the expression of individuality and common human concerns rather than numbers and labelling which are inherent procedures of quantitative methods (Singleton et al., 1993).

Their constructivistic approach to reality has been recognized as one of their strengths, particularly for health research. Ontologically, such methods regard

individual's representations of reality as socially and experientially constructed (Lincoln, 1992: 389).

By interviewing different people with varied perspectives, the intention was that of gaining a broad and deep understanding while maximizing the validity of the data. Thus, similarities and differences, consistencies and contradictions amongst perspectives were highlighted.

While most traditional needs assessments emphasize needs and deficiencies, the use of the qualitative approach allowed the identification of people's capacities (Lord et al., 1987). They provided elderly newcomers with opportunities to become partners in the research process (Matsuoka, 1993).

3. Discourse Analysis Assumptions

The origin of discourse analysis as a research method, may be traced to domains such as semiology, philosophy of knowledge and ethnomethodology (Coyle, 1995: 243).

It may be regarded as an analytical tool to implement the poststructuralist proposal of studying social issues through language. For that line of thought, the latter does not simply reflect psychological and social life but constructs it. This emphasis on the constructive role of language is one of the basic assumptions adopted for the discourse analysis. The former is regarded as the place where meanings are produced and having an important role in forming individual subjectivities, institutions and

political alternatives. Hence, it is interpreted as a site for both the production of social realities and for power struggles.

From this perspective, meanings derive from relations of difference and contrast. Linguistic patterns are regarded as being fluid, contextual and provisional. They share this unstable condition with the subjective and social orders which they contribute to construct (Seidman, 1994: 201).

Foucault's conception of "discourse" was accurately summarized by Young (1987: 113). Oriented by this interpretation the analysis of the official multicultural health discourse is based on the following assumptions:

(1) It exists as a field of statements and practices. The latter produce and communicate these statements according to certain rules. These constrain what is said and for what purposes.

(2) It is actualized by means of texts. All of them, by sharing meanings, contribute to the construction of its object of knowledge.

(3) The object "ethnic elderly" about which the multicultural health discourse produces knowledge is shaped by practices. They give it an existence in the literature on health and sickness. The same object is shaped by other discourses, as well (i.e., economic, political).

(4) Non-discursive practices, such as federally and provincially mandated programs influence this discourse. They shape its object by giving the elderly a distinctive

presence. They also stimulate the production of discursive statements by soliciting and financing research on that topic.

(5) Its authority is given by scholars and professionals acting as a circle of knowledge producers. Several organizations have been specifically created to promote and communicate that knowledge.

6) As part of a scientific discipline in a "normalizing" society (Foucault 1972, 1980), it aims at placing its object of study in a pre-existent or new classificatory system. Since the advent of the modern states, the subdivision of populations into categories (i.e. the young, the elderly, the poor, the disabled) has been a common practice implemented for administrative and regulatory purposes (Hewitt, 1983: 67).

7) It gives expression to particular interests as well as power relations. It has an "action orientation" which can be revealed through its analysis (Coyle, 1995: 248).

This method should be differentiated from traditional content analysis and literature reviews mainly because it has a "deconstructivist aim" (Seidman, 1994: 229). Based on the idea that discourse is not about, but constitutes its object of study, this type of analysis questions the discourse legitimacy by showing which interests it serves in a disciplinary society. Without disregarding the message, particular emphasis is placed in determining the influences which act upon the discourse process as a whole. (Lupton, 1992). Different socio historical, political, institutional, textual and personal

forces are addressed because they may hinder or enable the emergence of a discourse and its future developments.

Topics, themes and concepts in any type of discourse reflect underlying belief systems (Lupton, 1992, 1994).

This method also assumes that texts are susceptible to multiple readings and that each subject is positioned within a sociopolitical context. Thus, analytical insights regarding the official multicultural discourse on aging should be interpreted according to these assumptions which deny the possibility of universal truths.

4. Definitions

A good working definition proposed by Parker, identifies a discourse as "a system of statements which constructs an object" (1992: 5). Discourses are found at work in texts and different "signifying systems" (Seidel, 1993: 175) thus becoming objects susceptible to analysis (Parker, 1992).

For discourse analysis purposes "multicultural health discourse" was considered as a system of statements and practices which constructed its object of knowledge as being " health care which is provided in a culturally appropriate and sensitive manner" (CCMH, 1990: 1). "Multicultural discourse on aging" is used to refer to that discourse constructing the ethnic elderly identity as one component of its knowledge production.

5. Texts Selection

The search for the "official" construction of multicultural health themes and concepts, began with the selection of texts which have been institutionally produced since 1988, expressing expert perspectives on the subject. That date was suggested by the historical and philosophical relationships that exist between the "multicultural health movement" and the Multiculturalism Act adopted by the federal government in 1988 (Canadian Council of Multicultural Health (CCMH), 1990).

The analysis started by focusing on documents which were directly dealing with the subject such as the Report on Ethnicity and Aging (1988), two documents produced by the Canadian TasK Force on Mental Health Issues Affecting Immigrants and Refugees (1988 a and b), another by the Ontario Seniors Advisory Council (1988/89) and two reports produced in Manitoba (Nyman, 1991; Age and Opportunity, 1992). Then, proceedings of multicultural health conferences, workshops and institutional documents and newsletters were incorporated into the analysis for a better understanding of meanings attached to the main constructs.

When analyzing the conditions for the emergence of the multicultural health discourse, the scope was broadened to include multicultural and health policy documents, at the federal and provincial levels. All these texts were analyzed from the perspective that they were historically and ideologically linked in a chain of meaning construction.

6. Study Scope

The characteristics of the population and the sites where both discourses were produced imposed certain limits on the document analysis and the description of contexts.

The ethnographic study intended to reconstruct the discourse of subjects who were simultaneously viewed as new urban immigrants and as participants of two seniors groups.

Since one of the main purposes of this study was to compare lay and official discourses, the document analysis primarily focused on the construction of aging with reference to individuals born outside Canada.

When analyzing the context for the "official" multicultural discourse in Manitoba, demographic data in terms of immigration and language groups were considered for the entire province, but the analysis of its ethnic diversity concentrated on Winnipeg. This approach was suggested by the place of residence of the elderly newcomers, the localization of the seniors programs and the institutions which developed the official multicultural health discourse in Manitoba.

Perspectives on multicultural aging adopt particular features for residents of Quebec as well as for Native peoples in Canada and Manitoba.* Documents

*The reasons are discussed in Chapter 3, under the sub-heading "multicultural categories".

addressing these particularities deserve a type of analysis which exceeds the limits of this study. However, many of its conclusions may also be relevant for those distinct collectivities.

7. Levels of Meanings

While the theoretical framework follows Foucualt's ideas, another model developed by Fairclough (1993) was useful in setting the limits of text analysis. This author proposed to regard any text as carrying "ideational", "interpersonal" and "textual" meanings. These were defined as follows:

> Their domains are respectively the representation and signification of the world and experience, *the constitution (establishment, reproduction, negotiation) of identities of participants and personal relationships between them*, and the distribution of given versus new and foregrounded versus backgrounded information in the widest sense (Ibid: 136) [emphasis added].

8. Four Principles

In his investigation into the "rules of discourse", Foucault singled out four principles as methodological requirements for discourse analysis: of "reversal", of "discontinuity", of "especificity" and of "exteriority". They are respectively based on four notions : "the event, the series, the regularity, [and] the condition of possibility" (Foucault, 1970: 67).

The principle of reversal means to "reverse the systems and figures which are customarily seen as the sources of discourses in the history of ideas." The event must be opposed to the idea of creation (Ibid: 50). Foucault applied this principle for "critical" descriptions. It allowed him to understand how the discursive "forms of exclusion" were formed, what needs they responded to, how they were modified, what constraint they imposed and to what extent they could be evaded (Ibid: 70).

The principle of "discontinuity" suggests that "discourses must be treated as discontinuous practices, which cross each other, are sometimes juxtaposed with one another, but can just as well exclude or be unaware of each other."(Ibid: 67). "These series of discourses must be put in opposition to the assumption of the `unity of a work, an epoch, or a theme'." (Ibid: 50).

The principle of "specificity" assumes that discourse "is a practice we impose on things and there is not pre-existing significations". The events of discourse find in that practice their regularity (Ibid: 67).

The principle of "exteriority" suggest that when analyzing a discourse we must "go towards its external conditions of possibility, towards what gives rise to the aleatory series of these events, and fixes its limits" (Ibid: 67).

The last three principles were applied by Foucault for "genealogical" descriptions. These aimed at showing "how did series of discourses come to be formed, across the grain of, in spite of, or with the aid of these systems of constraints;

what was the specific norm of each one, and what were their conditions of appearance, growth, variation." (Ibid: 70).

Foucault introduced "critical" and "genealogical" descriptions as complementing each other; however, the latter was suggested for the study of the constitutive power of discourses (Ibid: 73).

9. Analytical Process

Although form and meaning are interdependent features of texts, the analysis initially concentrated on meanings at the "interpersonal" level (Fairclough, 1993: 136).

After the texts were reviewed in terms of their content, instances of recurrent ways of referring to the topic were identified. Those constructs which were frequently used revealed shared systems of meanings across texts. Extracts from these were further used to identify the origin of the terms and ways in which the constructed version was rationalized and legitimised (Denzin, 1989; Luborsky and Sankar, 1993). It turned out to be useful to pay attention to discursive features usually introduced to make the position constructed more persuasive. The use of "extreme case formulations" such as "always", "never" "nobody" and "everyone" was carefully monitored as part of the rhetorical analysis (Coyle, 1995: 249). Complementary constructs as well as others with vague referents could be highlighted. Applying the principle of "exteriority", the conditions of possibility in the form of intersecting discourses and events were identified (Foucault, 1970: 67). The comparison of similarities led to the identification

of recurrent patterns in the content and organization of the texts. At that stage, the underlying model, in terms of constructs and rationale, began to emerge (Luborsky and Sankar, 1993). A narrative about ethnicity and aging was reconstructed.

Next steps in the reading were devoted to finding out what purposes might be fulfilled by constructing the ethnic elderly identity according to that model. At that moment of the analysis, it was useful to apply the classification of discourses suggested by Seidel (1993). According to the discourse's action orientation she regarded them as "discourses of control/ exclusion or discourses of rights / empowerment" (Ibid: 175). Then it was examined as to what type of discourse it is, as well as if it really is an alternative to the "mainstream" discourse as it claims.

The identification of main themes, priorities, agents of change and proposed strategies for action in the official multicultural health discourse on aging provided data to formulate some hypotheses that may be regarded as conclusions. These refer to the possible impact of this particular discourse on the population it studied and the interests it may be promoting.

10. Evaluation

Although there are not fixed rules for discourse analysis evaluation, some criteria have been proposed. One, suggests that evaluation should be based on the degree of coherence that the analysis establishes amongst content, functions and effect of the discourse. Another proposal adds that analysis "should be fruitful, that is, should

provide insights that may prove useful in the analysis of other discourses" (Coyle, 1995: 255)

11. Data Sources

The whole study data were collected by means of a document analysis, semi-structured interviews of social and health care service providers and focused life history narratives from elderly newcomer residents of Winnipeg.

Documents analyzed included federal and provincial bulletins and newsletters, reports from provincial and federal workshops and Conferences on multicultural health issues in general and aging in particular, as well as federal health policy documents related to these topics and reports of multicultural research.

A broad scope of perspectives on multicultural health were collected through the interviews with fifteen health and social service professionals with different areas of expertise. They practiced in varied settings such as community clinics, hospitals, governmental and voluntary agencies, as well as in multicultural and ethno-specific organizations.

Finally, nine elderly newcomers shared with the researcher their narratives. Seven are members of a multicultural seniors organization which was created five years ago in Winnipeg while two are members of a "mainstream" seniors' centre.

12. Spaces of Discourse

The professional perspectives were collected in private and public settings, while the elderly newcomers were interviewed while attending two seniors' organizations in Winnipeg.

These were considered as "natural settings" where official and lay discourses and practices related to ethnic aging interacted (Lincoln and Guba, 1989: 189). As contexts, they reproduced the dominant discourse of service provision for the well elderly and shaped meanings attached to experiences of aging in Winnipeg. They also represented spaces where elderly newcomers were identified as being ethnics. Inside these contexts, their discourse emerged blending past and present, social and individual identity constructions.

13. Professional Discourse

Semi-structured interviews were the instruments to reconstruct how professionals and bureaucrats working in Winnipeg view and / or contribute to the policy making on multicultural health issues affecting individuals who are aging in Manitoba.

13.1 Sample

The sample included fifteen informants: three nurses working in community clinics and health education, a retired nurse who is a Board member of the

multicultural seniors organization, a multicultural health advisor to the Manitoba Minister of Health, three gerontologists working in governmental and voluntary agencies, an agency settlement officer, a health community outreach worker, a multicultural program coordinator, two social workers and two physicians with direct experience with elderly newcomers who are residents of Winnipeg.

13.2 Sample Selection

Informants were selected using snow-ball sampling. As no generalization purposes were involved, the main criteria for their inclusion were their previous experience in the field of multicultural health and aging policies and professional practices, as well as their willingness to participate in the study.

14. Interview Guides

The guides used to interview each type of informant are presented in Appendices A-1, A-2 and A-3 . The items for the professional interview guide were selected assuming that the assessment and management of cultural factors is a main issue for health and social service providers (Thompson and Thompson, 1990). In the case of health care providers, the items included related to five main categories of cultural barriers to clinical care which have been identified in the literature: (1) language use and nonverbal communication patterns, (2) medical roles and

responsibilities, (3) explanatory models of disease; (4) contextual factors and (5) emotional impact and / or stigma (Clark, 1983: 607).

Professionals were contacted through introductory letters and appointments were established by phone. Twelve interviews were carried out in their offices and the remaining three at informants' homes.

15. Field Work Context

Since Ethos is the unique organization which provides services to multicultural seniors in Winnipeg, it seemed to be from a methodological point of view an ideal setting to meet elderly newcomers from different ethnic backgrounds. There it was possible to explore not only their own interpretations of their needs, worries and concerns but also how official multicultural discursive practices were affecting their lives as well as the future survival of their group.

The description of the Ethos organization presented in the following paragraphs was derived through the analysis of printed and audio visual materials such as Ethos annual reports, brochures, local newspapers articles and a video-tape showing a multicultural intergenerational party.

A series of non-participant observations of the seniors' group meetings as well as semi-structured interviews with the Program Coordinator and three Board members, were also implemented. These added information for a better understanding of the main issues and problems which were affecting this seniors' organization.

All these interviews were tape recorded and transcribed verbatim. The non-participant observations, which were recorded using field notes, provided first hand information on the interactions and activities performed during the seniors' group meetings and outings.

15.1 Ethos' History

In the summer of 1989, several agency representatives who adhere to the definition of ethnic seniors as a group with special needs, obtained the support of Discover Choices, a federally funded Health Promotion program for seniors which had been piloted in Manitoba and Saskatchewan since 1988, to sponsor a Picnic in Assiniboine Park (Winnipeg) (Camp Ethos, Final Report, 1990). After a massive attendance of "multicultural seniors" to that event, Ethos was formally created as the Multicultural Seniors Coalition of Manitoba Inc., in 1990 and opened its own office in Winnipeg in April 1991. (Manitoba Council for Multicultural Health Inc. Newsletter, 1991:1). "The term "ethos" is an ancient Greek word symbolizing the fundamental spiritual characteristics of a culture" (Manitoba Society of Seniors (MSOS), 1991: 9).

Representatives of the Ethiopian, Italian, German, Spanish, Hindu, Punjabi and Filipino communities were members of its first Board (Esposito, 1993). Its "inter agency advisory committee" included ten advisors who belonged to the most important governmental and voluntary agencies involved in the provision of mainstream health and social services to seniors in Manitoba (ie: Discover Choices,

Age and Opportunity, Seniors Directorate). A long standing and powerful organization such as the Manitoba Society of Seniors (MSOS) lent them an office to hold meetings and to prepare the first Ethos summer camp (Camp Ethos Final Report, 1990) and promoted their activities through the MSOS journal (May 1991: 9).

15.1.1 Mandate

According to its promotional presentation Ethos was founded to be: "a coalition of seniors representing various cultural groups", "a community non-profit organization operating under an elected Board of directors", a "human service bridge linking multicultural seniors with each other and the Canadian community as a whole" and a "special needs group" (Ethos' brochure, 1993).

Its main purpose is "to advocate for ethnic/immigrant seniors who experience difficulty accessing mainstream services because of language and cultural barriers" (MSOS Journal, 1991: 9).

15.1.2 Members

Everyone can become a member and membership fees are not compulsory. Although the Program Coordinator reported that there are one hundred seniors on the membership list, at the time of this study, only a dozen members were participating regularly. This number increased to thirty on the occasion of a workshop on disability, which included a chartered bus to and from the site as well as free refreshments and food.

According to the Program Coordinator, Ethos regular membership declines during the winter months because seniors are used to visiting relatives in their former home countries, where at that time of the year the weather is usually mild.

With respect to their sociodemographic characteristics, women outnumber men, representing approximately seventy five percent of the regular participants. At the time of the field work, the age range of these members was fifty five to eighty years.

15.1.3 Activities

These are similar to those usually included in the program of mainstream senior centres such as crafts, traditional games, health promotion and education sessions, outings to parks and museums. Ethos members felt very proud of the annual ethnic fashion show at Portage Place which is promoted as one of their "major events" (Manitoba Health/Council on Aging, 1993).

English as a Second Language (ESL) classes are one of the activities highly appreciated by most of the members. Participants reported that regular classes at schools were not appropriate for seniors. There were also economic reasons involved in that preference since sponsored dependents are not eligible for government subsidized ESL classes (Ethnicity and Aging Report, 1988: 25). A considerable number of participants in the Monday afternoon ESL classes were Canadian citizens whose mother tongue was Spanish. Some of them had lived in Winnipeg for twenty years and still were having difficulties communicating in English. Precisely, they were those who strongly supported Ethos' policy of accepting participants in the English classes based

on their needs and not on time of residence. These classes used to be provided by a volunteer teacher. At the time of the study, the Program Coordinator took over that role.

A sample of monthly activities are presented in Appendix C.

15.1.4 Staffing

The Program Coordinator was at that moment the only paid staff. (Ethos Annual Report, 1993). Her style of organizing and developing activities was very pragmatic based on resources available and short term programming. Her role was complex involving relations with Board members, with other agencies and senior organizations as well as looking for new sources of funding.

Volunteers were the main human resource for the delivery of different activities such as crafts, English classes and health promotion. The Winnipeg Volunteer Centre has been cooperating with the senior group on a permanent basis.

15.1.5 Funding

Ethos used to enjoy financial support from Federal and Provincial official agencies and local non governmental organizations. Members and volunteers implemented bingo and craft bazaars as additional fundraising sources. Financial uncertainty at the time of this study was related to the funding agencies' policies. Among them were acknowledged the need to re-apply annually, compete with other organizations for a limited number of grants, and meet simultaneously the criteria of

quite different organizations. As similar problems affecting other multicultural programs have been described in Manitoba (key professional informant, 1994) and in Great Britain (Blackemore and Boneham 1994) one may suspect that a permanent striving for survival is the common fate of organizations serving "ethnic" clients.

15.1.6 Location

Ethos operated in two rooms located in the same building and floor as the provincial Age and Opportunity offices. Its location in downtown Winnipeg is a very convenient feature since most elderly newcomers live within or close to that area. None of them complained regarding problems of crime or violence in this neighborhood.

The main room was used for all the indoor activities. In one of its corners, there were always tea, coffee and cookies on a table, as a clear reference to its definition of "drop-in-cafe". One of the walls was used to exhibit the crafts made by the seniors as part of their fundraising strategies. The furniture included tables and chairs, a t.v. and video set. They had a good stock of recycled and new materials for their crafts as well as some non-perishable food.

15.1.7 Board Members

Countries of origin of the Board members were: EL Salvador, Nicaragua, Philippines and Canada. Board members were to be elected according to the stated organizational policy. By the time this study was conducted, the current president was trying - without any success at that moment - to find somebody willing to replace her

in that role. Precisely, it was mentioned by the Program Coordinator that it was difficult to obtain a long term commitment from those willing to assume such responsibilities.

16. The West End Senior Centre

The other setting in which elderly newcomers were interviewed is a multipurpose senior centre sponsored by Age and Opportunity. In response to the needs of elderly immigrants from Hong Kong, it began to provide educational and recreational programs in both English and Cantonese.

Its paid staff is composed of the Centre Director, the Centre worker and a Meal Coordinator. This senior centre offers the kind of activities which are usually found in most "mainstream" centres not only in Winnipeg but in most North American cities. A sample of the programs implemented at the time of this study is presented in Appendix C.

There, Cantonese speaking seniors receive assistance with forms and letters, interpretation, getting information on government programs or specialized services for seniors, English classes as well as a Chinese meal program (Manitoba Health/ Council on Aging, 1993).

Both settings in which the field work took place shared a common philosophy in terms of services targeted to the well elderly. However, they differ in terms of the quantity and quality of the material resources available to provide these services. The

impact of these differences is addressed when analyzing the newcomers discourse in Chapter 5.

17. Entrance to the Field

Preliminary contacts with the multicultural organization began one year before the implementation of the field work. After sending a letter to the President of the Board, the researcher was invited to explain the purposes of the study to the Board members. After satisfying their requirements , permission to conduct the research was granted.

The first day of fieldwork took place at the multicultural organization office during an "ethnic food party" hosted by two Hindu members. The researcher was initially introduced by the Program Coordinator as a Graduate Student who would conduct a study there to obtain a Master's degree. From the very beginning the study received great support not only from her but also from the seniors. They seemed to feel happy that their views were considered important in spite of an organizational context characterized by decreasing membership and funding.

The receptiveness of the elderly was largely based on our common "newcomer status". The researcher's ability to speak Spanish was an additional asset in a place where interactions were definitely based on language group pertinence.

It was a constant feature of meetings at the office as well as during workshops and the summer camp that those speaking the same language would sit together with

sporadic exchanges of words in English and gestures among members of the different language groups.

Although it was clear from the very beginning that I was not a volunteer, I tried to be helpful and assist in such activities as serving meals and cleaning. I shared lunches and tea with them on different occasions. I waited with them at the bus stop when the daily summer camp activities were over, travelled with them in a chartered bus on the occasion of a workshop developed at a seniors' housing complex and watched their grandchildren improvised theatre performances during the summer camp.

Data gathering tasks were developed in such a way that they did not interfere with the drop-in nature of the organization and the time frame imposed by the activities already programmed. In all cases the day and time of the interview were established by the informant. In one case it meant waiting several hours until a group of Hindu elders finished a card game.

Interviews and observations were conducted at the mainstream seniors' centre, the multicultural seniors' organization office and one school room which was used for the two-week summer camp activities during the months of April, May, June and July of 1994.

In the case of the mainstream seniors' centre, access was granted, some weeks before the beginning of the field work, by the Centres' Manager of Age and Opportunity after receiving a detailed written description of the objectives and

characteristics of the study. It is also important to point out that it is part of the policy of this voluntary organization to promote training in the field of gerontology. At that centre, I was introduced to the group of Cantonese speaking seniors during a morning English class. Although I was received with friendly smiles and my personal background and presentation on the objectives of the study were correctly interpreted to the elderly by the Centre worker, I left the centre without knowing if anybody would agree to become a life history narrator. The day after that meeting, the Centre worker informed me that two of the Chinese elderly had "volunteered" to be interviewed.

18. Sample of Elderly Newcomers

The nine elderly selected from both senior groups constitute a "natural" non probabilistic sample of elderly newcomers. This "naturalistic sampling" was guided by informational and not by statistical considerations. It intended to maximize information instead of providing generalization of findings (Lincoln and Guba, 1985: 202).

In order to compare the findings of this research with those of a study recently carried out in Winnipeg (Age and Opportunity Report, 1992) it was initially adopted the same definition of elderly newcomers. They were identified as "individuals aged 55 years or more who have been permanent residents in Canada for ten or fewer years" (Ibid: 14). Once in the field, the criteria was modified to include an informant who was fifty years old. This decision was taken after a newcomer's self-identification

as a "senior". The time frame of ten years corresponds to the minimum period of residence in Canada required by the Old Age Security program to qualify for its benefits (Age and Opportunity Report, 1992: 14).

19. Rapport and Probes

Following an interpretative and ethnomethodological approach each interview was structured as a particular social interaction (Matsouka, 1993) supported by a guide. In that way it was ensured that relevant topics would be included in a given session, but it was flexible enough to allow the informant to introduce new items as well as his/her priorities and personal interpretations (Silverman, 1985). A good rapport with the informants was obtained through conveying respect and demonstrating appreciation for their time and their willingness to share their feelings and experiences. Since the purpose was to motivate in-depth responses (Patton, 1990) probes were introduced when necessary. Common probes used included showing expectant interest and a series of questions such as : who else? How do you feel then?, When was it?

20. Overcoming Communications Barriers

As Spanish is my mother tongue, that was the language used to interview two Spanish speaking newcomers. Since all the Filipino newcomers and a Hindu lady had a good command of English, these interviews were conducted in English.

To communicate with a Punjabi speaking man, the life history schedule was translated into Punjabi. His narrative was translated then into English and the researchers' probes into Punjabi. The translator was another member of the Punjabi speaking group who was acceptable to the narrator due to the facts that he was also aged and male.

With the Cantonese speaking newcomers, the interviews were conducted in that language with simultaneous translation into English by the Program worker.

21. Life Histories

The life history approach has a long tradition in the social sciences and has been successfully used to study bio and psyco-social changes, as well as to describe immigrants and elderly group experiences (Disman, 1987; Holzberg, 1984; Kaufert, 1990; Li, 1985; Luborsky, 1993; McCall, 1985; Myerhoff, 1978; Thomas and Znaniecki, 1918).

As a method of data gathering, life history is an "oral autobiographical narrative generated through interaction"(Bertaux and Kohli, 1984: 217). Its selection for the description of the elderly newcomers' discourse was based on the following reasons:

(1) It is appropriate to study experiences of immigration and settlement as they are defined and understood by their protagonists (Bertaux and Kohly, 1984, Driedger, 1989). By describing events over time, it allows us to place the immigrant's present life in Winnipeg into the perspective of his/her whole life.

(2) It helps people to regain self-worth and meaning in life by reconnecting to earlier accomplishments, fond memories and valued identities. (Fry and Keith, 1986; Holzberg 1984; Luborsky, 1993; Myerhoff, 1978).

(3) It is appropriate to test the existence of universal themes in the aging process (Myerhoff and Simic, 1978) as well as exploring the changing definitions of self and the world in a person's career (Bogdan and Taylor, 1975).

(4) Western assumptions about structured interviews are not shared by respondents of different cultural backgrounds (Blackemore and Boneham, 1994).

(5) It contributes to seeing elderly informants as equal partners interacting with the social researcher (Disman, 1987).

21.1 Life History Schedule

The life history schedule (see Appendix B) reflects my particular theoretical framework and topical interests.

It was designed assuming that:

1. old age is part of a developmental process;
2. human development is the result of people's interpretations and re-interpretations of themselves and their situations and not the outcome of individuals developing in definite stages (Botella and Feixas, 1993). It was adopted an interpretation of the elderly individual as an active, self-reflexive

agent in society. Thus, aging is viewed as an "aleatoric" and flexible developmental process (Starr, 1983: 266).

3. despite the wide commonalties of difficulties and needs, elderly people differ in the interpretations they give to their lives and to aging.

The life history schedule was constructed to display each individual's life along a temporal continuum with three "turning point" moments: before, preparatory and after immigration. The items selected were orientated to a description of the biological, psychological, social and cultural dimensions of the narrators' lives (Mandelbaum, 1973: 181).

The inclusion of items regarding the meaning and functions of group membership for the elderly person's resettlement process, ensured comparisons not only among respondents perspectives but also with the information collected through the non- participant observation of the group meetings. Most of the informants in the sample consented to their narratives being tape recorded. In the few cases in which the interviewees denied that permission, the interview content was written verbatim. To complete each life history narrative, at least two sessions with each informant were required.

22. Data Analysis

In order to compare within and between the narratives transcripts were prepared to reproduce as exactly as possible the spoken language and the interaction developed during the interviews (Helling, 1988).

Setting the dimensions of each narrator's life was useful during the interview process to build up an appropriate interaction and later when organizing the abundant data for subsequent analysis (Mandelbaum 1973: 180). During such organizational tasks, "turning points" of the narrator's life emerged from the transcripts analysis. These were defined as "major transitions" when the individual "takes a new set of roles, enters into fresh relations with a new set of people and acquires a new self-conception." (Mandelbaum, 1973: 181).

Immigration and resettlement processes qualify for that definition. Continuing review of the data led to the identification and further description of the ways in which the elderly narrators adapted to those turnings in order to maintain their self- continuity . Categories inferred from the transcripts were collected in files and used in several steps of comparisons within and between the cases of the sample (Helling, 1988).

Although there is not a unique method for narrative analysis, the latter should be based on the interpretation of the narrators' interpretations of things (Riesman, 1993).

The following questions were useful to guide such interpretation:

* How do these people construct their beliefs?

* How do they manage their lives?
* Why do they think, feel , and act the way that they do?
* Under which conditions do they think, feel and act that way?
* What are the consequences of their beliefs, feelings and actions? (Lofland and Lofland, 1984; Charmaz, 1990).

All relevant knowledge about past and present contexts affecting individual's interpretations were included in the analysis of the transcripts. (Bertaux and Kohli, 225).

Once each life history was interpreted and an outline and chronology drawn up, a review session with each informant was arranged. This allowed them to make additions and expansions of the themes identified (Frank and Vanderburgh, 1986).

The interpretation of these narratives finally adopted the form of a "systematic thematic analysis" (Plummer, 1983: 114).

The identification of themes from the professionals and newcomers transcripts was implemented taking into consideration frequency and meaning, similarities and differences. First, those statements that appeared most frequently were singled out. Secondly, statements that were marked by the informant as specially meaningful for them were added to the list (Luborsky, 1994: 196).

Themes identified in each discourse were finally compared.

23. Field Notes' Analysis

The field notes taken during the senior group meetings once transcribed, were useful to identify events, type and frequency of the interactions, topics discussed and behaviours.

This information was compared with that obtained from the multicultural senior group coordinator, the board members and the elderly participants, in order to measure consistency among the different data sources.

24. Comparative Analysis

The following table summarizes the main topics of this study, the sources and methods for data gathering:

Table 2.1. Comparative Analysis of Multicultural Discourses on Aging

TOPIC	DATA SOURCE	METHOD
official discourse	* documents * pertinent literature	Discourse analysis
professional discourse	* professional perspectives and practices; Program coordinator Board members	semi-structured interviews
lay discourse	* elderly newcomers' narratives * social interactions in seniors' groups	life histories & non-participant observations

25. Validity and Reliability

The criteria to judge the rigour of a study differ according to the type of research paradigms involved (Lincoln, 1992: 381).

Research based on a positivist paradigm is expected to be objective. Objectivity has been conceptualized as the "distanced and neutral posture of the inquirers and the appropriateness of methods" (Ibid: 381). It is measured in terms of its validity and reliability.

Validity of a research is usually examined in two dimensions: internal and external. Internal validity is measured in terms of "isomorphism with reality", while "external" in terms of generalizability of findings (Lincoln, 1992: 381; Deutscher, 1970). An instrument is regarded as valid when " it measures what it is supposed to measure" (Rosenbaum, 1988: 56). It is reliable if it yields stable responses under conditions of repeated observations (Denzin, 1970).

In the case of qualitative methods based on a naturalistic paradigm, the researcher as instrument in the process of data gathering has been regarded as a potential source of biases. For its control, careful self-examination is recommended (Rosenbaum, 1988: 56). Some authors suggest that in ethnographic studies external validity should be judged in terms of "comparability" and "translatability". Thus, researchers should describe the characteristics of the group studied to promote comparability, and the methods and analytical categories to allow for translatability. (Le Compte and Goetz, 1982: 34, cited by Rosenbaum, 1988: 58). Kirk and Miller

1986: 72) emphasized the need to ensure reliability by documenting all the procedures involved in the research process.

Therefore, while there is agreement in the literature that there are specific problems of validity and reliability that may affect qualitative data, there are different recommendations to approach and solve them (Brink, 1987; Denzin, 1970; Deutscher, 1970; Frank and Vanderburgh, 1986; Helling, 1988; Li, 1985; Lincoln, 1992; Rosenbaum, 1988; Silverman, 1993).

Taking into consideration this variety of proposals, to ensure the validity and reliability of the research data the following procedures were undertaken:

(a) A design based on a triangulation of methods or multiple data sources (Denzin, 1970) provided by discourse analysis, semi-structured interviews, life history narratives and non- participant observation;

(b) Convenience samples which included individuals whose profiles as newcomers and professionals conformed to a typical pattern (Frank and Vanderburgh, 1986).

(c) Keeping a field journal to monitor the existence of a balance between engagement and neutrality in the way observations, communication and interaction with informants were taking place. It included all kind of impressions, thoughts and feelings as the data gathering tasks developed.

(d) Feedback from the informants to ensure that their perspectives were correctly described and interpreted. In the case of the life history narratives, each

espondent was asked to expand on any sections of the story which lacked clarity and to describe regularities and relationships among the areas of experience mentioned.

(e) Contextual field notes to enrich the tape recorded interviews. They included descriptions of the setting, of nonverbal behavior of the informant, distractions, interruptions and notations about the activities of other persons present in the place (Rodgers and Cowles, 1993).

(f) As it is a kind of design which may be improved, all the methodological decisions taken throughout the study were recorded.

(g) Losses and gains in group membership were documented and their effects identified.

(h) Pre-test of interview schedules.

(i) A section in the thesis has a detailed description of the methodology implemented and instruments for data gathering.

Li (1985) emphasized that the apparent inconsistency of respondents' feelings about the past does not reduce reliability, rather it enriches their stories. He also remarked that official records and other secondary sources of data are "equally susceptible to unreliability" since they reflect institutional interests (Ibid: 71).

26. Confidentiality and Anonymity

Prior to data collection, respondents were thoroughly informed about the objectives of the research and asked for written consents (form in Appendix D). In all cases anonymity was guaranteed as no personal names were used to identify the participants. Interviews were tape recorded with the consent of the respondents. Once all transcripts were available for analysis, these tape records were erased.

CHAPTER 3: THE OFFICIAL DISCOURSE ON MULTICULTURAL AGING

This chapter introduces the analysis of the official multicultural discourse on aging with a discussion of the role of discipline-based discourses in contemporary societies. It follows with a description of the conditions for the emergence of the "official" multicultural discourse at the federal and provincial levels. Then, main categories and themes around which the ethnic elderly identity has been constructed are presented. Particularities in Manitoba are highlighted. Finally, some hypotheses on the role of this discourse are formulated.

1. Bio-power and Discourse

The purpose of this chapter is to explore various aspects of a discourse which presents itself as promoting the philosophy of multiculturalism in the field of health care. It declares to represent the interests of minority ethnic groups excluded by the mainstream health and social service system. (Canadian Council of Multicultural Health (CMH), 1990).

The theoretical assumptions of discourse analysis and the process for its implementation were described in the methodological section of this thesis. Now, in order to understand the role that a discourse on multicultural aging may have in our society, it is relevant to introduce Foucault's conceptualization of bio-power (1977, 1978, 1980). The latter refers to modern forms of regulating both the reproduction and productivity of bodies. Historically, it emerged with the decline of medieval

sovereignty and became dominant throughout the nineteenth and twentieth centuries. Foucault interpreted that its emergence was instrumental for both the accumulation of capital and people. Social and health policies became state instruments for the creation and circulation of power by controlling the production and maintenance of populations. Foucault's notion of "bio-politics" (1978) refers to a new domain of political life which emerged with capitalism. In that context, bodies became politically relevant due to their central roles as producers and consumers.

Two aspects of this process are relevant for the discursive constitution of ethnic aging. First, with bio-politics the individuals' rights to health and to the satisfaction of basic needs are recognized (Foucault, 1978). "Need is also a political instrument meticulously prepared, calculated and used" (Foucault, 1977: 26).

Secondly, disciplines such as clinical medicine, psychiatry, pedagogy, psychology, criminology, were described by Foucault (1977) as providing discourses constructing and regulating those rights. These provide technologies of intervention and norms to exercise power over bodies. In his opinion, such common practices as individuals' differentiation, their quantification, the ranking of performances according to certain standards represent typical disciplinary technologies of a normalizing society (Foucault, 1978).

Previous to an evaluation of the role of the multicultural health discourse when constructing its object of knowledge, the following questions were suggested by the application of Foucault's methodological principles (1970):

(1) Which were the conditions shaping the emergence of the official multicultural health discourse?

(2) Which discourses did intersect in the construction of the ethnic elderly identity?

(3) Which are the main themes around which that construction was developed and legitimized?

(4) Who may benefit from its proposals?

Each of these questions are discussed in the following paragraphs.

2. Constructing the Conceptual Chain

By applying the principle of "exteriority", the conditions for the emergence of the official multicultural health discourse were identified. Then, they were analyzed applying the principle of "discontinuity" as suggested by Foucault (1970), as well.

Rather than the presentation of a historical narrative, a series of discourses which intersect with the official multicultural discourse on aging are highlighted. They have produced a repertoire of themes and constructs which framed the emergence of that discourse and constrained its future development.

2.1 Conditions for Emergence

The following discourses and events may be singled out among these conditions:

First: Discourses constructing a "welfare state" crisis have set up health and social policy priorities in terms of their costs. They influenced the construction by the discourse of gerontology of a resource perspective (Tornstam, 1992) ideologically expressed through the constructs of "aging well".

Second: The discourse on multiculturalism, at the federal and provincial levels, which provided an ideology and categories for the management of social diversity,

Third: Professionals and spokespersons from different ethnic communities, with increasing social visibility and political power, who were identified as community leaders and / or key informants, and

Fourth: Changes in immigration patterns promoting the settlement of immigrants coming from non traditional countries,

Each of these conditions are analyzed in the following paragraphs.

2.1.1 Shifting the Emphasis

A review of documents produced since the 1980's at the federal and provincial level suggested the progressive shaping of a policy for planning and delivering health care for the elderly. It was formed around three service delivery themes: a focus on community care, coordination of the service delivery and health promotion. It was based on the assumption that the provision of services in the community would be more economic than in institutions and respectful of elderly people's preferences.

Community care was associated with the enhancement of independence while institutionalization was regarded as reinforcing dependence and as a last alternative (Health and Welfare Canada, 1986; NACA 1983, 1990).

In the field of health and social services, the shift towards a "community care" approach was accompanied by less funding for the provision of programs on one hand; but on the other, it promoted the emergence of new types of technologies and professionals trained to work at the community level (i.e., community development and settlement workers).

The second theme of this discourse of gerontology is reflected on health service policies implemented around the constructs of "continuum of care". Based on the philosophy mentioned above, the latter should start with health education and promotion programs for "aging well". Within that scheme, seniors centres were increasingly visualized as "wellness centres" (Leanse, 1986) and families, friends and neighbors were constructed as a "social network" to help in the fight against premature institutionalization (NACA, 1990; Manitoba Health, 1992: 14). Different support services for the elderly were designed to retain them in community settings (Havens, 1989, 1990, 1993 a and b). In Manitoba, a discourse on needs and services has been developed through the systematic study of its population since the 1970's (Manitoba Department of Health and Social Development, 1973, Vol. IX: A). Its particularities are presented when analyzing the official discourse in that province. Now, it is only

introduced to draw attention to its contribution with the federal health policy on aging, to the development of a multicultural version of aging in terms of needs to be served.

2.1.2 The Relevance of Ethnicity

The origin of the expert discourse constituting ethnic identities in the Canadian context, could be traced to the first colonizers. Since the middle of the eighteen century, that type of discourse began to develop knowledge:

> The collection of Canada's ethnic origin data has a long history. The first question appeared on the 1757 census of what is now Nova Scotia. Since confederation, such a question has been included in every census excepting 1891 (White, 1992: 165).

Through the following centuries, ethnicity continued to be textually reproduced as a relevant category for social differentiation as well.

In the following paragraphs the origins of some constructs adopted by the official multicultural health discourse are highlighted. This description is not intended to be a chronology of events; rather it aims at connecting the evolution of the "multiculturalism movement" (Kallen, 1982) and the government multiculturalism policy, with the current official multicultural health discourse.

2.1.3 Multicultural Categories

The American philosopher Horace Kallen is credited with the ideological foundation of the "mosaic model" conceptualized as "multiplicity in unity". In Canada,

this model was reproduced in 1938 by the publication of J.M. Gibbon's book: " The Canadian Mosaic" (Kallen 1982: 162, 163).

Multiculturalism as an ethnopolitical social movement which emerged in the 1960's presented itself as a Third Force of non dominant Canadian ethnic communities. Although they represented the interests of nearly one - third of the Canadian population by 1964 (Kallen, 1982), their proposal of multiculturalism with multilingualism, did not prosper.

The adoption of a "policy of multiculturalism within a bilingual framework" may be considered as a particular instance of "redefinition of identities" by the Canadian state. (Breton, 1986: 42). The following paragraph describes that process:

> In the past substantial public support has been given largely to the arts and cultural institutions of English-speaking Canada. More recently and largely with the help of the Royal Commission's earlier recommendations in Volumes I to III, there has been a conscious effort on the government's part to correct any bias against the French language and culture. In the last few months the government has taken steps to provide funds to support cultural-educational centres for native people. The policy I am announcing today accepts the contention of the other cultural communities that they, too, are essential elements in Canada and deserve government assistance in order to contribute to regional and national life in ways that derive from their heritage yet are distinctively Canadian (Canada, House of Commons, 1971, pp. 8545-46, cited by Breton, 1986:49).

The construct of "barriers" gained particular status in the multicultural vocabulary when it was announced that:

> The Government will assist members of all cultural groups to overcome cultural barriers to full participation in Canadian society (House of Commons, Debates, October 1971, cited by Kallen, 1982: 238).

In the 1980's, another category, that of "visible minorities" was constituted when the "symbolic character of public institutions" was again redefined (Breton, 1986: 59). It received official recognition in 1984 as one of the designated groups by the Report of the Royal Commission on Equality in Employment. It was subsequently constructed as a target group for protection against discrimination by the Employment Equity Act of 1986. Statistics Canada (1990: 71,72) operationalized that category as conformed by ten ethnic origins: Blacks, Indo - Pakistani, Chinese, Korean, Japanese, South East Asian, Filipino, Other Pacific Islanders, West Asian and Arab, and Latin American, excluding Argentinean and Chilean.

As a result of this process of differentiation, "English speaking", "French speaking", "native people", "other cultural communities" and "visible minorities" became "official" categories.

The Canadian Multiculturalism Act (1988) refers to multiculturalism as an inherent characteristic of a Canadian identity (The House of Commons of Canada, 1988, Bill C-93: 3).

This process of constitution of identities by the Canadian government developed within a framework of political confrontation. Contested discourses were promoted, with different claims and strategies, by both the Quebecois nationalist movement and revived nationalist movements of Aboriginal peoples. Although, as social movements, both date from the 1960's, it was throughout the constitutional debates of the 1980s and 1990s, that their claims acquired particular relevance (Jenson, 1993: 339).

Their self definition as collective nationalities (Jenson, 1993) which renders ethnicity an unacceptable label for them, has influenced the setting of limits for my discourse analysis.

The peculiarities of the multicultural policy in Quebec were another factor considered, as well:

> The unease of the Quebec government about the multiculturalism policy has remained strong ever since its inception, which has translated into support for a more integrationist model than in the rest of the country (Paquet, 1994: 66).

My exploration of the discursive constitution of ethnicity and aging from a multicultural health perspective, acknowledged all these facts by limiting the research scope to elderly people born outside Canada. It does not mean that those other collectivities were excluded by the multicultural health discourse. Quebec's representatives participate with their own chapter as active affiliates of the Canadian

Council of Multicultural Health. With respect to Aboriginal peoples, the official multicultural health discourse presents itself as a resource. Upon request, it offered Aboriginal peoples assistance and support for the preservation of their traditional health practices and the development of health related initiatives (CCMH, 1990: 15).

The multicultural vocabulary was developed in the official documents with a vague rhetoric. The latter affected the content of the multicultural health discourse as well as its practices. In its content, through a process of borrowing the multicultural categories. In its practices, by stimulating some critiques and proposals which question the " desirability and viability" of the multiculturalism policy (Abu Laban and Stasiulis, 1992: 38).

2.1.3.1 The Meaning of Multiculturalism

Multiculturalism has been developed as a discourse which has provided ideological constructs to accommodate Canadian diversity (Tepper, 1994: 95) while at the same time it became the site of ideological struggle (Lewycky, 1992: 381, Abu-Laban and Stasiulis, 1992: 38). Critiques to multiculturalism voiced both from right and left wing perspectives (Filinson, 1992) may seriously jeopardize the implementation of multicultural health initiatives.

Most of the multicultural health advocates as well as other proponents of the Act, interpreted it as a sincere acceptance of pluralism (Masi and Disman, 1994). They considered that the Canadian government wished to promote public recognition by the British dominant cultural group of the rights of marginalized or historically dependent

cultural groups. The emergence of new political elites and lobby groups representing ethno- specific interests was linked to that policy (Helly, 1993).

Other multicultural health advocates had gone further and interpreted this official policy as an integral part of a correct definition of health and as a solid base for a" healthy Canada" (McLeod, 1992) since "it recognizes that many Canadians from different cultural backgrounds experience unequal access to resources and opportunities" (Berube, 1990: 1).

Kallen (1982) has conceptualized the multicultural movement as interested in the promotion of social reform. Initially, it had focused on issues of equal access to political, economic and social power, moving later on, towards addressing issues of cultural and linguistic rights. Finally, it became concerned with the need to combat racism and discrimination in Canadian society.

Precisely, since the end of the 1970s, multicultural policies have been oriented towards addressing these issues related to discrimination and integration of immigrants groups into public affairs. Social forces related to new immigrants coming from Third World countries, the political activism of ethnic groups and Aboriginal peoples were among the main factors that motivated such policy changes (Helly, 1993).

However, from a structural perspective, this policy has been denounced as a form of class control by the charter ethnic groups who remain overrepresented in the elite structure of power (Porter, 1965) and as a strategy to de-politicize minority communities (Li and Bolaria, 1985).

Others have expressed their concern that it has been counterproductive to the pursuit of equality and the result has been the isolation of ethnic groups with their own cultural traditions preserved in a racially stratified economic system (Ramcharan, 1982).

From another perspective it has been pointed out that funds allocated under the label of multiculturalism have been spent without any systematic assessment of the purposes of the expenditure. Closely related to these statements, are political proposals which called for decreasing the funding for multicultural programs, the preservation of cultural background as a matter of personal choice and the integration of ethnic cultures to the national culture (Reform Party of Canada, 1990: 23). From a similar line of thought it was argued that in Canada's interest, immigration must be reduced to a minimum to accept only young, skilled and literate workers (Campbell, 1995). According to this position, orientation programs which help elderly newcomers to integrate to the Canadian society should not be publicly funded.

The response of the multicultural health discourse to conservative critiques was the emphasis on the promotion of programs based on already available community resources and newcomers' personal skills (Manitoba Council for Multicultural Health Inc. Conference Summary, 1989). It also accepted that "Canada was not yet a nirvana of equality" and identified "access" and "equity" as the main issues in the provision of community services for ethnic groups (Doyle, 1986: 10, 11).

As it was suggested by Lewycky, one may suspect that the ideological debate around the meaning of multiculturalism will continue beyond the 1990's (1992: 396). While the future content of that discourse remains uncertain, in the past decades it has been connected with the regulation of the diversity generated by Canadian immigration policies.

2.1.4 Immigration

Changes in immigration patterns have been recognized as one of the main preconditions for the emergence of the 'official" multicultural health discourse. Precisely, the latter was constituted around the premise that the health and social service system should be responsive and sensitive to the cultural diversity generated by that immigration policy. (Masi, 1993). Demographic data support that perspective.

In 1991, thirteen percent of the total Canadian population reported a mother tongue other than English or French (Statistics Canada, 1992). Since 1950, the number of immigrants to Canada from European countries had diminished (now it is estimated at only 15%) but immigration has increased with people arriving from Central and South America, East Africa, South and Southeast Asia (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988a). "The result is a society that is more racially, ethnically and culturally plural" (Masi 1993a: 17).

The following table reflects the relative weight of the non official languages among those aged 65 and over in the whole country as well as in Manitoba:

Table 3.1. Official and Non-Official Language Groups, 65 years and over, Canada and Manitoba, 1991.

	Canada	%	Manitoba	%
Official language groups	2,525,795	79.7	94,410	68.5
Non-Official language groups	644,175	20.3	43,975	31.5
	3,169,970	100.0	138,385	100.0

Source: Statistics Canada, Mother tongue. Single responses. Ottawa: Supply and Services. Canada 1992. 1991 Census of Canada.

In 1991, thirty non official language groups were reported for the whole country and twenty three in Manitoba. Almost thirty two percent of the elderly reported a non- official language as their mother tongue in Manitoba. (Statistics Canada, 1992). (The different language groups are presented in Appendix E).

3. Institutional Support

The Canadian Council on Multicultural Health (CCMH) which is the organization that represents the multicultural health movement at the federal level, was formed in 1986 when "a group of individuals were called together at the Ontario provincial conference entitled "Partnerships for health - Part I".

As a result of that meeting, a central coordinating body was created to promote and assist in the development of multicultural health care within each of the provinces and territories. (CCMH, 1990: VI).

Its mandate is that of being "committed to the promotion of multicultural health and to ensuring that health policies and services show understanding and respect and reflect the cultural diversity of our society" (CCMH 1990:3).

The CCMH ensured as an element of its plans for action to maintain a permanent path of communication with governmental representatives (1990: 10). Recognition of this mutual understanding has been publicly acknowledged. During one of the sessions of the Second National Conference on Multicultural Health, the Minister of Multiculturalism and Citizenship told the audience: "You will continue to have a willing and committed partner in the federal Government" (Weiner, 1992: 245).

The CCMH as representative of the official perspective on multicultural health issues, has identified its mission as being: "committed to the implementation of the Multiculturalism Act (1988), the Charter of Human Rights and Freedoms (1982) and the Canada Health Act (1984)." (CCMH, 1990: 3).

The institutionalization of the multicultural health discourse successfully expanded to include affiliates in all Canadian provinces. Its ideological framework, which is shared by all the provincial multicultural health organizations, includes the promise to address the challenges of "Achieving health for All: A Framework for Health Promotion" discussion paper in its strategic plan for action (CCMH, 1990: 1). Thus, content and proposals of the multicultural health discourse are delimited by this original adherence to governmental policies.

Multicultural health initiatives have received governmental support, as well. As an example, of the 429 projects funded by the Federal Seniors Independence Program since 1988, almost one-fifth have addressed "cultural diversity in aging" (Catley-Carlson, 1992: 79). Among them, two have been developed in Winnipeg, Manitoba : "the Immigrant Seniors Project" under the supervision of Age & Opportunity, and "Ethos", the Multicultural Seniors' Coalition of Manitoba.

A series of health policy documents have also participated in the constitution of the main themes and constructs of the official multicultural discourse on ethnic aging (Health and Welfare, 1982: 84, 1988) These have defined ethnic groups as affected by cultural and language barriers and singled out senior immigrants as being at risk for developing mental health problems. Precisely, these were extensively addressed by the Task Force on Mental Health Problems Affecting Immigrants and Refugees (1988, a & b) which was formed through a joint initiative of Multiculturalism Canada and the Health Services Directorate of Health and Welfare Canada (Williams, 1986: 16). Following this line of thought, the National Advisory Council on Aging(NACA) identified ethnicity and aging issues among the challenges for the Canadian aging society in the 1990's (NACA, 1989). It also implemented a series of consultations which resulted in an inventory of barriers affecting the access to health services (Hill, 1992: 131).

The previous discussion provided an overview of the conditions for the emergence and institutionalization of the official multicultural health discourse. It

suggested that this process has been developed under professional management and following multicultural and health policies guidelines.

The next paragraphs describe the main themes which were identified through the analysis of the discursive construction of the ethnic elderly.

4. Constructing Multicultural Aging

4.1 Differentiation

Since the nineteenth century, as Foucault (1977) has disclosed, normalization became one of the great instruments of power in contemporary societies. With respect to the elderly, "aging well" has been patronized by the gerontological discourse as a desirable goal (Hazan, 1994: 15). The challenge posed to the multicultural health discourse was to accomplish the normalization of ethnic aging starting from its differentiation. The constructs and rationale for attaining that purpose, are the object of the following description.

4.1.1 Mainstream and Minorities

Elderly experiences are displayed into a discursive space which is divided into a "mainstream" and many "minority" cultures (Ethnicity and Aging Report (E&A), 1988). Ethnic seniors are defined as being similar to "mainstream" elderly because they share the fate of all the members of this age based category (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (CTF), 1988a: 79). However, due to their differences they are set outside that category.

The dichotomy mainstream / minorities around which these differences are introduced, seems to be constituted with floating signifiers.

"Mainstream" is given the meaning of a dominant Canadian culture based on "anglo-saxon middle class values" when used in institutional documents (CCMH, 1990:1). However, this construct has been deprived of meaning when constructed from a subjective perspective:

> It is difficult to understand what to make of the term "mainstream". The Task Force heard presentations from many groups across Canada who reported that they felt completely cut off from the mainstream... If so many people feel disenfranchised, it is difficult to claim that there is such a thing as a mainstream. (Beiser, 1989: 53)

Similar ambiguity is found regarding the other pole of the dichotomy. As has been identified in this discourse, some conceptual confusion over the use of "ethnic group" and "minority" exists. People "of neither English nor French origins", sometimes are referred to, using the term "minority" (Bergin, 1988: xx) and sometimes the term "ethnic" (E&A, 1988: 1). The construction of a residual category has been acknowledged as resulting from the inability "to find an acceptable substitute" (E&A, 1988: 1).

In Manitoba, a recent study assessing needs of senior newcomers have operationalized ethnic groups as "minority immigrant groups" (Age & Opportunity, 1992, Appendix B1:1).

According to Flanagan (1985) the term "minority" was proposed in 1932 by Donald Young, to replace the word "race" which by the turn of the last century, with a massive immigration of Eastern and Southern Europeans both to the United States and Canada, was used to refer to "what today would be called ethnic groups" (Ibid: 107).

4.1.2 Heterogeneity

The apparent disagreement in terms used to construct ethnicity as object, is compensated by the common acceptance that "they are an heterogeneous group" with different needs and expectations (E&A, 1988: 14; Manitoba Council of Multicultural Health (MCMH), 1989 Workshop: 1). Some differences are constituted as having a physiologic base. Groups such as Chinese, Greeks, and Italians, are identified as being genetically predisposed to thalassaemia. Ethnoracial background has been related also to a differential metabolism of drugs and intolerance to specific foods (Masi and Disman, 1994: 502).

Differences among ethnic groups are also rationalized using a systemic approach. Ethnic membership and ethnic community's degree of institutional completeness (Breton, 1964) are interpreted as being in mutual interaction (E&A, 1988: 15).

4.1.3 Ethnic community

Ethnic community characteristics such as "size, interests and ability to advocate" are viewed as having a decisive impact on the "quality of life" of their senior members (E & A, 1988: 15; Age and Opportunity, 1992: 52).

This construct helps both to differentiate and to normalize the ethnic identity. It helps to normalize, when the ethnic community constituted as a basis for social support, becomes part of a continuum of care. In the differentiation stage, it is constructed as a mediator resource which smoothens newcomers adaptation both to aging and to the host society (CTF, 1988 a:18; CCMH, 1990, MCMH, 1989:, OACSC, 1988/89; Age & Opportunity, 1992: 76).

4.1.4 Group with special needs

Following the discourse on "needs to be served" which conditioned its emergence, the official multicultural health discourse includes ethnic elderly subjects into that discursive circuit as a sub-category with special needs (E&A, 1988: 24; CTF, 1988a: 79; Age and Opportunity, 1992: 32, 74).

4.1.4.1 Subgroups at Risk

Some subgroups such as elderly sponsored immigrants, those with mental health problems and those who need long term institutional care, are singled out as being at highest risk. (E&A, 1988: 24; Canadian Task Force on Mental Health Issues Affecting Immigrant and Refugees, 1988a: 80,83; OACSC, 1988/89: A 12; Nyman, 1991: 39).

Many conditions have been identified as risk factors for developing mental health problems. Among those frequently used to construct immigrants and refugees as subjects at risk are:

a. traumas and long standing stress prior to migration

b. inability to speak one of the official languages

c. separation from family members

d. unfriendly reception by the host country

e. decreased socio-economic status

f. isolation from others of similar cultural background

g. life cycle stage at the time of migration

h. lack of information on the host country prior to immigration

i. unemployment and underemployment (Nyman, 1991: 39,40)

Two other discourses have been lending form and meanings to the multicultural health discourse on these matters. First, the tendency to break down "the aged" into subgroups (i.e., "young-old" and "old-old", "competent"and "frail") has been identified as an "integrative device" and a "regulated subdivision" of the discourse of gerontology (Green, 1993: 177). Secondly, a type of "discourse on risk" intersects with the official discourse. Originally the term risk was constructed as an statistical category for epidemiological purposes. Progressively the medical discourse assigned it the meaning of a "state of being or symptom of future illness". Elderly people and their families are targeted by that discourse to develop awareness of their "risks" and seek professional assessment. (Kaufman, 1994: 431).

4.2 "Normalizing" Ethnic Aging

In the following paragraphs, the rationale underlying the normalization of ethnic aging is described. As a process, it included not only a project for positive aging but also of multiculturalization of the health and social service system.

4.2.1 Aging Well

Diversity, which initially was highlighted by the official discourse as a constitutive feature of its object, is finally simplified around the constructs of "aging well " or "positive aging". "Sound physical and mental health, financial security, comfortable housing and a supportive social environment are seen as the essential elements of aging well" (E&A, 1988: 13).

By promoting an ideal type of aging as a goal for mainstream and ethnic elderly, both categories may be best assisted. "Independence" is the core value to be ensured by retaining the elderly in the community. (E&A, 1988, Masi, 1989, Symposium: 65, NACA, 1983, 1990).

4.2.2 Barriers

Among the many factors hindering the "aging well" of the ethnic elderly the following have frequently been identified: lack of language proficiency, absence of / or limited social support; small size of some ethnic communities; a "youth oriented" mainstream society; lack of information on available services, lack of accessibility and financial dependency (CMHC, 1988; MCMH, 1989; Task Force on Mental Health Issues affecting Immigrant and Refugees, 1988a). Following this line of thought, in

Manitoba, an exhaustive classificatory system of barriers was produced to assist those interested in improving newcomers' access and utilization of mental health services (Nyman, 1991).

4.2.3 Professional Roles

Service providers are envisioned as those who can help ethnic seniors to "age well". They must provide information and be aware of the influence of culture on behaviors. Thus, they may cooperate in increasing the access to services and in the process of changing a system which should acknowledge cultural and racial diversity (E & A, 1988: 23; CCMH, 1990; Masi,1989, 1993, Masi and Disman, 1994).

4.2.4 Cross Cultural Care

These are central constructs for the official discourse because they legitimate its existence among health and social service professionals. The discourse provides them techniques to manage interactions with clients from different ethnic backgrounds. Professionals have been advised:

1) To avoid stereotypes based on "text book generalizations" and to assess the specific cultural context of their patients;
2) To consider the effect of their own cultural norms, values and biases.
3) acquire the knowledge and expertise required for cross-cultural practices (CCMH, 1990: 12; Masi and Disman, 1994: 502).

Sources of misunderstanding between professionals and clients have been related to "health beliefs" and "values" and explained in terms of "cultural differences"

(Masi, 1989, 1993; Masi and Disman, 1994: 503). A common meaning attached to the construct of "culture" in this discourse is that of "shared values, beliefs, norms, mores, and symbols among groups of people" (Masi and Disman, 1994: 499).

As part of the training to provide culturally sensitive care, professionals are reminded that western values of individualism and independence are part of one of many possible models for social relationships. Therefore, alternative health care systems based on others values should be respected.

Cultural sensitivity is constituted also as the outcome of changes in professionals attitudes. New models for "effective cross-cultural communication" (Thompson, 1992: 113), community development (Urbanowski, 1992) and experiential learning (Wong and Srivastava, 1992: 116) have been developed to train those identified by the official discourse as agents of change.

4.2.5 Population Studies

Each minority group is constituted as having its own perception of aging and a social value for the role of seniors (E&A, 1988; CTF, 1988; MCMH, 1989). Ethnoracial backgrounds have been acknowledged as affecting health status and help seeking behaviours, as well. Thus, the official discourse interested in the promotion of appropriate cross cultural care, has encouraged the production of "ethno specific and multicultural-health related information" (E&A, 1988; OACSC, 1988/89, Age and opportunity, 1992, MCMH, 1989; Nyman, 1991; Sabloff and Herrera 1992: 271, Masi and Disman, 1994). The purpose was clearly stated: "We need a good deal of research

so that we can build a data base which can be translated into services and programs" (E & A, 1988: 29, Ujinoto, 1991).

4.2.6 The Issue of Access

Ethnic elderly are constituted as having special needs to be served but unable to use services due to lack of access.

The list of studies and workshops addressing access problems is considerably large and many of the more recent ones are presented in Appendix F. These are indicators of a long lasting professional interest to integrate newcomers into the health and social service system. The official multicultural health discourse made of this interest a crucial issue.

Criticism of the "mainstream" health system abounds in the discourse. Access problems are frequently constituted as the result of a " bio-medical, mono cultural / western design" which is reflected in professional training and standards of care (Hill, 1992: 142; Francis, 1993: 4). Other times, a bureaucratic model oriented by values of efficiency and cost effectiveness is blamed for hindering the access. However, this model has been reproduced when multicultural health was socially marketed as favouring consumer satisfaction and a good corporate image (Siu, 1992; Berube, 1992).

Availability of services has not been constituted as a main problem. Usually the discourse emphasizes that services for seniors already exist (E & A, 1988: 14). Based on

the construction of seniors as having special needs, the issue becomes one of service appropriateness (E&A , 1988: 16, Masi and Disman, 1994: 502).

Through this issue the "official' multicultural health discourse legitimates its claim of promoting an alternative to the mainstream health and social services. Multicultural health texts show the existence of consensus around the need for structural changes in the health care system, introducing innovations in service delivery and the training of service providers (Beiser, 1990: 127, CCMH, 1990).

4.2.7 Organizational Change

This is another theme around which the official discourse focuses great attention. Particular consideration was given in the documents to the development of proposals and recommendations. Among the more recurrent, the following were selected:

1) Representatives of different ethnocultural communities should be incorporated in decision making bodies which regulate and control health care practices (CCMH, 1990; Beiser, 1990; E&A, 1988)).

2) Hiring policies should promote the incorporation of service providers who belong to different cultural backgrounds (CCMH, 1990; MCMH, 1989; Beiser, 1990; Nyman, 1991.)

3) Foreign trained professionals should have their credentials assessed (CCMH, 1990, MCMH, 1989; CTF, 1988a; Beiser, 1990).

4) Training and incorporation of health interpreters as cultural brokers should be implemented in health services (Beiser, 1990; CCMH, 1990).

5) Translation of information into different languages should be a common practice (E&A, 1988; OACSC, 1988/89; Nyman, 1991; Age and Opportunity, 1992).

6) English as a second language classes should be adapted to seniors' expectations (E&A, 1988; MCMH, 1989).

5) Outreach to ethnic communities should be ensured (MCMH, 1990; MCMH, 1989).

6) Expand the hours of service provision (Masi, 1993).

7) Education / sensitization programs to acquaint Canadians with ethnic seniors experiences of immigration, resettlement and adaptation (E&A, 1988),

8) Creation of non-profit nursing homes for ethnic seniors and homes for the frail elderly (E&A, 1988).

4.2.8 Seniors' Participation

While on one hand the ethnic seniors are constituted as being overwhelmed by problems and lacking an organized advocacy base (CTF, 1988a: 82) , on the other, they are expected to take the initiative and be involved in the planning of programs and services (E&A, 1988: 10; Age and Opportunity Report, 1992: 72). Among the ethnic elderly those who are more acculturated are singled out as "potential leaders" to work towards the resolution of problems they and their peers face (CTF, 1988a: 82).

However, a recent study questioned the ability of "key informants" in reflecting the concerns of other members of their ethnic communities (Age and Opportunity, 1992: 76).

At the research level, researchers were advised to "move away from academic or professionally owned projects"(CCMH, 1992: 293). A "mutual participatory model" has been proposed. It relies on the identification of relevant research questions by members of ethnocultural communities and the translation of scientific information in ways that can be used for policy making (Anderson, 1992: 88).

4.2.9 Community Care

In its policy statements the CCMH "supports the development of a Multicultural Health Community Care System" (1990: 19). Ethnocultural groups are constituted as protagonists of that development and community health organizations advised to be opened and outreach to persons from different ethnic backgrounds (CCMH, 1990: 19).

4.2.10 Socio-economic Determinants

Financial dependency has been included among the special problems affecting ethnic elderly. Changes were suggested in pension, taxes and job creation policies (i.e., promotion of community "cooperative ventures" for seniors) (E&A, 1988; Masi, 1989c: 65).

4.2.11 Equity

This construct is used to legitimate the particular emphasis placed on cultural differences as well as proposals for systemic changes. Equality is differentiated in the

official discourse from sameness: "In order to apply the principles of equality, one must understand the differences that occur among people and respond to them appropriately" (Masi and Disman, 1994: 502).

"The objective might be adaptation of health care services to the requirements of culturally diverse populations to ensure more equal treatment outcomes." (Saldov and Chow, 1991: 19)

5. Internal Dissent

The process of constitution of "multicultural health" as object of knowledge included ideological discussions in terms of constructs and priority areas. Some voices inside the official discourse attached to ethnicity a political meaning. They disagreed with the strong emphasis placed on culture which shadows the relevance of poverty and discrimination affecting health status and care (Anderson 1992; Lock, 1993). Others disagreed with the model orientation and the excessive professionalization involved in the implementation of individual and institutional changes (Bonar and MacLean, 1985).

6. Manitoba's Peculiarities

Since the main features of the "official" multicultural discourse on aging have been already identified, the following analysis focuses on particular aspects of

Manitoba's version. Among those conditions that shaped the emergence of the discourse in Manitoba, the following are relevant:

First: its historical conformation as an ethnically diverse society.

Second: its elderly population has been object of systematic studies for long periods. Manitoba's services for the elderly are well known for their organization and the quality of care provided.

Third: Winnipeg was selected as the site to pilot a federally funded health promotion program which targeted ethnic newcomer seniors.

6.1 Ethnic Diversity

The discursive construction of ethnicity and aging in Manitoba has to be related to a historical narrative on colonization and immigration. Both English and French settled in Manitoba in the seventeenth century. In the mid of the nineteenth century immigrants from Ontario began to arrive. Throughout the late- nineteenth and most of the twentieth centuries, Manitoba became home for hundred of thousands of immigrants. Their countries of origin were reflecting the occurrence of international conflicts, economic crisis and changes in Canadian immigration policy. During the 1950's and 1960's, the shift has been from Western European to Southern and Eastern European countries. In 1968 a new immigration law opened Canadian doors to people of all nationalities. Non-traditional immigrants particularly from Asia, Africa and Latin America settled in Manitoba.

Since 1986, the larger number of immigrants came from the Philippines, Poland, Hong Kong, and Vietnam. Ninety one percent of immigrants who came to Manitoba in 1989 were destined for Winnipeg (Nyman, 1991: 36). The following table shows the main countries and percentages of immigrants who settled in this province:

Table 3.3. Percentage of Adults Age 55 and over Entering Manitoba as Immigrants, 1989.

Country of origin	%
Philippines	36.9
China	12.8
India	10.7
Vietnam	4.3
Other	35.3

Source: Employment and Immigration Canada (1989) Special run for Social Planning Council, Ottawa: CEIC.

Sixteen thousand seniors immigrated to Winnipeg between 1979 and 1989 (Hurd and Sturley, 1990: 6)

The latest 1991 census data (Statistics Canada, 1992) shows that the language groups with larger number of elderly in Manitoba are of European origin (see Table 3.4). Ukrainian, Polish, German and French are the language groups with a proportion of elderly which is over the provincial average. Most of these ethnic elderly of European origin are the pioneers who settled in the West to develop agriculture and

farming activities. Clustered in rural communities they developed a "small town lifestyle" (Driedger and Chappell, 1987: 56).

Table 3.4. Proportion of elderly population in each of the ten larger language groups. Manitoba. 1991.

Language Group	% 65 years and over
Ukrainian	45.8
Polish	33.3
German	20.5
Other languages	19.4
French	17.3
English	10.8
Tagalog (Pilipino)	9.0
Chinese	8.0
Portuguese	6.2
Cree	5.8

Source: Statistics Canada. Mother tongue. 1991 Census.

Although the proportion of elderly from non European countries in each language group (see Appendix E) is small compared to those of European origin, demographic projections indicate that this proportion will increase in the near future.

The origins of Winnipeg's ethnic diversity may be traced to the period between 1896-1914. Then, the arrival of immigrants from northern and central Europe, modified the city's predominantly British and French cultural dominance. (Thraves,

1992: 95). An important feature of Winnipeg's social geography are the ethnic neighborhoods established during that period and which have persisted to the present. Since the mid-1960's, immigrants from non traditional countries began to arrive.

A study on newcomers'patterns of residence in this city, demonstrated that new immigrant groups are moderately to highly segregated from each other and from all other residents. These emergent ethnic neighborhoods has been impelled by socioeconomic and linguistic factors (Thraves, 1992: 103).

6.2 Population Studies and Services

At the community level, many of the first services for ethnic elderly were provided by ethnospecific and religious organizations. Manitoba has been recognized as a pioneer in the systematic study and implementation of services for the elderly population. Concerns with the social aspects on aging may be traced to 1955 when the Social Welfare Council of Winnipeg conducted the first Canadian study on aging. Its recommendations led to the foundation of Age and Opportunity in 1957 and the development of the First Conference on Aging in 1958. Winnipeg was also the place in which the first Canadian multipurpose seniors' centre and first and second geriatric day hospitals were located. Residence in personal care home became an insurance service in 1973. Universal home care services, regarded as the first program of its kind in North America, were provided since 1974 (Manitoba Council on Aging, 1989: 2). Support Services to Seniors was launched in 1984.

The official multicultural discourse on aging emerged in a context in which the elderly population has beeen studied in terms of needs and services. The "Aging in Manitoba: Needs and Resources" study (Manitoba Department of Health and Social Development, 1975, V.9) conducted in 1971, is regarded as the "largest needs survey of the elderly anywhere in the world at the time." In 1976 the survey was repeated for a sample of elderly residents in the community and as a project continues up to date (Marshall, 1993: 7). Another feature of this study which is of relevance for the Manitoba multicultural health discourse, is the classification of elderly needs into pre-determined areas and the subsequent evaluation of services and future planning in terms of those needs. In order to measure the magnitude of needs among elderly living in the community and / or in institutions, needs were classified into the following areas: psychosocial, shelter, household maintenance, ethnocultural, physical health, mental health, economic, proximity to family and availability of resources (Manitoba Department of Health and Social Development, 1973, Vol.IX: A).

The influence of this discourse on needs to be served is dominant in Canadian research, as well (Driedger and Chappell, 1987: 88).

The organization of the health and social services along a complex continuum of care is another relevant condition affecting the action orientation of the official multicultural health discourse:

> The full continuum of health and social services includes not only informal care, support services, home care (including adult day care and respite care), nursing home care, chronic and rehabilitative institutional care, day hospitals, acute care, care from physicians and other health processionals; but also the broad spectrum of social services including pensions (or other income security measures), affordable housing, special interest groups, senior centres, older adult centres, senior educational programs, and all the age -integrated social programs (Havens, 1993a: 18).

In the 1990's, the great majority of the elderly in Manitoba (almost 89%) are defined as "independent". Their "needs are met in the general health and social service system". The needs of those who require support to remain at home are professionally assessed by a "case coordinator" in partnership with "consumers". Success may be measured by the fact that "in 1985, Manitoba had more people using home care than it had in nursing homes" (Havens, 1993a: 3, 4, 9).

According to the latest data reported, 6.7% of Manitobans over 65 use home care services and 5.8% are in personal care homes. A remaining 0.5% are awaiting placement in chronic hospitals or personal care homes (Maynard, 1994: 73)

The shift to community care was fully endorsed as part of the provincial health action plan (Manitoba Health, 1992: 14 -16). Within this scheme, elderly people became consumers/partners with needs best served by community based services.

Language barriers affecting access to information on senior services have also been acknowledged by the provincial government. An informative handbook

describing services available, printed in official and non official languages, has been distributed annually and updated every three years (Manitoba Health / Council on Aging, 1993).

The dominant influence of the institutional component of the continuum of care and the limited support for health promotion initiatives in Manitoba has been recognized (Havens, 1993b: 3; Manitoba Health Advisory Network, 1989). In that context, the implementation of a health promotion program with ethnic elderly newcomers as its target population, may well be regarded as a recognition of the legitimacy of the multicultural health discourse proposals.

6.3 A Multicultural Health Project

Another common pattern of urban settlement in North America, has been the concentration of new immigrants in inner city communities. In response to this pattern, innovative health promotion programs targeting elderly inner city residents has been developed (Wechsler and Minkler, 1986). Inspired by the success of the Tenderloin Seniors Outreach Project (TSOP) in San Francisco (USA), Discover Choices, a federally funded health promotion program assisted in the development of Ethos in downtown Winnipeg. The initiative was legitimated by their sponsors using the official construction of the ethnic elderly as a group with special needs, isolated and hard to reach (Hurd and Sturley, 1990: 7).

6.4 Multiculturalism Policy

In Manitoba, official support for multiculturalism may be traced to 1970 (Task Force on Multiculturalism, 1988). Many initiatives which developed during the following two decades opened the path to the adoption of a multicultural policy by the provincial government in 1990 (Manitoba Multicultural Secretariat, 1990).

As it happened at the federal level, on the ocassion of a conference evaluating tmulticulturalism policy in the last twenty years in Manitoba, the governmental multicultural rhetoric has been challenged by another historical interpretation:

> The history of racism, discrimination, contempt for immigrants from other that British cultures combined with differential legal treatment, including the denial or removal of the right to vote, has been transformed into a multicultural mythology of the contribution of the waves of immigrants to the development of Canadian values, institutions and policies (Debicki, 1992: 31).

6.5 Institutional Frame

In 1988, Dr. Joseph Du, a physician practicing in Winnipeg and provincial representative on the recently formed Canadian Council for Multicultural Health, was joined by a group of professionals concerned with the promotion of multicultural health issues. In November of that year, they formed the interim Manitoba Council for Multicultural Health. Following that event a consultation process which was "time consuming but vital" took place (Manitoba Council for Multicultural Health Inc., (MCMH) 1990; key informant interview, 1994).

"The working committee was able to develop a strong consensus regarding the core issues involved in developing a participatory model for community based discussions on multicultural health" (MCMH, 1990: 2). The final outcomes were the planning of a Conference which was held on February 1989 in Winnipeg and the subsequent establishment of the Manitoba Council for Multicultural Health. During that Conference, a Workshop on ethnicity and aging was developed. Participants' questions and recommendations revealed the emergence of a multicultural health discourse at the provincial level along the lines of the "official" themes and constructs (MCMH, 1989).

Other provincial organizations have also showed interest in multicultural health issues. Among these, the Manitoba Intercultural Council endorsed in 1987, a proposal by the Mental Health Association of Winnipeg to establish a specialized service for immigrants and refugees with personnel from their communities of origin (Manitoba Intercultural Council, 1987: 5).

6.6 Constructing Newcomers' Identity

The main source to analyse the Manitoba version of the official discourse on ethnic aging was a needs assessment study conducted in Winnipeg, shortly after the adoption of the Manitoba Multiculuturalism Act in 1990. Given the nature of the institutions which provided support for that project, the text may be regarded as an official discursive construction of the elderly newcomers' world in Manitoba (Age and

Opportunity, 1992). Since this discourse shares the main themes and constructs described above, the following paragraphs focus on its specific features.

6.6.1 Service Initiative

This discourse presents itself as the product of a historical institutional commitment to serve an ethnically heterogeneous elderly population in Manitoba. Thus, current interest in implementing multicultural health proposals is legitimized as part of a permanent service philosophy. The assessment of elderly newcomers' needs is rationalized, however, using core constructs of the multicultural health vocabulary. It is promoted as a necessary stage for providing culturally sensitive programs and services, identifying barriers and improving accessibility. It also intends to provide assistance to other social and community agencies, and to suggest new culturally appropriate programs and services (Age and Opportunity, 1992).

6.6.2 Target Communities

The discourse acknowledged the fact that the larger number of recent immigrants to Manitoba came from Asia, by focusing on elderly members of Filipino, Chinese, East Indian and Vietnamese communities (Ibid: 6).These newcomers were constituted as being linguistic and "visible minorities" (Ibid: 14, 15).

6.6.3 Competing Perspectives

Elderly newcomers' assessment of their aging experiences in Winnipeg were constructed as depending on the convergence of newcomers', key informants from target communities and social service providers' perspectives (Ibid: 14).

Information on ethnic aging, was sought with the assumption that it is problematic, that there are linguistic and cultural barriers hindering service provision. These should be identified as well as the service providers' awareness on newcomer's problems. Finding appropriate approaches to overcome these barriers is one of the explicit goals of this discourse (Ibid: 13, 14). The newcomers' problematic aging was constituted as conformed by nine "predetermined problem areas". These were: family, language, employment, finances, housing, transportation, health (both physical and mental), social and recreational activities and information on social services (Ibid: 18).

Perspectives on newcomers' needs were presented as initially divergent:

> Whereas the focus group participants emphasized the areas of language, finances and transportation, key informants said that employment was one of the most important areas of concern. The services providers tended to emphasize the area of information-gathering, more than transportation and language difficulties (Ibid: 75).

Despite these different opinions, consensus was obtained around the best service model:

> All three groups were similar in the ways suggested to improve the quality of service for ethnic newcomers seniors. A bridging method, in which the ethnic newcomer senior would gain access to the services of the mainstream agencies, but within the relative comfort and familiarity of a setting in which they are free to speak their own language and interact with same-group peers, was emphasized by all three groups (Ibid: 76).

7. Conclusions

The analysis of the official multicultural discourse on ethnic aging provided relevant data to identify the main features of its normalizing aim.

It has constituted its object of study by two sequential processes. The first oriented towards a differentiation of the ethnic elderly from the rest of the aged population on the basis of unmet special needs. The second aimed at "normalizing" the ethnic elderly in terms of proposals for "aging well".

The originality of the Manitoba version, resides in the process of normalizing ethnic newcomers' aging. An initial stage of controversial perspectives ended in a standardized strategy to manage diversity. By orienting the assessment of needs towards different problematic areas to be ranked by several stakeholders, the discourse constructed the setting of priorities as a controversial issue. However, since needs exist to be served, it legitimized the bridging model by presenting it as being subscribed by all the parties. Professional support for this type of model has been promoted in the social service literature, as well (Nyman, 1991 : 42; Matsuoka and Sorensen, 1991).

Professional control is legitimized through the construct of barriers to access and underutilization of health and social services. The practice of cross cultural care ensures the professional management of the process of integration of the ethnic elderly into the health and social care system.

The multicultural health discourse constructed a narrative of exclusion of minorities by a mainstream system. The plot is developed around the existence of

"barriers". They are constituted as being rooted in individual and system characteristics. Information, referral, facilitation, interpretation, outreach to the individual in the ethnic community, needs assessments, surveys, multicultural courses, are part of the technological repertoire to promote "aging well" among the ethnic elderly.

The recognition that alternative health care practices are as valid as alternatives to those dominant in western countries, may legitimize the expansion of the health service market to address ethnic differences.

The identification of the conditions of emergence and the articulation with other discourses, revealed that the official discourse constituted its subject drawing upon pre-existing classification schemes . Among other dominant discursive influences, the "discourse on needs" and the "discourse on risk" have particular relevance. The first is inherent to the practice of bio-politics which aims at maximizing the use of bodies by determining their needs in terms of consumption of services. From that perspective the official multicultural health discourse contributes to "establish a hold on bodies" (Racevskis, 1983: 98). With respect to the "discourse on risk", several studies have documented and analysed the particular interests that clinicians and geriatricians have defended through such discursive practices (Kaufert and O'Neil, 1993, Kaufmann, 1994). These studies and Foucault's work (1980) suggest that the identification of certain individuals as having special needs or as being at high risk, makes them amenable for control and correction.

The official narrative includes proposals for systemic changes and for ethnic elderly participation. There is an inherent contradiction in a discourse which suggests that a "special needs" group can participate effectively (i.e., with authonomy and authority) in changing the health care system.

Some of the limitations of the discourse originate in the discourses from which it borrowed its conceptual structure. Immersed into a preexistent system which constructed the elderly as a medical problem (Estes and Byney, 1989) and a dependent social group (Katz, 1993) it is difficult for the official multicultural discourse to move beyond these boundaries when adding the ethnic factor. Further, the emphasis on cultural differences blurrs the relevance of socioeconomic determinants of health. However, forces drawing attention to issues of poverty and inequality were identified inside that discourse. They may be regarded as potential sources for discursive change.

Ambiguous conceptualization and unrealistic expectations may conceal the official multicultural health's action orientation.

7.1 Role of the Official Discourse

The constructs, themes and rationale described above give support to argue that the official multicultural health discourse is contained by the dominant medical discourse which credits it with legitimacy and support for its practices.

With respect to the discourse of gerontology, the official muulticultural discourse on aging, adds the emphasis on cultural differences as another dimension to

be included in the appropriate management of aged bodies. What Green (1994: 194) says regarding the political economy of aging approach, may well be applied to our official multicultural discourse on aging: it "feeds on gerontology and, in ingesting its accommodating host, becomes part of what it feeds on."

Underlying the issue of access, are the assumptions that "problems" are best resolved through the application of biomedical solutions and that any increment in the use of services should avoid duplication in service provision. The discourse's action orientation of contributing to the demand for health and social services which benefits those in charge of service provision seems to be ensured.

The following chapter enriches the previous discourse analysis with the description of the perspective of health and social service professionals working in Winnipeg.

CHAPTER 4: MULTICULTURAL HEALTH DISCOURSE IN ACTION: THE PROFESSIONAL DISCOURSE

In order to provide a context for the description of the professional discourse, this chapter begins with a discussion of the role of expertise in contemporary societies. It follows with a discussion on the meaning of cross cultural training. Finally, the main themes and issues identified in the professional discourse are described and related to the official multicultural discourse on aging.

1. Multicultural Knowledge / Power

Foucault's works (1977, 1978, 1980) draw attention to the role of professionals in the so called welfare state. Provided with privileged bodies of knowledge they identify which behaviours are problematic and by what norms. Rather than agents of change, he described them as agents of normalization. who, by defining anomalies and providing therapeutic procedures, excercise control over bodies . They perform instrumental roles for the production of "well "adjusted individuals. The development of new technologies of "discipline", linked to both the emergence of a new "clinical gaze" (Foucault, 1975) and the human sciences, at the end of the eighteen century, has supported these normalizing tasks (Hewitt, 1983: 74).

In Manitoba, policy makers have assigned health and "other care providers" the role of helping individuals "to choose effective services" and to receive a "realistic and timely access" to them (Manitoba Health, 1992: 3).

Health and social service professionals have also been identified by the official multicultural health discourse as key protagonists for the implementation of institutional change and the delivery of culturally sensitive services (Canadian Council on Multicultural Health (CCMH), 1990: 12).

Among health professionals, nurses have been pioneers when in 1974 they created the Transcultural Nursing society. Subsequent undergraduate and post-graduate nursing programs, with particular emphasis on cultural sensitivity and transcultural techniques, were implemented in most of the Canadian provinces (Masi, 1988 : 2176).

The recognition of the legitimacy of the "official" multicultural discourse at the academic level, continued when some Canadian universities included multicultural content in their curricula. The objective was to "foster the emergence of a generation of culturally sensitive" professionals (Lecky 1992 : 2211; Multiculturalism and Citizenship Canada, 1992: 9). Hospitals located in "multicultural" cities such as Montreal, Toronto and Vancouver were also receptive to the multicultural philosophy and implemented projects for organizational change. Their main purposes were to improve service accessibility with language and cultural barriers minimized. In British Columbia, twenty two health care agencies joined efforts and in 1995 are embarked on a two year project to develop multicultural organizational change. In Richmond,

B.C., the General Hospital has implemented health education programs which are delivered in the newcomers' mother tongues. In Winnipeg, both the Health Sciences and St. Boniface General Hospitals keep extensive lists of staff who speak different languages and can assist patients facing language barriers. The International Centre of Winnipeg also provides interpreters when necessary. The recognition of credentials of the foreign trained professionals is one of the multicultural health topics still waiting for a rational solution (Manitoba Council on Multicultural Health Inc., 1989).

While some multicultural health advocates have insisted on the need to integrate multicultural topics throughout the entire curricula (Lecky 1992: 2212), the usual practice at the university level has been to offer introductory courses. (Toumishey 1993: 112). The risks of such short training are great and may lead to a "tendency to think of cultural beliefs as just the thrills and trimmings which get in the way of the real business of modern health care, namely the repair of sick bodies" (Lock 1993: 141). A basic conceptual framework proposed by Toumishey (1993: 116) for a multicultural health introductory course included constructs such as "culture/cultures; values and beliefs; intercultural communication; health seeking behaviour, health care options; therapeutic interactions; professional and client responses; therapeutic interventions, complementary behaviour and desired outcomes."

One of the main objectives pursued with such type of courses is that health practitioners became aware that theirs as well as their clients' cultures influence behaviours (Toumishey 1993: 113). Lock (1993) analysed in detail the many issues

which are involved in the implementation of serious multicultural health training. Among them, she singled out "the culture of analytical medicine", the traditional role of health care professionals as "decoders" of patient complaints to be placed into "named diseases" and the free use of key concepts such as culture, race, ethnicity, class and gender without an appropriate understanding of their "multiple meanings and implicit values" (Ibid: 113, 141, 143). Extending this line of thought, we should consider the possibility that these categories may be used as tools to regulate the quality of life of the population, its health , security and stability (Hewitt 1983: 67).

2. Professional Discourse in Winnipeg

The set of statements used by the professionals to define and describe the elderly newcomers' problematic and relevant multicultural issues in Manitoba conformed to the "ideological systems" (Kress, 1985: 28) of the society in which they are practicing as well as those of the contemporary biomedical knowledge and practice (Lock 1988: 3; Harwood,1985: 7).

Meanings and values of these systems permeate their personal experiences, their academic training as well as the existing health and social policies on aging. Biomedicine has been characterized as a "culture" in search of disease and not health, with a preference for limiting the definition of problems to measurable, biological abnormalities which can be handled by a technological fix (Harwood, 1985: 7).

2.1 Multicultural Awareness and Agendas

Although health and social service providers shared a common perspective as "experts" trained in North America, different agendas and levels of awareness were identified. Sources of data were both the literature and their discourse reconstructed from the interviews.

Since the multicultural health movement in Manitoba is a relatively recent phenomenon, it should not be surprising that among the fifteen professionals who agreed to participate in this study, only three were directly involved in the implementation of multicultural health proposals. These informants seemed to have a good knowledge of the main constructs and issues of the official multicultural approach to health care in Canada. Twelve received some information on multicultural health issues through their academic training. Among these, four were serving ethnospecific groups with clients coming from the former Soviet Union, Laos, El Salvador, Chile and Nicaragua.

2.1.1. Medicine, Power and Multiculturalism

A deconstructive reading of the rhetoric used to convince physicians of the convenience of being culturally sensitive shows that it is greatly based on terms of preservation of their traditional roles and power.

Two quotes taken from the literature are illustrative in that respect:

> Doctors must understand different cultural needs and norms if we are to maintain our role as respected consultants (Masi, 1989: 1087).

> If cultural barriers build a wall between doctors and the community, the community will seek assistance from other types of practitioners who are more culturally sensitive (Masi, 1989: 1087).

Among social service professionals different levels of awareness were found . While nowadays there is a trend to promote a "bridging model" to overcome access barriers (Age and Opportunity Report, 1992; Nyman, 1992; Matsuoka and Sorenson, 1992), many social service professionals working in voluntary organizations in Toronto and Winnipeg seemed unaware of these problems (Doyle and Visano, 1987; Age and Opportunity Report, 1992). With reference to the Winnipeg situation, one of the gerontologists interviewed, with a long experience in a voluntary seniors' organization, mentioned that most of the social service professionals that they contacted lacked experience with ethnic elderly clients. Her evaluation was confirmed when selecting the sample of professionals. It took a long time to find health and social service professionals with direct experience on these matters to interview.

2.2 Main Themes

The sample of professionals included five men and ten women who were working in the health and social service field in Winnipeg. Their ages ranged from twenty five to eighty one years. Three of them were born outside Canada.

The following are the main themes identified in their discourse.

2.2.1 Dependence and Expectations

Commonalties and differences between "mainstream" and ethnic elderly newcomers were constructed around the concept of independence. While the basic needs were considered to be the same for both categories of elderly people, ethnic newcomers were characterized as "more dependent" on their children and with different expectations based on a different system of beliefs and values. These included to be respected and taken care of by their families. One of the informants characterized the process through which elderly newcomers can become "independent" as slow. Financial dependency was emphasized by two professionals involved in the development of programs for seniors:

> The most important problem is that they are dependent on their children. They are anxious to get their pensions, the children do not realize that their parents need money to go out, that they need to buy a bus pass for them. Maybe their children need the money to send their kids to ethnic-religious private schools (Multicultural program coordinator).

> One of the problems in the newcomers families is the role reversal: parents are no more those who have money, here they are dependent on their children and as they feel that respect is related to money, these elderly feel a lack of respect, they feel they lost their previous status. This produces usually anger (Mainstream seniors' organization director).

One professional practicing in a long term facility introduced the idea of "levels of dependency" and categories inside the elderly. The "well elderly" represent "eighty five percent" of the aged population and those who are "really dependent" are only two percent of that aged category. He was the only one who recognized that problems of communication exist also with the so called mainstream elderly. He commented that in a "wellness centre" where he was an advisor, aged people complained that their doctors did not listen to all their worries and concerns.

Some of the social service professionals interviewed seemed sincerely worried because they perceived the newcomers expectations in terms of what Hazan (1994:15) has defined as a "mass of material exigencies". They felt they should help to satisfy these expectations in the context of a shrinking labour market and scarce agency resources.

Another defined the immigration process as rewarding only for second generations, suggesting that elderly newcomers have no other alternative but to fight for their survival.

2.2.2 Communication

All the professionals agreed that language barriers were the main problem affecting all aspects of the ethnic seniors' lives as well as the quality of the service provided. According to the professional evaluations, the lack of English proficiency generates "depression", "inner -direction", "loneliness", and hinders their opportunities to find a job. Treatments had to be slowed down in order to address language barriers

and sometimes compliance was affected. Transportation to professional offices became a serious problem because the elderly newcomers could not read the names of the streets.

Some professionals mentioned that they tried to overcome the patient's language barriers through the help of a bilingual staff member. Among this group, one social service provider mentioned that her agency developed informative material on resources available in Manitoba as well as income tax clinics for newcomers in their mother tongues. One mentioned the International Centre as a resource to ask for interpreters. One key informant was concerned about the fact that people did not understand the difference between translation and interpretation. She emphasized the need to promote the use of professional interpreters who not only know the language but also the patient's cultural values and beliefs.

One professional brought to my attention the fact that ethnic elderly who have lived for decades in Canada still do not speak English because they have lived and worked inside their ethnic communities.

2.2.3 Multicultural Health Policy

One informant commented on the lack of political will to implement a multicultural health policy in Manitoba. She came to that conclusion when a document prepared in May 1991 by the Advisory Committee on Multicultural Health, making suggestions to the Manitoba Health Minister was still waiting to be published in June 1994.

One professional, involved in settlement work, was concerned by an official policy which denies free access to English as a Second Language classes to those who become Canadian citizens. She suggested that "literacy should be a right".

2.2.4 Funding

Two informants who were dependent on short term grants to develop services to newcomers, were concerned with the uncertainty generated by current modalities of program funding.

> We are struggling to survive, to compete with other organizations, some of these seniors do not have the skills to go to other organizations. But the luck is sometimes on the side of the good simple people that are trying to survive, so you never know... (Multicultural program coordinator).

One representative of a government agency that used to provide funds for a multicultural seniors' organization, commented on the existence of competing criteria for assigning funds to multicultural programs in this province. She interpreted this decision as meaning that financial support was cut because the government did not think that this group was really doing a good job. In that case she commented that they do not need "to pay for votes" as did some other government agencies.

2.2.5 Foreign Credentials

Two professionals mentioned the problem of the accreditation of foreign credentials. Professionals trained outside Canada realize that their credentials will not

be recognized or face the reality that their skills are either obsolete or may be useless for the employment market in Winnipeg. The foreign trained professionals affected by these facts are visualized as suffering frustration and depression: "The employment they can find is far below the level either of their expertise or their skills" (Settlement officer).

> We do not have a system in Manitoba of really giving people the credit for what they know and what they have done and some of them give up in disgust and can never practice their medicine . Some of them go back to their home or go back to the bottom of the pile and start all over again which must be very hard (Multicultural health consultant).

2.2.6 Family Relationships

Some informants mentioned that intergenerational conflicts are very common. Given the fact that most of the elderly came to Canada as sponsored immigrants, usually they live with their children and grandchildren. Lack of "vital space" in those homes and different lifestyles generate conditions for conflicts to arise. There is a perception that some children did not honour their sponsorship contracts and do not care for their parents. One professional commented that elder abuse and neglect were becoming common issues among ethnic groups. Two informants mentioned the fact that some elderly newcomers do not have opportunities to learn English because as soon as they arrive they are assigned babysitting tasks.

2.2.7 "Old "and "New" Ethnic Groups

The issue of inter ethnic cooperation between "old" ethnic groups and newcomers from Third World countries was mentioned only by one health professional who evaluated it as the result of a "lack of interest" from those who came first. Some professionals working for ethnospecific organizations mentioned that solidarity with the newcomers was expressed by the "old" ethnics through invitations to participate in social activities.

2.2.7 Education and Information

All of these informants shared the belief that education and appropriate information are crucial for the integration of the elderly to Canadian lifestyles. One respondent mentioned that it was important to increase the public and professionals' awareness of the importance of culture in their own and their client's lives. She emphasized that culture affects not only immigrants or refugees: "Everybody has a culture and it affects the way they respond when they are sick." Only one informant commented on the need to fight against "stereotypes and recipes used to address problems of ethnic people". She evaluated multicultural education as either "almost non existent" in some settings or " full of misinformation" in others , which means that it still has a "long way to go".

2.2.8 Programs

With regard to the implementation of programs, ethnic newcomers were defined as "hard to reach". One key informant recognized the fact that community leaders sometimes do not represent either the interests or the priorities of their ethnic communities, but seniors' organizations have to rely on them as the only available contact.

Two professionals working in voluntary organizations identified seniors centers as appropriate places where ethnic elderly newcomers can learn how to adapt to the host society. One of these professionals mentioned that it was important to respect the preferences of each ethnic community regarding places and organizational styles. As examples in Winnipeg, she mentioned that while the Chinese seniors seemed happy with the services provided by the West End Senior Centre, the Punjabi speaking elderly wanted to have their own organization where religious practices are addressed, and asked Age and Opportunity to provide them with resources to develop their own project.

2.2.9 Health Beliefs and Practices

Professionals working with Indochinese and Punjabi elderly mentioned that in both groups, it is a common practice to use traditional remedies and when "these did not work" then they would go to a doctor who speaks their mother tongue. Some professionals acknowledged that "home remedies" are very useful and that this lay

knowledge should be preserved and improved through health promotion and education.

One physician mentioned that Spanish speaking elderly patients used to come to his office with vitamin injections in their pockets because they thought that these were more effective than pills. He also mentioned that some of these patients believed that the cold weather "caused" their arthritis. Comparing services sought by both groups, he mentioned that while Canadians used sometimes go to chiropractors newcomers did not.

2.2.10 Risks factors

Three informants specifically mentioned the ressetlement process as a generator of "risk factors" for the development of obesity and diabetes. Among these, they identified the shopping habits, the abundance of food in the supermarkets, the "stress" related to financial problems as well as the lack of exercise due to cold weather or the incentive "to go out to work" as the most important factors.

No other differences in type of diseases or conditions were acknowledged between mainstream and elderly newcomers.

2.2.11 Geographical Disorientation

One informant introduced a relatively unusual appreciation on the effects of the new environment:

> The elderly, specially those coming from the South hemisphere, lose their sense of orientation. This is so because of a very simple reason. In Buenos Aires or in Santiago of Chile, the sun is placed in the North while here it is located towards the South. So here they feel that their "magnetic needle" has been changed and they find difficulties in order to orientate themselves. Also they are disorientated by the fact that the days are so short in winter and so long in summer with so much light.

2.2.12 Gender Issues

Two professionals mentioned the strong gender differentiation that they observed among certain ethnic groups and especially the low status of women. A program coordinator commented on some Hindu men during a party:

"They treat women differently, they are used to eating first".

2.2.13 Access to Mainstream Services

The common practice of elderly newcomers to look for services provided in their mother tongues received different evaluations. While one physician accepted it since he was one of those who served an ethnic specific clientele, two nurses perceived the phenomenon differently. One of them accepted that,

> They always try to go to a doctor of their ethnic community, and the same is applicable to other service providers: lawyer, pharmacist, dentist. They like to speak in their first language and therefore professional services are sought inside their ethnic communities.

The other commented with concern:

> I understand that people are doing that but I would like to think that if I have breast cancer, I would be able to go to the best doctor regardless of his nationality. So forcing people into these enclaves and 'ghettoizing` them medically, is a system failure.

3. Conclusions

The identification of these main themes in the professional discourse reveals that although informants differ in their levels of awareness on multicultural health issues, all of them share a common construction of the elderly newcomers as problematic. The impact of that definition should be evaluated in the frame of the status assigned to expert discourse in contemporary societies. Given the current "general politics of truth", professionals are trained to determine "what counts as true" (Foucault, 1984: 73). Their discourse is based upon the assumption that expert knowledge is a close approximation to truth about what exists in the objective world. This knowledge is the means by which science constructs and manages human problems.

The many problems mentioned by the professionals operationalizes the official construction of the ethnic elderly as a group with special needs. In the professional discourse is found expression of the categories of the "discourse on risk", the constructs of barriers and the issues of access. Financial dependence is mentioned as part of a broad definition of dependency. It is constructed as a family problem and a feature of differentiation from the mainstream. Its origin is disconnected from the social context,

and regarded by some professionals as the inevitable price of immigration in senior years. The implementation of programs is also constituted as difficult due to the absence of political will, lack of appropriate funding and target population characteristics.

With these themes and a rationale which disregards the importance of structural factors, the professional discourse legitimizes the official multicultural health discursive constructions. Again, while expert discourse and practices ensure professional intervention, the benefits for the population whose needs it declares to serve remain uncertain.

The following chapter broadens the scope of this discussion with the description of the main themes identified in the elderly newcomers' discourse.

CHAPTER 5: THE ELDERLY NEWCOMERS DISCOURSE

In this chapter the sociodemographic characteristics and the needs, worries and concerns of the elderly newcomers aging in Winnipeg are described. The relevant themes and rationale of their discourse interpreted from their narratives are identified.

1. Introduction

Eight of the nine members who were interviewed met the initial definition of "newcomer", that is, being fifty five years of age or over and a resident of Canada for a decade or less. When one of the informants reported that he was fifty years old, "retired" and enjoying the activities of one of the seniors' groups, his case became a clear instance of the subjective nature of age categories. He was then included in the sample.

The first seven subjects presented in the tables (see Appendix G) were members of the multicultural seniors' organization (Ethos) while the remaining two belonged to the mainstream seniors' centre.

The data were collected through narratives which focused on some relevant conditions and events from the respondents' lives. These were emerging along a temporal continuum constructed as a "before - preparing - after immigration" process of continuities and changes (see Appendix B).

In the following paragraphs elderly newcomers main sociodemographic features are presented. These provide the basic information to understand their backgrounds and motives to immigrate to Canada. Next, the main themes of their discourse are introduced.

2. Demographic Characteristics

The nine interviewees, four women and five men, were born in six different countries: El Salvador, Nicaragua, China, Vietnam, India and Philippines and ranged in age from 50 to 74 years (Apendix G - Table 1G). Although women outnumber men in the 65+ group in Canada and in Manitoba (Statistics Canada, 1993) the reverse occurred in this non probabilistic sample. This may be, in part, determined by a cultural pattern among these newcomers which promote male participation in "out of home" activities.

All of them lived in the community and would be defined according to the gerontological discourse as "young well elderly" individuals.

Three newcomers who were born in Philippines, two females and one male, had the best command of English of all the sample. One man from El Salvador and a woman from Nicaragua were still at a 'beginners" level in their command of English as well as the two Cantonese-speaking men of the mainstream senior centre. Among the two Punjabi speaking members, while the woman could communicate in English due

to her former educational level and time of residence in Canada, the man, with only six months in this country, was striving to put together some sentences.

Eight of the informants belong to extended families with sizes ranging from four to sixteen members. Of the four women, one was still married, one was single, another was a widow and the fourth was separated. All the men were married, one of them three times.

Age at marriage ranged from twenty to twenty seven years and the number of children of those marriages ranged from two to ten. Two seniors had survived two of their children respectively (Appendix G - Table 2G).

Only one had no previous experience living in urban areas. Most of them used to live in comfortable houses with running water and appliances before moving to Canada. Only two of them did not have refrigerators but it was because electrical power was not available in rural areas (Appendix G - Table 3G). Most of the houses in which they lived in their home countries differed from the ones they are living in now. Those in their former home countries were made of bricks and in one case included a galvanized iron roof. One of the informants built his first house, in his former home country by himself and the second one with the help of his sons after coming back from jobs, schools and during the weekends. Another woman from the Philippines commented on the vulnerability of the houses in Winnipeg: "they would not survive the strong winds of my home country". None of them complained of their actual places of residence.

3. Length of Residence in Canada

Their time of residence ranged from seven months to nine and a half years which provided a sample of seniors in different stages in the settlement process (Appendix G - Table 4G).

4. Status, Sponsorship and Living Arrangements

Regardless of their motives for leaving their former home countries, these elderly newcomers referred to immigration as a process of intergenerational caring and personal improvement. They came to Canada because they loved their children or wanted to take care of an elderly parent, but also because they envisioned Canada as a caring and peaceful country (Appendix G - Table 6G).

Most of them were living in the same house with those who sponsored them. Living arrangements were based on pragmatic decisions such as helping with the care of grandchildren or saving the money which otherwise would be used to pay a rent.

At the time of this study, most of them were landed immigrants (Appendix G - Table 5G). One respondent strongly refused to become a Canadian citizen. She made up her mind based on her feelings that "in India everybody loves each other", while in Canada her daughter was abused by her husband and became a single mother with two children. She felt that her daughter could not improve her income and attrubuted this to discriminatory practices in the office in which she worked. Although this

informant described with detail the way in which the marriage was arranged and that her daughter travelled from India to marry a man whom she never met before, she blamed her son in law for having political ambitions and being disconnected from his "good" family of origin, who lives in England. She also complained about having to live with her daughter. According to the Hindu tradition, she would rather live with her son who had established his family in another Canadian city .

None of them mentioned any serious problems in the relationships with their sponsors. They usually referred with pride to their children's and grandchildren's accomplishments.

5. Previous Knowledge About Canadian Lifestyles

Most of them acknowledged that they had a very slight knowledge of Canadian lifestyles before immigration (Appendix G - Table 7G). Since all of them came from countries with mild weather, one of the most important adaptations was to learn how to dress and how to walk on slippery streets. A very common coping strategy was mentioned by the youngest woman:

> The weather is terrible specially in winter. But we are here already and we have to accept it and we have to try to do something about it. There are wonderful things about the winter that we do not have in my country, because if you are watching the snow flakes falling you wonder how the Lord made such a thing.

6. Gender and Socio-economic Status

The educational level among these seniors ranged from grade three to second year of college. Two of the four women had paid jobs in their former home countries in traditionally female professions such as dressmaker and teacher. The other two have always been homemakers. Among the men, two worked in farming activities, another as a policeman and the remaining two owned small businesses (Appendix G - Table 8G).

Although they had worked in their former home countries, here they have only a limited income and were anxiously waiting to qualify for the Old Age Pension benefits. They mentioned as usual sources of income "the 55 plus" government allowance and their children's financial help. Only one man mentioned "savings" as a regular source of income (Appendix G - Table 9G).

Their plight and related feelings was expressed by one of them:

> I used to be very busy in my home country and I would like to work here too. Sometimes we say: "better we should go back to El Salvador". There we could work, but our kids said to us: "why are you going to lose your lives working there if we feel the obligation to help you and will have to send you money there anyway? Instead of sending the money there, it is better for you to stay here with us". We are here for their safety. If it was not for the war** and the kids we would not apply to come to Canada. At our age we had not major problems there. The problem existed for the young people.

**informant refers to the civil war in El Salvador.

One of the youngest female seniors described common feelings of newcomers who are working in jobs which are not directly related to their former education and training. She worked during more than twenty years as a teacher and now in Winnipeg she is working as a home care aid:

> I am working, you have to work. I do not really want to stay idle. I am an active person and I am independent too and I do not want to depend on somebody, still I am young. I am skinny but strong. It is a part of life that you have to grow and you have to improve yourself and share with others.

After being asked about her feelings regarding her job she replied:

> I like it very much but I cannot use my skills and be what I really am. I am worried about my future. I am a practical art teacher. I used to teach stenotype secretarial and crafts; I know how to type but I have to undergo some training on the computer.

Most of the respondents were looking for some kind of paid job. I was surprised when about to start my observations at Ethos, I was approached by a seventy four year old lady wearing a traditional Hindu dress, asking for help to find a job.

These real facts affecting elderly newcomers in Winnipeg give support to those who are advocating flexible and not compulsory retirement policies, to those who recommend shortening the period that newcomers have to wait to qualify for the Old Age Pension benefits, and to those who are marketing the benefits of hiring mature employees.

7. Social Life and Activities Before Immigration

Most of these seniors, with the exception of one confessed "workaholic" and a Spanish speaking female who had to move from one country to another in order to save her life, enjoyed active social lives and were involved in community programs in their former home countries (Appendix G - Table 10G). These findings give some support to the hypothesis which relate previous social involvement with future participation in seniors' groups (Jerrome, 1992: 17; Taietz, 1976: 222; Ward, 1979: 444). They also suggest that when social involvement is highly valued, "barriers" to access may be not a relevant issue.

8. Care of the Elderly

All these newcomers identified families as being the primary source of support for their elderly members in their former communities and institutionalization as an exceptional practice (Appendix G - Table 11G). All their narratives emphasized that older people in their former home countries are highly respected and cared for by their children. Based on these previous experiences they may well expect that their children will care for them and disapprove of institutions as an alternative to family caregiving practices. These findings coincide with recent definitions of the family as " 'the first line of defense` against the onset of serious problems among older people" (Gelfand

1994:112). One of the informants commented that the large number of children in the families of his former home country guaranteed that somebody will take care of an elderly parent.

All of them considered filial responsibility as a core value. One of the younger members of the multicultural group who is caring for her old mother at home and also works for a home care program for elderly citizens in Winnipeg, described her feelings on this topic as follows:

> The respect given to our elders is different. We do not even place our parents in nursing homes; we take care of them. Our country is very family oriented. That is why we do not have much problems in our country looking after our family. For example, I am living with my mother and my sister, and when I am working somebody looks after my mother. We share the responsibilities.
>
> Do you think this is because you are a special family or because it is the common way to do things?
>
> This is the way; even our relatives, if nobody in my family can take care of my mother because we are busy, our relatives, aunts, uncles, nieces, nephews will look after my mom.

She completed that opinion with her view of the Canadian born elderly:

> When they are old and they want to live by themselves then they have the problem of loneliness, because sometimes they do not have even relatives. It is too boring to live by yourself not having anybody to talk to; isolation and loneliness is a problem. It is not easy. This is their life in Canada.

9. Food Habits

Most of them had to adapt to new shopping habits in Winnipeg and to new patterns of socio-economic transactions (Appendix G - Table 13G). On one hand, this saved them time. However, it resulted in the loss of all the rich social interactions which were involved in the practices of shopping in open public markets in their countries of origin. The observations of different practices attached to the preparation and consumption of "ethnic" food in both seniors groups revealed its multidimentional meaning: a cultural identity trait for these seniors, was also instrumental as a programmatic device for the promotion of inter-ethnic interactions.

It could also be recognized through some of the elderly narratives how the expert discourse on " health promotion", socially marketed through a rhetoric which suggests "life style changes", had begun to affect the everyday lives of these newcomers. One of them mentioned having "improved" her diet in Winnipeg by eating more vegetables and fruits but she also mentioned that it was because she did not "like to eat frozen meat". She also mentioned that walking was part of her strategy to maintain her good health.

"Dietary acculturation" has been identified "as one of the many behavioral consequences of immigration" (Krondle and Lan 1993a: 189). The meaning as well as the different kind of changes involved in adapting to Canadian lifestyles were described in detail by one of the Spanish speaking newcomers. Most of his life he lived in a rural area. There, he and his family used to cultivate corn and rice completing they

daily diet with fish. As they did not have a refrigerator they used to dry the meat. Later on in his life, when he moved to the capital city, they enjoyed running water and electrical power. They bought a refrigerator and began to buy food in the public market. Other changes resulted when his wife began to work and they had enough money to buy what they needed. After they immigrated, one of the big changes for him was to get used to the abundance and variety of food available. He began to gain weight and at the time of this study he was on a "diet" which include a good quantity of fruits and vegetables following his doctor's recommendations.

Meanwhile, other elderly newcomers in the same seniors' group, seemed happy with their former food habits. Observations at lunch times and during the Summer Camp activities, suggested that elderly newcomers from India maintain a strong adherence to their food habits. Hindu women used to eat "chapaties" (pancakes filled with vegetables) accompanied with tea while some of their grandchildren were eating hot dogs and drinking soft drinks. All of these items were brought from their homes showing the easy coexistence under the same roof of "eastern" and "western" food habits and preferences. While some official multicultural texts mention that in some cases conflicts arise among "traditional" parents and more "assimilated" children and grandchildren, in this sample there was a pacific coexistence among "eastern" and "western' food preferences. It may well symbolize the existence of peaceful intergenerational relationships among these individuals outside the boundaries of this group.

The differences observed among ethnic groups in adapting to the food habits of the host society, have been explained as being dependent not only on favorable circumstances for assimilation but also on the influences exerted on individuals by traditions and family values (Krondle and Lan, 1993a: 190).

10. Perceptions of Health Status

Most of the respondents indicated that they felt in "good health" with two of them emphasizing: in "very good health" (Appendix G - Table 12G). It was identified through their narratives the internalization of core societal values such as the association between youth and good health. The biomedical assumption that health is "a project for the self to work on" (Gordon 1988: 36) found expression in the elderly discourse, when some of them associated their good health with past "healthy" practices such as "weight lifting", "body building" and "daily exercise".

11. Help Seeking Behaviour

It is a generalized practice among these newcomers to seek health care from a physician who speaks their mother tongue (Appendix G - Table 14G). This health seeking behaviour has been interpreted in the literature as a problem of access motivated by language and cultural barriers which finally ends in the underutilization of "western health services". (Age & Opportunity Report, 1992: 43). However, most of the health professionals who are serving these elderly newcomers are practitioners

inside a " western health system". They benefit from their additional asset of speaking some of the languages of the latest wave of immigrants. As happened with "ethnic" restaurants and newspapers, these health care professionals have become providers for an "ethnic" demand. It seems that "culturally relevant alternatives" (Age & Opportunity Report, 1992: 43) for obtaining health care are available in Winnipeg and these elderly newcomers take advantage of them.

Only one problem of access was mentioned by two Filipino women and it concerned the time they usually have to wait till they get health services. They evaluated this as a "different practice", compared to the quick response in their former home country.

12. Alternative Health Practices

When comparing the western medical model with non-western views on health care, Ebrahim (1992: 57) mentioned that people can move easily from one model of illness and healing to another. In this sample, those elderly who have been exposed before immigration to non- western systems showed a "pluralistic" approach to their health care. Among these newcomers, one was used to herbalist medicine when living in Mainland China, but since he moved first to Hong Kong and after to Winnipeg, he became used to "western" medicine. A Hindu woman mentioned that she preferred homeopathic medications and "when they do not work" she used allopathic drugs. A man from Vietnam, indicated how different procedures for selling medications in

Vietnam and in Canada may affect the way he is taking care of his health. Here he needed a medical prescription to buy what in Vietnam he could get over the counter or directly from the pharmacist. The rest of my informants had only experiences with western medical practices.

Hispanic people in the United States, have been identified in the literature as prone to seek health care from "curanderos" or "folk healers" (Thompson and Thompson, 1990: 147). This did not apply to the Spanish speaking elderly in this sample, probably due to their personal histories. One of them used to cooperate in community health programs in a rural area. Another in the same language group, had two sons who were physicians, one of them practicing today in Mexico city.

13. Losses

Most elderly newcomers in these groups indicated that they are feeling better in Canada, than they used to in their former home countries (Appendix G - Table 15G). They seem to enjoy leisure time after years of hard work. However, there were also a few who cannot forget tragic circumstances and events. That is the case of a Spanish speaking woman when describing the way in which one of her sons was killed:

> "He was a physician working in a hospital in Managua. One day the 'sandinistas` came there and said to the staff of physicians and nurses: "you have been cooperating with the government so you must die"; although they promised

> not to work any more they were burnt alive. The only thing that allowed us to recognize that my son was dead was a medal which was found in that place. I am still waiting to see him alive because I did not see his corpse.

Friends, relatives, the landscape and the mild weather of their former home countries were mentioned as losses which they accepted as part of the "price" they had to pay to live in Canada.

Some of the women could find ways to compensate for their losses by the adoption of roles that apparently gave them opportunity to express "their dominant selves" (Disman 1987: 70). Motherhood was of primary importance for them in the past and taking care of their grandchildren in Winnipeg was a way to feel respected and needed.

One man who in his former home country, used to work in leadership positions had the opportunity to use that kind of skill by becoming the Program Coordinator's informal assistant.

14. Religion

Their religious beliefs are very important. Many seniors mentioned that they do not worry about the future because "God will provide". A Punjabi lady enumerating activities of an elderly person in India mentioned "prayers" as a regular practice. Most of them are involved in different activities developed in their churches or temples (Appendix G - Table 17G). In terms of continuity, this is another practice which they

keep alive from their former home countries. As Gelfand suggested, religious involvement is generally an important factor in the life satisfaction of elderly people (1994: 132). Its importance in their lives could be measured by the fact that several respondents indicated that they tried to live within walking distance to a church or temple.

For one of the Spanish speaking seniors, his relationships with the Catholic church were decisive in his opportunity to land safely in Canada. He described his current involvement with a church, which is very popular among Spanish speaking people in Winnipeg, as follows:

> Now that the activities related to the English classes has diminished a little, we began to participate in the Catholic church activities as we used to do in El Salvador. We have a daughter who is a nun and a nephew who is also a priest from my side and another nephew who is also a priest from my wife's side; so we always had a connection with the church. That is why we feel the need to cooperate with the church activities.

For those less familiar with Latin American history it should be noted that in most countries of that region, the Catholic church is a powerful state sponsored institution. Since colonial times, members of low income families used to improve their socio- economic status by becoming nuns or priests.

15. Needs in Everyday Life

The younger respondents expressed more clearly their needs to improve their command of English and update their skills in order to find a job. Only one of the seniors of the multicultural group fatalistically accepted that their age is a barrier to finding a job (Appendix G - Table 19G).

For some members a "need" to meet was to obtain free bus tickets in order to participate in more activities in the multicultural organization. The provision of free transportation for senior group members was mentioned as a long standing issue of concern by the Program Coordinator and one of the Board members. Although bus tickets were provided on a daily basis to those who asked for them, both informants agreed that most of the seniors or at least their children should pay for that service.

16. Main Worries about the Future

Five seniors were worried about their health. One woman was worried about her daughter. Almost all of them mentioned financial uncertainty as their main worry.

17. Ethnic Community and Mother Tongue

All of these elderly newcomers participated in religious and social activities promoted by their ethnic communities. Only one Spanish speaking lady commented sadly about the fact that when she became a Canadian citizen she could not go to a Spanish speaking seniors' group any more. At the time of this study, many respondents identified bureaucratic rules as serious drawbacks. These were affecting not only the

access and permanence into ethnospecific social groups but also the provision of English as a Second language classes in public schools.

Sharing the same language was a solid base of interaction among senior members. Members of the same language group were observed sitting together during the different group activities regardless of their length of residence in Canada.

18. The Relevance of the Peer Group

Although there are differences in their personal involvement in the seniors group activities, all of them have found opportunities to learn English, socialize, meet with people who speak the same first language and support each other in the process of adaptation to a new environment.

For the Spanish and Punjabi speaking elderly the need to learn and improve their English proficiency was their main goal when joining the seniors organization. The two Cantonese-speaking newcomers who were attending activities at the mainstream centre seemed interested in improving their English, while at the same time enjoying recreational activities. These different approaches may be related to the different resources available in both seniors organizations and their respective ethnic communities.

Members of smaller ethnic communities are usually more interested in learning the language of the host society (Breton, 1964).

A significant feature among members of the multicultural group was that they usually came alone to the office, while members of the mainstream senior centre usually attended with a spouse or friend. In one circumstance friendship developed between two Hindu women.

With only one exception, all the seniors perceived the group as the only alternative for going out of their homes.

For those who were Canadian citizens but not yet fluent in English, the ESL classes which were provided by a volunteer or the Program coordinator were one of the few places where they could be assisted without paying fees.

A founding member of Ethos defined its goals as follows:

> Ethos is a place to enrich your thinking. Differences are important and these have an impact in their lives. We need a focal place where people can come and learn to understand the differences. It is a place to enrich the lives of these people. They need a caring environment, leaders with sensitivity and that their needs should be assessed.

Some of the frequent participants in the seniors' group activities, are also members of Ethos Board. At the time of this study, the country of origin of these were Philippines, El Salvador, Nicaragua, India and Canada.

Most of Ethos' members were coping with limited economic resources in their everyday lives outside the seniors group; they were aware of the lack of funds affecting the organization's functioning, as well. Their suggestions included to augment the

office space, the number of active members and to obtain a permanent source of funding.

Meanwhile they were working in the construction of marionettes and other crafts made of recycled materials with the hope of raising additional funds.

19. Conclusions

The narrative re-constructed (Charmaz, 1990) from these nine elderly newcomers focused life histories, revealed the existence of a discourse on aging in Winnipeg around shared values, beliefs and socio-economic statuses.

The repertoire of themes that they shared included their construction of both immigration and caregiving as processes driven by patterns of mutual assistance among generations. These are strongly connected with core values such as reciprocity and filial responsibility. Needs were constructed in terms of language proficiency, skills upgrading, job finding and income. Their worries and concerns were constituted in terms of fear to physical and financial dependency. They reported an "intra-ethnic community" orientation when seeking services. Another theme identified revealed the impact on some of these elderly newcomers lives of health promotion or "life style intervention" strategies (Coreil et al 1985: 428).

Barriers to access services was not constructed as a relevant issue. This finding may be interpreted as being related to three concurrent factors: the elderly newcomers'

positive self evaluation of health status, the availability of service providers who speak their first languages and their long standing social involvement.

They constructed their positive aging in a new environment in terms of a good relationship with their families and their participation in religious and social activities in both their ethnic community and peer group. They did not evaluated the ethnic community as an alternative to the multicultural group. The latter was viewed as a place to make friends, to learn a new language and skills and as an attractive alternative to staying at home. Despite some dramatic losses, positive evaluations of their new environment were constructed in terms of their physical safety and better future for their children.

With regard to the emergence of a "multicultural" identity that may transcend both their being elderly and ethnic, as a product of a freely chosen "we" instead of an imposed "other", there were identified some potentially favorable indicators. Among them, mutual respect for their respective cultural backgrounds, the sharing of activities and the evaluation of the group as a positive place to meet with their peers may be underscored.

CHAPTER 6: COMPARING DISCOURSES

This chapter begins with a comparison of the main themes identified in the official and lay discourses. Points of convergence, dissent and links with other discourses are discussed. It follows with several proposals for action suggested by the study findings. The evaluation of the research process, methodological limitations and insights are described. Finally, some topics of interest for future research are proposed.

1. Priorities

As it has been previously stated the official multicultural health discourse constructed the ethnic elderly as a group with special needs. Based on that characterization, it intends to normalize the latter through proposals for positive aging and integration to a culturally sensitive health and social system under professional management. Access issues and models for organizational change to overcome barriers and minimize underutilization of services acquire relevance in that scheme. Professionals practicing in Winnipeg, shared and acted according to that construction.

The elderly newcomers constructed needs around financial, language proficiency, skills and job finding problems. Their discourse constituted poverty as a relevant issue. Similar findings have been reported by other studies as well (Age and Opportunity, 1992; Anderson, 1991b).

As MacLean and Bonar have suggested, "ethnic elderly people suffer from hardship in old age as the result of social forces rather than of individual characteristics" (1987: 212).

The elderly newcomers discourse is asking for an approach that should take into consideration the socioeconomic determinants of health. It gives support to discourses promoting policy initiatives in areas of income security and subsidized housing (Marshall, 1993).

As it was previously stated, some voices inside the official discourse pointed out the need for the multicultural health agenda to prioritize issues of social inequality as much as those related to cultural sensitivity (Anderson, 1991 a & b; Lock, 1993). The strategies for action proposed by participants in the Ethnicity and Aging Workshop (1988) to reduce the financial dependency of ethnic elders are reflecting that line of thought.

2. Professional Roles

The professionals interviewed for this study practiced in different settings and manifested different levels of awareness on multicultural health issues. However, they all agreed on the definition of the elderly newcomers as a group with special needs. Their discourse reinforced the official view of the elderly newcomer's world as problematic and legitimize their intervention. Dependency which has been constructed as elderly newcomers' main difference from the mainstream, was regarded

as a family issue. This discourse ends cutting the ethnic aging process from its structural roots.

The expression "these people" was used by some professionals to refer to the newcomers. Underlying it operates the "we / they dichotomy" described by Auger (1993: 158), expressing a style of professional practice in which "we" are tolerant of "their" needs. Precisely, based on a catalogue of needs, the discourse of gerontology has identified strategies for "successful aging" providing biomedical solutions for socially constructed problems. Even when interventions adopt the form of social support and/ or mutual aid, they are frequently subjected to some sort of surveillance disguised as "facilitation" (i.e., B.C. Ministry of Health, 1988).

3. The Meaning of Immigration

Some professionals assumed that "stress" is a risk factor associated with diseases such as obesity and diabetes. They also defined immigration and acculturation as "stressful" processes. Official documents likewise constructed immigration in senior years as a risk for developing mental health problems. Contrasting with that view, elderly newcomers narrated that experience as a dynamic process, including some dramatic losses, but encouraged and supported by visions and experiences of Canada as a caring and peaceful country.

4. Aging Well

Some of the newcomers' references to lifestyles changes such as walking and following a good diet, may be interpreted as instances of the "new hygiene" (Armstrong, 1983: 10-11) gaining a place into the elderly newcomers' everyday world.

Illness in the discourse of prevention has become something latent in all members of society (Willimas and Boulton, 1988: 232). Some of the health service providers interviewed defined ethnic elderly health problems from that perspective. They associated aging well with the choice of appropriate lifestyles. This perspective is officially supported by a discourse which recommends "to focus health promotion efforts on concepts of exercise, activity and fitness, particularly among older adults" (Penning and Chappell, 1993: 254). It should be connected with some evaluations on the way elderly people are experiencing the aging process. A study by Roos, Havens and Black (1993), analyzed data on Manitoban elderly people. They estimated that between 1971 and 1983 there was a twenty nine percent increase in the number of persons over the age of 65 in Manitoba, but a seventy percent increase in the number of elderly who were in poor health.

To appreciate the benefits which ethnic newcomers would obtain by their integration into a system based on these assumptions and outcomes it is necessary to discuss the meaning of "aging well". As Tornstam (1992: 322-23) has observed the discourse of gerontology has developed a "resource" perspective according to which old people are expected to keep active and fit. In that scheme, illness becomes a form

of self-inflicted punishment. Therefore, "aging well" from this perspective, means to manage properly one's own life to make it productive and effective.

At the same time, the emphasis placed on the maintenance of independence is fueled by economic interests. The initiatives and resources of the elderly to take care of themselves, may be utilized to save money at a time when the reduction of health care costs gained relevance in public discourse. The elderly have also been constructed as a powerful consumer force of leisure and health care. As Moody (1993) has pointed out old people have became a target of a "postmodernist life course discourse" which promotes a multiplicity of life-styles. This discourse has constructed age appropriate behaviours as if these were the product of voluntary choices and actions (Ibid: xxxi).

The "biomedicalization of aging" which has been associated with "the growth of a multi-billion - dollar medical industrial complex" (Estes and Binney, 1989 : 594) has developed as a process which does not differentiate between "we" and "them"; on the contrary everybody is invited to consume. The elderly newcomers, whose health problems did not differ from the mainstream, were not reluctant to accept that offer but they utilized the system in their own way. They selected professionals among those who spoke their mother tongues.

5. Access to Services

The official multicultural health discourse emphasizes issues of attitudinal and institutional change to improve service utilization by members of ethnic groups.

Contesting this perspective, the elderly newcomers discourse discloses the availability of "culturally relevant alternatives" for obtaining health care services in Winnipeg. Similar findings were reported by a recent needs assessment study (Age and Opportunity, 1992).

One key professional informant interpreted that particular help seeking pattern, which is limited to the resources available in one's ethnic community, as reproducing an "ethnic enclave" ideology which in her opinion should be resisted. This may be true, but that orientation appears to be thoroughly compatible with the rules and forces operating in a capitalistic market.

6. Who Should Care

On this issue there seems to be discourse convergence. Both official and lay discourses, although based on different rationales, assign a salient role to the family in caring for their elderly members. Many studies have demonstrated that despite the increasing number of women working in paid labour and divorce rates, the role of the family in taking care of their older members is still a common pattern (Chappell, 1994). Also, the discourse on health reform promotes the shift towards community care services. In many western countries, these are based on the availability of families and friends as care providers. It has been estimated that this informal network is already providing almost 80 % of all the personal care to seniors (Chappell, 1993: 146, Havens, 1993b: 37). Multicultural health discourses seems in agreement on this issue

and gives further support to the construction of an interface of family and formal care within a continuum of care (Havens, 1993b: 40).

7. Multicultural Coexistence

While only two of the professionals interviewed made express reference to the term, no one in the sample of elderly people used the word "multiculturalism". Only one came close to the notion of a shared identity by referring to the group members as "here we are all foreigners". Most of them manifested their ethnic identity in "behavioral" terms (Harwood, 1985: 8).

Instead of talking of their "ethnicity" , they just expressed it by dressing as they used to in their former home countries, enjoying their foods and speaking and singing in their mother tongues.

The term "discrimination" was used by one newcomer and was considered as a "British" attitude here and in her home country.

The official multicultural health discourse assumed that although ethnic elderly individuals are different, they share a common fate premised upon a history of voluntary or enforced migration. This commonality was regarded as a solid base to initiate a multicultural program in Winnipeg. However, at the time of this study, the lack of language proficiency affecting its members was not appropriately addressed.

Despite the limited interaction observed amongst different language group members, their narratives transmitted a shared vision of the senior group as one of the

most important connections with the "outside" world. Observations conducted at the seniors group, revealed the existence of mutual respect when sharing program activities. These attitudes represent a solid base for a multicultural coexistence.

8. The Peer Group

Seniors organizations have been identified in the literature and by service providers as appropriate settings for mutual support and to learn and practice how to "age well" (Jerrome, 1992: 190; Leanse, 1986: 105; B.C. Health, 1988; Manitoba Health, 1992). The mutual support which is promoted in this type of settinng is based on the experience of sharing and is useful for the socialization into new roles. For these elderly newcomers as for many seniors in Canadian society, joining an organization is proof of their ability to lead an active life.

Similar to those British elderly studied by Jerrome (1992: 190), these newcomers provided examples of successful "resistance to adverse circumstances." The multicultural group provided them with a place for sharing their feelings and experiences while adapting both to aging and a to a new environment..

9. The Own Ethnic Community

There is agreement in the literature regarding the mental health benefits that newcomers get from resettling in an ethnic/cultural enclave with a supportive network, at least during the initial periods of adjustment (Baker, 1993; Breton, 1968; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988 a & b).

The elderly narratives confirmed that evaluation when referring to their participation in religious and recreative activities within their respective communities.

10. Programs

Education and the provision of information to the public and the ethnic elderly are the mechanisms officially recommended to overcome communication and cultural barriers. Among the professionals, only those directly involved in ethnospecific or multicultural programs were aware of the difficulties for getting financial support. Limited funding was singled out by board members and the program coordinator of the multicultural seniors' group, as the main cause for programing on a short term basis.

11. Recommendations

As previously stated, elderly newcomers discourse constituted their needs as related to income, language proficiency, skills upgrading and job finding techniques. The study findings and relevant information (Manitoba Health / Council on Aging, 1993; Age and Opportunity, 1993/94)) show that services to address these needs are available and accessible in Winnipeg.

One of the problems identified while conducting the observations in the multicultural program was that English as a Second language classes were, at that moment, developed with a great degree of improvisation. In contrast with the situation

at Ethos, educational services for mainstream older adults have, in recent years, been reflecting the viability of proposals which onstructs a "new economic life course" (Myles and Street, 1995: 336). Based on an "age integrated" model they promote the availability of opportunities for education, work and leisure during the whole life course (Riley, 1994, cited by Miles and Street, 1995: 349).

Elderly participants in the multicultural seniors' group would benefit from a program which respects them as formal students by providing services oriented by older adult education principles. Regular English classes in the context of the seniors group may be combined with long distance courses at home. A community television channel may be an appropriate medium to provide that service. Continuing education departments of the University of Winnipeg and Manitoba are recognized resources which may provide professional and technical support.

Once the language barrier is adequately addressed the rest of the needs may be met by using programs already in existence for elderly living in the community (Havens, 1990). Creative Retirement Manitoba and Age and Opportunity have been providing services to address educational and job related needs of the elderly since their inception. Precisely, the role of the multicultural seniors' organization could be to connect newcomers to these services.

The conditions of poverty which have been revealed by the lay discourse, bring new meaning to health promotion activities. The modification of adverse social conditions should be included into the health promotion agenda. However, the

traditional source of funding for multicultural health programs has been jeopardize by a discourse on fiscal restraint. This context suggests a proposal for the application of a self help/mutual aid approach for income generation. Resources already available in the multicultural seniors group may be further developed. During my observations, many of the group participants were involved in the production of different crafts. The peer group which has been a continuous source of social support may well become the basis for a cooperative venture for craft production or any other profitable initiative.

The three federal programs which were designed to guarantee a basic income for the "mainstream" elderly have been characterized as inadequate to provide for a standard of living above the poverty line (Battle, 1994: 27). However, in the case of these ethnic elderly, this source of income may make a great difference in their everyday life. Thus, the recommendation made by participants at the Ethnicity and Aging Workshop in 1988 to reduce the period of ten years required to qualify for one of those programs, the Old Age Security benefits, remains still valid and waiting for serious consideration.

12. Methodological Limitations and Insights

As it was stated in the description of the methodology implemented to conduct this study, the findings presented above and in the preceding chapters are the result of

my particular interpretation of texts and narratives oriented by exploratory and descriptive methods.

Life history narratives provided rich material to reconstruct elderly newcomers feelings and perceptions of their adjustment to a new society. They also were appropriate fro eliciting their construction of main worries and needs while aging. However, these findings are limited by the very nature of the interviews and sample. Although a guide oriented the life history narratives and their content was further discussed with the informants, they selected particular aspects of their identities and lives to present. Therefore, data should be considered as the result of a negotiated and emergent dialogue.

When selecting the sample, participants seemed to represent the perspective of ordinary elderly urban immigrants. However, the study findings suggest that these newcomers may be unique in some aspects. They had a history of social involvement prior to immigration, a positive evaluation of their health status added to their access to culturally relevant health services in Winnipeg. Similar considerations in terms of unique features may be extended to the professionals who have accepted to be interviewed.

With respect to the discourse analysis method, its theoretical assumptions lead to a focus on issues of power relations and the role of professionals as agents of intervention. Themes and rationale for this discourse revealed its action orientation. Through the application of Foucault's methodological principles (1970) the official

multicultural health discourse was ideologically connected with other dominant discourses. This understanding set limits on expectations in terms of subject empowerment. It suggests reaching this goal by listening not only to the elderly newcomers' voices but also to the few who inside the official discourse prioritize social as well as systemic changes.

13. Future Research

This study turned out to be concerned with the discourse on elderly newcomers who participate in multicultural peer groups. There is in Winnipeg a considerable number of other elderly newcomers, who have been defined by the professional discourse as "hard to reach". Future research re-constructing their perspective may be an opportunity for testing the hypothesis of underutilization of services by ethnic newcomers. The relevance of such research is suggested by the importance assigned to that issue in the official multicultural health discourse rationale.

Future research as my study did, may also take advantage of discourse analysis strengths for the study of health policy texts. One timely instance is represented by the current discourse on "health reform" which may have different meanings and consequences for different communities.

Some professionals identified gender inequality as a problem affecting ethnic newcomers. Women represent in Canada the larger number of recipients and providers of informal and formal care (Havens, 1993b: 11). Given their particular socio-

economic statuses, elderly newcomer women's health related needs and concerns should be included as a prioritized topic in the research agenda on women's issues.

14. The Research as Process

The exploration of these competing discourses had for me a double relevance. First, as a sociologist I have always been interested in studying the impact of structural social forces on individual's lives. Thus, the construction of identities within the frame imposed by the globalization of the economy and transnational migration streams, caught my "sociological" attention. As Smith (1992: 523) has suggested, representations of personal and collective identity cannot ignore that the "world is now a single social space." As a result of this movement, identities tend to be made of multiple cultural and discursive repertoires. One of the valuable outcomes of this study was precisely the identification and description of some of the forces involved in that process of identity constructions in the Canadian context. Secondly, at the personal level, this study was conducted while I was experiencing my own process of resettlement. Elderly newcomers ' narratives not only provided me with the material to reconstruct a discourse, but also with role models for creative adjustment to a new culture.

The description of these competing discourses suggested also the need to be actively involved in the promotion of a more humane social definition of aging in a new environment.

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APPENDIX A: Interview Guides

Appendix A-1: Informant: Program Coordinator

Gender

Age

Mother tongue

Program coordinator since ....

Main tasks

Hours of work

How the programs are designed

How the programs are implemented

Current program content

Relations with the board

Relations with other senior organizations

Relations with the multicultural senior group:

a) number of members

b) membership rules

c) description of the worries, concerns and needs of the elderly newcomers and mainstream elderly

d) type of help provided to the members.

APPENDIX A- 2

Informant: Health Care Provider

Gender

Age

Mother tongue

Other language/s spoken

Frequency receiving ethnic elderly newcomers in your office

Country/s of origin

Common motives for the consultation

The communication process

Treatment and compliance

Health beliefs and practices

Patient expectations of his/her role and responsibilities

Differences and commonalties between ethnic and Canadian born elderly patients

Courses on multicultural health as part of your professional education and /or personal interests.

Other comments on aging in a new environment

APPENDIX A- 3

Informant: Social Worker

Gender

Age

Mother Tongue

Language/s Spoken

Country/s of origin of the client, group/s served.

Description of worries, concerns and needs of the elderly newcomers

Commonalties and differences with the mainstream elderly

Communication

How do they access the social service agency

Type of help provided

Follow up of clients in terms of integration to the new society

Social life: within / outside ethnic community

Courses on multicultural issues

Other comments on aging in a new environment

APPENDIX A-4

Informant: Multicultural Consultant

Gender

Age

Mother tongue

Multicultural health in Manitoba

* main issues

* policy

Role of health and social service professionals

* defining the problems

* understanding the problems

* solving the problems

The needs, worries, concerns of elderly newcomers

Differences with " mainstream" elderly

Role of seniors groups / community centers

How long have you been involved

Did you see improvements in the last years? (i.e., awareness, outcomes for the newcomers)

Other comments on aging in a new environment

APPENDIX B

Life History Schedule

Gender

Age

1. Before Arrival

* Place of residence (rural / urban)
* Family size
* type of house (materials, number of rooms, running water, appliances)
* education
* marital status and age at marriage
* children , number and gender.
* social life : friends, activities, membership.
* health history in terms of significative illnesses and problems
* health beliefs and practices
* type of health care services available
* food consumption habits
* food shopping practices
* cost of living
* experience/s with elderly people (as caregivers)
* common practices regarding elderly people
* other topics.

2. Preparing to come to Canada

* Motives for leaving the home country
* losses (house, relatives, friends)
* type of sponsorship
* previous information about Canadian society and lifestyles
* Other important events and related feelings.

3. After arriving to Winnipeg

* Age at arrival
* Landed immigrant status / Canadian citizen/ other
* Length of residence

* Marital status
* Living arrangements (alone, with spouse, children)
* Main source of income
* Importance of own ethnic community
* Health status
* Health beliefs and practices
* Experiences with health care professionals
* Foods usually consumed
* Shopping practices
* Feelings about being a person of... years of age
* Needs in everyday life
* Knowledge related to meet these needs
* Main worries for his/ her future
* First time experience/s in the multicultural senior group
* With whom does she/he usually go
* Activities in the group
* Feelings about being a member
* What will he /she do instead
* Suggested improvements
* Friendship outside her/his peer group.
* Friends inside and outside own language group.

APPENDIX C

Program Samples

Multicultural Seniors Coalition of Manitoba Inc.
305 - 323 Portage Avenue
Winnipeg, Manitoba
R3B 2C1
Ph. 943-1177

ETHOS CAFE

June 1994

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
MAY S M T W T F S 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	2:00-4:00pm English Class Singing Practice ETHOS SONG		1 1:30-3:30pm Craft	2	3 Seniors Day in Winnipeg ~~12:30-2:30~~	4
5	6 2:00-4:00pm English Class	7 Disabled Committee Meeting 2:00-3:30pm	8 Program Committee Meeting Craft	9	10 [illegible] Trip to collect wild flowers	11
12	13 2:00-4:00pm English Class	14	15 Craft 1:30-3:30pm	16	17 nothing planned	18
19	20 2:00-4:00pm English Class	21	22 1:30-3:30pm Cards & games (outdoor ?)	23	24 1:30pm Visit to the Ukrainian ~~Museum~~	25
26	27 2:00-4:00pm English Class	28	29	30		JULY S M T W T F 3 4 5 6 7 10 11 12 13 14 17 18 19 20 21 24 25 26 27 28 31

WEEK TWO

MONDAY, JUNE 6

9:00 E. S. L.
10:00 COOKING FOR ONE OR TWO CLASS
1:30 CARPET BOWLING

TUESDAY, JUNE 7

9:00 E. S. L.
9:00 SNOOKER & POOL
10:00 PAINTING
10:00 EXERCISE TO MUSIC
12:00 NOON MEAL
1:00 BLOOD PRESSURE CLINIC
1:00 JOHNNY B'S FRIENDLY FILIPINE DANCE
1:30 DRAWING

WEDNESDAY, JUNE 8

9:00 SOCIAL GATHERING
9:00 QUILTING/CRAFTS
10:00 SHUFFLEBOARD
10:30 E. S. L.
12:00 CHINESE MEAL
1:00 LINE DANCE

THURSDAY, JUNE 9

9:00 E. S. L.
9:30 TAI CHI VIDEO
10:00 LADIES SNOOKER
12:00 NOON MEAL
1:30 BINGO

FRIDAY, JUNE 10

9:00 E. S. L.
9:00 TABLE TENNIS

WEEK THREE

MONDAY, JUNE 13

9:00 E. S. L.
10:00 COOKING FOR ONE OR TWO CLASS
1:30 CARPET BOWLING

TUESDAY, JUNE 14

9:00 E. S. L.
9:00 SNOOKER & POOL
12:00 NOON MEAL
1:00 JOHNNY B'S FRIENDLY FILIPINE DANCE

WEDNESDAY, JUNE 15

9:00 SOCIAL GATHERING
9:00 QUILTING/CRAFTS
10:00 SHUFFLEBOARD
10:30 E. S. L.
9:30 DENTAL CLINIC
1:00 LINE DANCE

THURSDAY, JUNE 16

9:00 E. S. L.
9:30 TAI CHI VIDEO
10:00 LADIES SNOOKER
12:00 NOON MEAL
1:30 BINGO

FRIDAY, JUNE 17

9:00 E. S. L.
9:00 TABLE TENNIS

APPENDIX D

Multicultural Health Discourses and Elderly Newcomers Aging in Winnipeg

CONSENT FORM

The purpose of this study has been explained to me and I agree to be interviewed by Dora Replanski. I understand that this study will assist her in the completion of her Thesis for a Masters in Community Health Sciences and that this may well be of no benefit for me.

I understand that my opinions and responses will be kept anonymous and that confidentiality will be strictly respected in any materials used publicly, unless I give written permission (below) for my statements to be attributed to me. I also understand that I can chose not to answer any question and that I may end the interview at any time.

Signature: ——————   date: —————

I do give permission for my statements to be attributed to me.

Signature: ——————   date: —————

I was explained that tapes will be erased and kept under lock and key in any case. I give permission for tape recording this interview.

Signature: —————   date: —————

Interviewer signature ———   date: —————

APPENDIX E

Table 3.2. Language Groups in Maintoba, 1991

	Total Population	65 yrs. and over
Single responses	1050800	138385
English	799935	86280
French	46930	8130
Cree	21195	1220
Inuktitut	70	0
Italian	4885	710
Portuguese	6670	415
Spanish	3915	85
German	63140	12920
Yiddish	1645	1240
Dutch	4420	1220
Croatian	735	65
Czech	1055	215
Polish	10865	3615
Russian	975	360
Ukranian	32805	15040
Slavic langauges, n.i.e	760	85
Finnish	385	105
Hungarian	1975	490
Greek	1430	105
Armenian	30	5
Arabic	540	35
Gujarati	370	20
Hindi	535	30
Persian (Farsi)	455	10

Punjabi	2795	190
Tamil	200	5
Japanese	415	145
Korean	615	40
Chinese	8285	665
Vietnamese	2180	40
Tagalog (Pilipino)	10010	910
Other languages	20585	3995

Source: Statistics Canada, 1992.

APPENDIX F

Studies and Workshops

Grell, F "Excerpt from a Preliminary Study of Immigrant Problems and Needs in Ottawa." International Immigrant Services Committee. Ottawa, 1976.

Browne, O. "Survey of Citizenship Education Opportunities and the Responsiveness of Service Agencies to Immigrants' Needs in the Ottawa-Carleton Region." Ottawa-Carleton, 1979.

Workshop on "Service Delivery in a Culturally Diverse Community," examined the need for social service and health institutions to integrate policies and practices in meeting the needs of minority ethnic groups. Sponsored by Ontario Human Rights Commission, Race Relations Division, and Ottawa-Carleton Immigrant Services Organization, 1982.

"Trends 1985," Publication of The Social Planning Council of Ottawa-Carleton. Community consultation on needs of racial and ethnic minorities included 37 seven ethnic leaders and direct service providers such as immigrant aid workers, day care providers and educators. Toronto, 1985.

Training workshop on issues related to the delivery of health care in a multicultural community sponsored by the Victoria Hospital and the London Cross Cultural Learner Centre, Toronto, 1985.

One-day community dialogue entitled "Health is a cultural affair," sponsored by the Continuing Education Division of Ryerson Polytechnic Institute, Toronto, 1985.

Schall, U. "Survey of Frail, Elderly and Needy German-Speaking Citizens in Ottawa-Carleton", sponsored by the German-Speaking Alliance of Ottawa. The population studied included 105 frail elderly German-speaking immigrants, Ottawa, 1986.

Doyle, R. and Visano, L., "A Time for Action: Access to Health and Social Services for Members of Diverse Cultural and Racial Groups in Metropolitan Toronto," for The Social Planning Council of Metropolitan Toronto. It Included a survey of 135 mainstream health and social service organizations, several representatives of ethno - specific service organizations and 160 clients, Toronto, 1987.

Bergin, B. "Equality is the Issue." A study of Minority Group Access to health and Social Services in Ottawa-Carleton, conducted for The Social Planning Council of Ottawa-Carleton and The Access Committee of Ottawa-Carleton. Although study findings only allowed tentative conclusions on service use by minority ethnic groups, researchers considered that the underutilization hypothesis was generally confirmed. Informants included 128 senior administrators of health and social service organizations, 17 ethnic associations' leaders, 19 mainstream providers, 17 immigrant aid workers, 2 Aboriginal Canadian counsellors and 40 clients.

Workshops in cities throughout Ontario and in Ottawa, on the topics of health care for women and the elderly, mental health and access to services sponsored by the Multicultural Health Coalition, 1988.

Ontario Advisory Council of Senior Citizens "Aging Together: An Exploration of Attitudes Towards Aging in Multicultural Ontario," 1988/89.

Canadian Mental Health Association, Manitoba Division Inc, Report prepared by Nyman, B. : "Increasing Access. Developing Culturally Accessible Mental Health and Social Services for Immigrants and Refugees," Winnipeg, Manitoba, 1991.

Wood, M. "Access to Social and Health Services by Ethnic Seniors in Vancouver" for the Special Council Committee on Seniors, City of Vancouver, Vancouver Health Dept. and Social Planning Department, 1991.

Age and Opportunity "Ethnic Elderly Newcomers Needs Assessment Report", prepared by Higgit, N. and Greenslade, L., as part of the Immigrant Project, Winnipeg, Manitoba, 1992.

APPENDIX G

TABLES ON ELDERLY NEWCOMERS
(1G - 26G)

Table 1G.
Elderly Newcomers Age, Gender, First Language and Previous Place of Residence.

Subject	Gender	Age (yrs)	First language	Previous Place/s of residence
1 (MO)	M	55	Punjabi	Small village and city in Punjabi area (India)
2 (Mu)	F	74	Punjabi	New Delhi (India)
3 (Mu)	M	65	Spanish	Rural area and San Salvador (El Salvador)
4 (Mu)	F	55	Tagalog	Manila (Philippines)
5 (Mu)	F	73	Spanish	Managua (Nicaragua) and cities in Costa Rica and Mexico
6 (Mu)	F	72	Tagalog	Naga City and Manila
7 (Mu)	M	74	Tagalog	Manila
8 (M)	M	62	Cantonese	Hong Kong
9 (M)	M	50	Vietnamese	Small village in Vietnam

(Mu): multicultural seniors' group
(M): mainstream seniors' centre

Table 2G.
Family Size (FS), Marital Status (MS), Age at Marriage (AM) and Number of Children (CH).

S	FS	M.S.	AM	CH
1	6	Married	20	4
2	4	widow	26	2
3	8	married	27	8
4	8	single	-	-
5	8	separated	20	6
6	9	married	18	7
7	10	married(*)	25	16
8	5	married	25	3
9	7	married	22	5

(*) married three times

Table 3G.
Type of House and Appliances, Before Arrival

1: bricks, running water, refrigerator.

2: big flat, bricks, many rooms and bathrooms.

3: small house in rural area with land to grow vegetables, without refrigerator.

4: duplex, brick and wood, three rooms and appliances.

5: house with appliances and running water

6: house made of wood and galvanized iron roof, without refrigerator at first.

7: rented big apartment with all appliances.

8: apartment, 900 s.ft. four rooms, two bathrooms.

9: house made of metal, four rooms, running water and appliances.

Table 4G.
Length of Residence in Canada

Subject	Years of residence
1	less than one (seven months)
2	six
3	four
4	three years and a half
5	seven
6	five
7	nine and a half
8	two
9	three and a half

Table 5G.
Status, Sponsorship and Living Arrangements

Subject	Status	Sponsored by	Living arrangements
1	L.I.	daughter	spouse and three children
2	L.I.	daughter	daughter and two grandch.
3	L.I.	government	spouse and children
4	L.I.	brother	mother and sister
5	C.C.	daughter	daughter, son in low and two grandchildren
6	C.C.	son	spouse and daughter
7	C.C.	daughter and son in law	younger daughter, son in law and grandchildren
8	L.I.	son	spouse and daughter
9	L.I.	son	spouse, four sons and one daughter

L.I.: landed immigrant
C.C. Canadian citizen

Table 6G.
Motives for Immigration

Subject	Motives
1	Family reunion
2	Help her daughter who is a single mother with two children
3	Afraid of the violence in EL Salvador and their sons were at risk of being killed.
4	Improve her economic status and take care of her elderly mother.
5	The violence in Nicaragua. She lived as a refugee in Costa Rica and Mexico before coming to Canada.
6	Family reunion
7	Came to help her daughter to take care of grandchildren. His wife did not like the winter and went back to Manila.
8	Family reunion after retirement; her son came to study first and he visited him many times.
9	Economic problems in Vietnam and family reunion, his son sponsored him.

Table 7G.
Previous Information on Canadian Society and Lifestyles

Subject	
1	Did not know anything but now he likes to live here
2	Nothing, and she regrets having send her daughter to marry here.
3	He knew that here it was very cold
4	Was informed by her family who lived here for many years
5	Did not know anything, only about the weather
6	Did not want to come to Canada, she was afraid to travel by plane
7	Her daughter gave him information. He likes cold weather:"It makes me feel healthy."
8	He came many times to visit her son before immigration
9	His son gave him some information.

Table 8G.
Gender, Educational Level and Work History

Subject	Gender	Education	Work history
1	M	Grade 8	rural work
2	F	" 10	homemaker
3	M	" 3	carpenter/ caretaker
4	F	" 12	teacher
5	F	" 7	homemaker
6	F	" 7	dressmaker
7	M	Two years univ.	food inspector/ foreman/ policeman
8	M	grade 8	limousine business
9	M	grade 10	small business

Table 9G.
Current Main Source/s of Income

Subject	Main source/s of income
1	Low paid job and children's help
2	Does not have any pension, receives 55 plus and children's help.
3	Government assistance and children's help
4	Works for a home care program for the elderly
5	Does not have any pension, receives 55 plus
6	Does not have any pension, receives 55 plus and daughter is "breadwinner"
7	Receives 55 plus and will receive the Old Pension benefits next November
8	Savings, - 55 plus and children's help.
9	His son's help.

Table 10G.
Social Life and Activities Before Immigration

Subject	Activities/social life
1	Very active and took good care of brothers'education.
2	Visited frequently her brothers and sisters, since she is in Canada goes every year to visit them.
3	Active in cooperative movement, public health volunteer worker, involved in catholic church activities.
4	Very active, many friends, member of a community centre.
5	She has only sad memories of her former life in Nicaragua, she was a single mother abandoned by her husband.
6	Many friends and liked to dance with her husband.
7	Many friends and extended family.
8	Did not have time for social life as he used to run a" twenty four hours business."
9	Many friends there.

Table 11G.
Care of the Elderly in Former Home Country

Subject	Care of the elderly
1	The family looks after their older members. He used to visit his parents every day.
2	Usually the son takes care of his parents. There are not homes for the elderly in New Deli. There are some seniors centres sponsored by the government. Elderly people spend their time praying and visiting relatives and friends.
3	Usually families have many members and somebody will take care of an elderly member. There are not many homes for the elderly.
4	Any relative cares for an elderly member of the family. She moved to Canada to care for her mother who is eighty two years old.
5	Extended family takes care of the elderly.
6	Elderly are highly respected and looked after at home, there is only one nursing home in the city.
7	The family takes care while in Canada "they kick you out."
8	In China the son takes care of his parents, they are highly respected.
9	In Vietnam there are lots of problems with the elderly because there is not too much to eat and they are too frail. His parents had passed away.

Table 12G.
Health Status Previous and After Immigration

Subject	Before	After
1	very healthy	very healthy
2	hypertension a broken wrist	feels healthy
3	minor problems never hospitalized	hypertension; on diet
4	in good health since childhood	only a little "tired"
5	after the earthquake hypertension	hypertension, all kind of allergies
6	ulcer, menopause brought nerves	better treatment for her ulcer, has "palpitations"
7	very healthy, "weight lifter"	on medication for hypertension "to prevent a stroke"
8	very healthy, only tuberculosis in 1949	very healthy, exercises regularly.
9	very healthy, only common colds	very healthy

Table 13G.
Foods Consumed and Shopping Habits Before and After Arrival

Subject	Type of diet and shopping habits
1	Before arrival: he used to eat all kind of food included milk and bought everything in the public market. After: same diet; his wife goes shopping in the supermarket.
2	Before: vegetarian diet which included green vegetables, cereals, "chapaties," did not drink alcohol, soft drinks for guests; drinks tea three times a day. Bought in open market almost every day the fresh vegetables and flour and cereals once a month. After: same diet, shops in supermarket.
3	Before: used to grow his cereals and eat fish from his fishing activities; as they did not have a refrigerator they used to dry the meat in order to keep it fresh. When they moved to the capital city they bought food in the market. After arrival: they got used to buy in the supermarket.
4	Before: used to eat poultry and fish which were bought almost every day at the public market. After: more fruit and vegetables, does not eat poultry and meat because there are sold frozen in the supermarket.
5	Before: it was a shortage of food in Nicaragua after the earthquake and the civil war. Likes to eat meat. After: eats everything; shopping in supermarket.
6	Before: used to eat meat once a week, fish every day, eggs, vegetables, fruits. Shopping in public market. After: same diet, shopping in supermarket.
7	Before: used to eat fish, meat, salad, barbecues. He went shopping every day because he lived close to the public market. After: eats everything and buys where it is cheaper.
8	Before: he used to eat "junk food." After: he still likes "junk food" and he eats all kind of food. Shopping in the supermarket.
9	Before: used to buy vegetables in the market. Not much food available and of low quality. After:in Canada is more expensive but of better quality. His wife goes to the supermarket.

Table 14G.
Experiences with Health Care Professionals in Winnipeg.

Subject	
1	He did not need health services; he believes that there are "good doctors" here.
2	She prefers homeopathic medication and when it does not work then she uses allopathic. No problems of access here.
3	Goes to Spanish speaking physician as "he likes to understand in his own language."
4	Goes to Filipino General practitioner and Canadian specialist. No problems of access but the waiting time to get an appointment.
5	Goes to Spanish speaking physician.
6	Received in Winnipeg better treatment for her ulcer than in Manila. Goes to Filipino and Canadian physicians; time to wait for appointment.
7	Goes to Filipino doctor at the Winnipeg clinic (is a walk in Clinic) since his arrival.
8	He feels healthy and prefers a Chinese physician for better communication.
9	He is in good health but he would rather go to a Vietnamese physician.

Table 15G.
Losses

Subject	
1	Relatives and friends.
2	She goes every year to visit her relatives in India and her house is empty and looked after by her brother.
3	One of his sons still lives in El Salvador and their house is rented to relatives. He is happy to be safe.
4	She lost many things, especially her friends; misses the mild weather.
5	She lost two sons in tragic circumstances, one killed by the guerilla in Managua in 1979 while working in the Hospital and the second in 1984 in a car accident. Due to the war in her former home country had to move to Costa Rica and Mexico before coming to Canada. She feels in "peace" now that she does not hear any shooting outside.
6	She did not mentioned nothing special but her previous work as a dressmaker and her husband's activities as an employee for a business company.
7	He did not feel he lost anything: "I am happier now than I used to be before"
8	He does not feel he lost anything. He wants to adapt to new society and is studying English.
9	He feels better here than in Vietnam.

Table 16G.
Importance of Own Ethnic Community

Subject	
1	For him is crucial as he has arrived seven month ago and still lacks English proficiency.
2	Meets with Punjabi speaking people at the Hindu temple.
3	Belongs also to the Spanish speaking seniors group "Guardia de Oro."
4	Used to go with her mother to Filipino parties although she mentioned quarrels inside Filipino seniors' building where she used to live before. She did not like the way they behave there.
5	She used to go to Guardia de Oro but when she became a Canadian citizen she "was not allow to go there any more."
6	goes to Filipino parties and commented: "Filipino people like nice dresses." She likes to dance with her husband
7	He is very active in his own community and in the seniors group.
8	He is a leader in the Chinese group at the mainstream centre: organizes parties and in charge of the coffee break during ESL classes.
9	He said that he belongs to the Chinese group although he came from Vietnam. As he understands Cantonese he feels comfortable with the rest of newcomers.

Table 17G.
Religious Beliefs and Practices

Subject	
1	Wears turbans, goes to the Hindu temple.
2	Important, goes frequently to the Hindu temple.
3	Very active in his home country and now in the catholic church activities; his daughter is a nun.
4	Very religious, accept her life as it is and wants to share her skills.
5	Very religious, as she was before.
6	Goes regularly to church ; "God decides on everything".
7	Very religious, goes to Saint Edward's church twice a week.
8	Did not mention.
9	Did not mention.

Table 18G.
Feelings of being a Person of Her/ His Age

Subject	
1	Good feelings as he is healthy.
2	Feels very strong and healthy.
3	In good health and active.
4	She acknowledges some changes as she is growing old such as being more "tired".
5	Feels in peace now , there are no more noises of war around her as it used to be in her former home country.
6	She looks at the mirror and sees an old person but she does not feel old inside. Only sometimes she feels her muscles and knees aching.
7	Sometimes he feels being as an eighteen years old, he feels very well.
8	He swims every day, feels better than before.
9	He is fifty and feels very well.

Table 19G.
Needs in Everyday Life.

Subject	
1	Learn English and find a good job.
2	Has everything she needs, although she is asking who can help her to find a job.
3	They cannot work here as they would in El Salvador and he feels they are dependent on their children and government assistance.
4	She needs a car, a dog for safety reasons and improve her skills.
5	She is not an ambitious person, she would like to have more money to go outside her home.
6	She is happy with what she has.
7	Nothing special .
8	Not special needs, he is enjoying life very much.
9	He is a young person enjoying an early retirement.

Table 20G.
Main Worries for Her/His Future

Subject	
1	Find a good job.
2	Worried about her daughter's future as a single mother and the discriminatory practices which her daughter suffered in her work and did not allow her to improve her income.
3	Be dependent on government and family assistance.
4	Problems with her mother who lived here for a long time and they did not get along well.
5	Does not complain, has no ambition.
6	She trusts that God will decide what is better for her.
7	Has not worries, he only prays God to give him good health.
8	Has not worries, smiles a lot.
9	Has not worries.

Table 21G.
First Time Experiences in the Seniors Group

Subject	
1	Eager to become a "full member," willing to listen and learn.
2	Came because her daughter phoned the program coordinator. She was "bored" and alone at home. She met a Punjabi speaking female friend in the group.
3	Enjoyed very much all the activities. He learned a lot about other cultures. "Here we are all foreigners."
4	She is a member of the Board. Used to teach English and crafts; she feels happy sharing her skills with the seniors. Cooperated with Portage Place show.
5	"Ethos is my refuge." She only assists to ESL classes because they give her only bus tickets for that activity.
6	Happy to participate specially in parties and workshops. She understands a little of Spanish and is able to communicate with the Spanish speaking members.
7	He is the oldest member of the group. He is a leader and the program coordinator considered him as an assistant. He is manufacturing marionettes in order to fundraise money for the seniors groups activities.
8	Enjoys parties, ping-pong and ESL classes.
9	Very enjoyable experiences.

Table 22G.
Usually Goes to the Group

Subject	
1	Alone.
2	Alone.
3	Sometimes with her wife, specially for parties.
4	Alone, she does not come to much now because she is working, she used to come with her mother who is also a member.
5	Alone, sometimes with a friend.
6	With spouse .
7	Alone.
8	With his wife.
9	Alone.

Table 23G.
In which Activities Are Involved

Subject	
1	ESL classes, playing cards during Summer camp with Punjabi speaking men.
2	Talking, listening, some crafts.
3	Singing, puzzles, going to workshops and outings.
4	Made flowers, share skills with the group.
5	Only ESL classes because only receives bus tickets for this activity.
6	Workshop, parties.
7	Very active in the group, goes to the office every day, provides materials and produce crafts to fundraise money, leads workshops.
8	ESL classes, ping pong, parties, outings.
9	ESL classes, parties.

Table 24.G
Alternative to Participation in Peer Group

Subject	
1	Do not know.
2	Stay at home, knitting and other crafts.
3	Go to the church and another seniors group.
4	She is working, does not come too much now.
5	Stay at home.
6	Cleaning and sewing at home.
7	Stay bored at home.
8	Stay at home.
9	Stay at home.

Table 25G.
Suggested Improvements

Subject	
1	He is a new member and likes all kind of people.
2	No suggestions.
3	No suggestions.
4	A better place because this is too small and obtain more funds to improve the services for seniors.
5	No suggestions.
6	The group needs more members, the old are not coming any more.
7	The group needs more funds and he is making crafts.
8	"What has to be done is always done".
9	No suggestions.

Table 26G.
Friendship Outside Own Language Group

Subject	
1	Not many for lack of English skills.
2	Only when she lived in another city, and with her grandchildren's baby sitter.
3	At Smith seniors' centre they met with Canadians who are learning Spanish.
4	Her ESL teacher is Polish. She has two new friends, one is Chinese and the other Hindu.
5	She has only Spanish speaking friends due to lack of English knowledge.
6	Not many.
7	He goes "wherever he feels he is welcomed."
8	Not many.
9	Not many.