Healthcare Experiences of South Asian Older Adults in Canada: Aging well, Engagement, and Access

by

Diya Chowdhury

A thesis

presented to the University of Waterloo

in the fulfillment of the

thesis requirements for the degree of

Doctor of Philosophy

in

Public Health Sciences - Aging, Health, and Well-being

Waterloo, Ontario, Canada, 2023

© Diya Chowdhury 2023

Examining Committee Membership

The following served on the Examining Committee for this thesis. The decision of the Examining Committee is by majority vote.

External Examiner	Dr. Suzanne Dupuis-Blanchard Professor
Supervisors	Dr. Paul Stolee Professor
	Dr. Catherine Tong Adjunct Professor
Internal Member	Dr. Kimberly J. Lopez Assistant Professor
Internal-external Member	Dr. Cosmin Munteanu Associate Professor
Other Member(s)	Dr. Elena Neiterman Continuing Lecturer

Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners. I understand that my thesis may be made electronically available to the public.

Abstract

Background: Racial and ethnic disparities in healthcare have negative consequences for the health and quality of life of immigrants, while the lack of clarity in healthcare systems on how to best provide social and health services for these populations further exacerbates these disparities. With an increase in immigration and in the number of older adults in the Canadian demographic landscape, further research is necessary to understand the diverse ways through which racialized foreign-born older adults experience aging and how structural determinants impact their health and healthcare experience.

Objectives: My research aims to (1) describe how foreign-born South Asian older adults define and conceptualize the notion of healthy aging, (2) examine South Asian-born older adults' experiences and approaches to patient engagement and healthcare decision-making (3) identify and understand the structural determinants and systemic factors influencing the healthcare experiences and well-being of South Asian older adults in Canada.

Methods: Employing a descriptive, multilingual, and cross-cultural qualitative approach, 47 South-Asian older adults (60+) were interviewed in a semi-structured format, in Hindi, Tamil, Punjabi, Urdu, Bangla, and English over Zoom. Interviews lasted an average of 84 minutes (min: 32, max: 120). I participated in 167 hours of online community events to support relationship building prior to the interviews.

Results: This thesis demonstrates that South Asian older immigrants are a diverse and heterogeneous population and that their conception of healthy aging is strongly influenced by their country of origin. The findings show how racialized foreign-born older adults might provide distinctive perspectives on the aging process and on social theories of aging due to their

simultaneous immersion in and belonging to global majority and global minority cultures. The findings also highlight the nuances of language and how miscommunication can arise even when patients and providers are conversing in the same language. Patient engagement and shared decision-making, including the desire for family involvement, are heavily influenced by both culture and gender. Additionally, perceptions of patients regarding the status of physicians can have a notable influence on patient engagement, leading to an increased tendency for patients to agree with healthcare providers' approach to care. Lastly, this thesis demonstrates participants' perceptions of access to virtual and systemic factors, such as mandatory assimilation and whiteness as a taken-for-granted norm impacting the health and well-being of South Asian older adults.

Acknowledgements

To my supervisory committee, I write this with profound gratitude to express my heartfelt appreciation for your invaluable support and guidance throughout my PhD journey. Your collective expertise and unwavering commitment have played an instrumental role in shaping my research and helping me achieve this milestone. I want to acknowledge the countless hours you dedicated to reviewing my work, attending meetings, and providing me with your feedback. I am deeply grateful for the opportunity to work with such a distinguished and dedicated group of professionals.

To committee member, Dr. Kimberly Lopez, your insightful comments and astute observations pushed me to think critically and encouraged me to reach for higher standards in my work. Your wealth of expertise and knowledge in the field of race scholarship that you have imparted to me has greatly influenced my work and will undoubtedly continue to do so in the years that lie ahead. I am deeply appreciative of your openness in addressing matters related to our work, and equally thankful for your insight into the significance and potential impact of this research. Your guidance and encouragement have been invaluable.

To committee member, Dr. Elena Neiterman, your constructive feedback and rigorous insights have continually pushed the boundaries of my knowledge and encouraged me to strive for excellence. You introduced me to the world of qualitative research, and I owe my love for it to you. I am thankful for your guidance, which has been a constant throughout my academic journey, spanning both my undergraduate and graduate years. You were one of my earliest mentors, and your teachings have enriched me immensely over time. Your presence on my PhD committee feels like a perfect closing chapter, bringing my academic journey full circle.

To my co-supervisor, Dr. Catherine Tong, I do not know where to begin. It is hard for me to find the words to say thank you to you for everything you have done and continue to do. From the very beginning, you provided me with the tools, knowledge, and encouragement to do this research well and with integrity. Your mentorship extended beyond the boundaries of academia, shaping not only my research but also my identity as a scholar. The weekly conversations we've had discussing research and life have been incredibly meaningful to me, and I will always hold those moments dear. Your ability to provide a supportive and nurturing environment has made all the difference during the ups, downs, and all-arounds of the last few years and your dedication to my success and belief in my abilities has been a constant source of motivation. I credit my passion for ethnogerontology to you. You have been a true mentor and a role model. From the bottom of my heart, thank you.

To my co-supervisor, Dr. Paul Stolee, words cannot convey how grateful I am to have had you as my mentor. You have played an indispensable role in shaping both my scholarly identity as well as my personal character as they stand today. I can say without an ounce of doubt

that I could not have accomplished this without your guidance, patience, and belief in my capabilities. Thank you for showing me what a true leader looks like and for teaching me that being a good researcher involves more than acquiring degrees and skills; it's about possessing a strong character. It has been a true privilege to work with you and gain knowledge from your expertise. As I move forward in my academic and professional career, I carry with me the lessons and wisdom you have imparted. Your influence will continue to guide me in all my future endeavors. Finally, it was inspired by you that I started my journey in gerontology. I owe my presence in this field to you, and for that, my gratitude to you knows no bounds.

To my friends, Zunaisha Shoaib, Helena Nascimento, Aiman Fatima, Catarina Nascimento, Sanjay Veerasamy, Karen El Hajj, Leonardo Romano, Giselle Garcia, and Ruah Alsaghier, thank you. Your presence in my life has been a source of strength and encouragement. I cherish the moments we've shared, both in and out of the academic sphere. Thank you for all the wonderful memories, for always lending an ear, and for the constant laughter. As an international student away from home, I have found another family in all of you.

To Christopher Vuong, my partner, I find it difficult to put into words the depth of my gratitude for the role you've played in my PhD journey. Your love, support, and understanding have been the bedrock upon which I've built this academic achievement. Throughout the countless hours of research, the stress of deadlines, and the trials and tribulations of this PhD, your patience and encouragement have been my saving grace. Your unwavering belief in me, even when I doubted myself, provided the strength to persevere. From the countless late nights to the postponed plans, you've selflessly stood by my side, always offering a listening ear when needed and providing a sense of normalcy when everything else felt overwhelming. You've been my rock, my confidant, and my greatest supporter, and for that, I am eternally grateful.

To Odditi Chowdhury, my mother, thank you does not begin to cover it. I am who I am because of you. Thank you for teaching me to be fearless, bold, and resilient, particularly in challenging times. Thank you for showing me by example to have fun with all my pursuits in life. Thank you for imparting to me the importance of giving and kindness. Thank you for being the incredible woman you are, for nurturing my dreams, and for always standing by my side. You've been my confidant in moments of uncertainty, my cheerleader in times of triumph, and my solace in moments of despair. As I stand on the brink of this significant milestone, I want you to know that this achievement is as much yours as it is mine. Your sacrifices for me have been immeasurable. I hope you look at this and think your sacrifices were worth it.

Dedication

To my mother

All that I am, or hope to be, I owe to you.

Table of Contents

List of Tables ..... ***xiv***

Glossary ..... ***xv***

Statement of Positionality ***1***

Chapter 1 ..... ***3***

1.1 Introduction ***3***

1.2 Background ***3***

1.2.1 Healthy Immigrant Effect 3

1.2.2 Immigration and health 4

1.2.3 Healthy aging 6

1.2.4 The role of culture in shaping the beliefs and behaviours of older adults 7

1.2.5 Patient and family engagement and shared decision-making 8

1.3 Research Objectives ***10***

1.3.1 Philosophical underpinnings 11

1.4 Chapter Summaries ***12***

1.4.1 Chapter 2 12

1.4.2 Chapter 3 13

1.4.3 Chapter 4 13

1.5 Notes ***14***

1.6 References ***16***

Chapter 2 ..... ***36***

Abstract 37

2.1 Introduction ***38***

2.2 Background ***38***

2.2.1 Defining and differentiating successful and healthy aging 38

2.2.2 Culture and ethnicity 40

2.2.3 The role of culture in shaping the beliefs and behaviours of older adults 42

2.2.4 South Asian older adults in Canada 44

2.3 Methods ***46***

2.3.1 Setting, context, and recruitment 47

2.4 Data collection ***48***
2.5 Results ***52***
2.5.1 Taking care of body 52
2.5.1.1 Food: nutrition and sustenance 52
2.5.1.2 Physical activity 54
2.5.1.3 Healthcare system 55
2.5.2 Taking care of mind and heart 56
2.5.2.1 Outlook: the importance of positivity, adaptability, and disposition 56
2.5.2.2 Religion and spirituality 57
2.5.2.3 Social interaction 59
2.5.2.4 Family 60
2.5.3 The integration of mind and body 61
2.5.3.1 Food: sustenance and tradition 61
2.5.3.2 Physical activity and spirituality 62
2.6 Discussion ***65***
2.7 Implications for Future Research ***70***
2.8 Implications for Practice and Policy ***71***
2.9 Limitations ***72***
2.10 Conclusion ***72***
2.11 Acknowledgments ***73***
2.12 References ***74***
Chapter 3 ..... ***92***
Abstract ***93***
3.1 Introduction ***94***
3.2 Background ***94***
3.2.1 The importance of patient engagement and shared decision making 94
3.2.2 Patient engagement and shared decision making in the context of older adults 95
3.2.3 Patient engagement and shared decision making in the context of racialized immigrant older adults 97
3.3 Methods ***100***

3.3.1 Research design and approach 100
3.3.2 Study setting, study population, and sample 101
3.3.3 Recruitment 102
3.4 Data Collection 103
3.4.1 Translation 107
3.5 Data Analysis 108
3.5.1 Theoretical models that inform analysis 109
3.5.1.1 Bronfenbrenner's Socio-Ecological Model 109
3.5.1.2 Multilevel Eco-Social Framework 110
3.5.2 Strategies for rigour 111
3.6 Results 113
3.6.1 The intricacies of language 114
3.6.2 The role of gender and culture 115
3.6.3 The role of family in healthcare decision making 118
3.6.4 Reverence or deference to the physicians' role 119
3.7 Discussion 121
3.8 Implications for Practice & Policy Considerations 127
3.9 Limitations 130
3.10 Conclusion 131
3.11 Acknowledgements 131
3.12 References 133
Chapter 4 157
Abstract 158
4.1 Introduction 159
4.2 Background 160
4.2.1 Defining access to care 160
4.2.2 Intersectionality 161
4.2.3 The intersectional oppression of the big three: white supremacy, patriarchy, and capitalism 164

4.2.4 The need for anti-colonial and anti-racist perspectives in examining and reframing healthcare 165
4.2.5 Cultural competence & cultural humility 167
4.2.6 The present study 169
4.3 Methods 170
4.3.1 Study, setting, and context 171
4.3.2 Sample, eligibility, and recruitment 171
4.4 Data collection and Analysis 172
4.4.1 Qualitative interviews 172
4.4.2 Theoretical framework: Multilevel Eco-social Framework 174
4.4.3 Qualitative analysis and strategies for rigor 175
4.5 Results 179
4.5.1 Access to care 180
4.5.1.1 The importance of language services 181
4.5.1.2 Access to virtual care 182
4.5.2 Culture competence and humility 185
4.5.2.1 The need for cultural competence in health care provision or services 185
4.5.2.2 Holistic vs biomedical model of care 187
4.5.3 Negotiating Candidacy: the need to "fit in" 189
4.5.3.1 The need to "fit in" and whiteness as a health provision/care standard 190
4.6 Discussion and Recommendations for Policy and Practice 193
4.6.1 Applying Lin's (2021) multilevel eco-social framework to the current study 193
4.6.2 The need to look at broader society to understand individuals' experiences 194
4.6.3 The need for translators and interpreters 196
4.6.4 Considerations related to virtual care 197
4.6.5 Whiteness as the standard, and making space for deviations from the standard through cultural competence and humility 199
4.6.6 Negotiating candidacy: fitting the mould of whiteness or shedding difference? 201

4.6.7 The complexities of immigrant identity through the lens of Du Boisian theory of double consciousness 202
4.6.8 Intersectionality 205
4.7 Limitations ***206***
4.8 Conclusion ***207***
4.9 Acknowledgments ***209***
4.10 References ***210***
Chapter 5 ..... ***244***
5.1 Conclusion ***244***
5.2 Multilevel Eco-social Framework: Connections and Critiques ***245***
5.3 Future Directions for Research and Practice ***247***
References ***256***
Appendices ***329***
Ethics Clearance Certificates 329

List of Tables

Table 2 - 1 *Participant Demographics* 50

Table 2 - 2 *Inductive, Evolving Coding Structure* 51

Table 2 - 3 *Interview/Focus Group Participant Pseudonyms and Demographic Information* ... 64

Table 3 - 1 *Participant Demographics* 104

Table 3 - 2 *Interview Participant Pseudonyms and Demographic Information* 105

Table 3 - 3 *Sample Interview Questions* 106

Table 3 - 4 *A priori & Emergent, Evolving Coding Structure* 112

Table 4 - 1 *Participant Demographics* 175

Table 4 - 2 *Interview Participant Pseudonyms and Demographic Information* 177

Table 4 - 3 *Sample Interview Questions* 178

Table 4 - 4 *A priori & Emergent, Evolving Coding Structure* 178

Table 4 - 5 *Summary of Themes and Sub-themes* 180

Glossary

Acculturation: a process individuals go through in reaction to a shifting cultural environment, when transitioning from one "cultural setting" to another (Berry & Hou, 2003). Acculturation should not be used interchangeably with assimilation, since other processes of acculturation, such as integration, separation, assimilation, and marginalization also exist (Berry & Hou, 2003; Berry, 2005; Thomson & Hoffman-Goetz, 2009).

Capitalism: a system where private individuals or entities have control over property, businesses, and industries, rather than the state, with the primary aim of generating profits (Sternberg, 2015).

Culture: the dynamic interplay between race, ethnicity, and human experience, that provides a sense of belonging to one's ethnic group (Torres, 2015). Culture largely impacts the way in which individuals make sense of their world and how they assign meaning to themselves and their surroundings (Hannerz, 1992; Torres, 2006); see definition of "Culture and Ethnicity" in Chapter 2 as it pertains to ethnogerontology.

Cultural sensitivity: while there are no universal definitions for this term (Benuto et al., 2021), for the purpose of this dissertation, cultural sensitivity is defined as "…the ability to recognise, understand, and react appropriately to behaviours of persons who belong to a cultural or ethnic group that differs substantially from one's own" (Porta & Last, 2018). While cultural sensitivity is related to the concept of cultural competence and cultural humility (see Chapter 4 for detailed definition and implications), there are subtle differences in the terms (see Benuto et al., 2021; Flowers, 2004).

Ethnicity: a background variable/component to which a person "belongs" based on their membership in one or more ethnocultural groups, which involves shared meaning through both social interaction and self-identification (Torres, 2015, p. 5); see definition of "Culture and Ethnicity" in Chapter 2 as it pertains to ethnogerontology.

Ethnocultural group: defined by common traits that are recognized by a group that constitute, but are not limited to, cultural traditions, ancestry, language, national identity, country of origin, and/or physical attributes (Kopec et al., 2001). Rather than relying solely on an oversimplified definition that only considers cultural variables such as language and skin colour, it is critical to recognise that ethnocultural groups must be understood in their context, which is neither monolithic nor immutable (Sasao & Sue, 1993).

Foreign-born Older Adult: individuals over the age of 60 who: (a) were born outside of Canada, and (b) currently reside in Canada. If they primarily select Canada as the place of residence, transnational older persons who spend a significant amount of time each year in their country of origin are also included. This term is used synonymously with "immigrant" (see below).

Global majority: a term, created to counteract the negative connotations associated with being labeled as racial minorities, that encompasses people who identify as Black, Asian, Brown, dual-heritage, Indigenous to the Global South (see below), or have otherwise been classified as 'ethnic minorities' (Campbell-Stephens, 2021; Khan et al., 2022). Presently, these groups collectively make up around eighty per cent of the world's population, establishing them as the current global majority (Campbell-Stephens, 2021; Lee et al., 2023). Considering current growth trends, the global majority is projected to remain so for the foreseeable future (Boyle, 2022; Morris, 2021).

Global North/South: the term "Global North/South" does not pertain to a conventional geographical area but rather signifies the disproportionate power and prosperity of countries in specific global regions (Trefzer et al., 2014). “Global North” includes economically affluent and influential regions including North America, Europe, and Australia (Khan et al., 2022; Lees, 2021). In contrast, the "Global South" comprises countries housing the majority of the world's population, but these nations have relatively young populations and lack significant resources, leading to economic dependency (Trefzer et al., 2014). These divisions highlight the association of wealth, including aid, with predominantly white nations, while others do not share this characteristic. In essence, it reflects the notion of wealth being tied to whiteness in those powerful regions (Khan et al., 2022; Trefzer et al., 2014). This dissertation uses the term Global North/South instead of “Western/non-Western” (unless used intentionally), which centres around Britain, Canada, and other colonizing nations.

Health disparities: avoidable differences in the burden of illness, injury, violence, or chances to reach optimal health that socially disadvantaged communities’ encounter (Braveman, 2014). Groups of people who have consistently faced greater social or economic barriers to good health and well-being because of their “race or ethnicity, religion, socioeconomic status, gender, age, or mental health; physical, cognitive, or sensory disability; sexual orientation or gender identity; geographic location” or other characteristics historically linked to discrimination or exclusion are negatively impacted by health disparities (Braveman, 2014, p. 2).

Immigrant: per Statistics Canada (2021), refers to “a person who is, or who has ever been, a permanent resident. Such a person has been granted the right to live in Canada permanently by

immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this group" (p. 11).

Marginalization: defined as "the process through which persons are peripheralized based on their identities, associations, experiences, and environment" (Hall et al., 1994, p. 25). Marginalization is linked to the social exclusion of individuals considered "undesirable" members of society (Kealy & Ogrodniczuk, 2010). It involves pushing a specific group into a powerless position that hinders their chances of survival and adequate quality of life (Adamshick, 2010; Baah et al., 2019). Additionally, marginalization is associated with both structural and social inequality (Cleary et al., 2014; Díaz-Venegas, 2014; Gerlach, 2015; Krohn et al., 2011; Sampson et al., 2014), which consequently raises the risk of poor health outcomes.

Older Adult: individuals aged 60 years and older. Because I am focusing on the immigrant population, I employed the World Health Organization's cut-off of age 60 for older adults, which is consistent with how the term "older adult" has been used in other studies with individuals in South Asia (Marmamula et al., 2020; Prasad et al., 2022; World Health Organization (WHO), 2021).

Other/othered: includes groups and individuals affected by racism but encompasses all individuals subjected to intentional exploitation by dominant systems such as racism, cisheterosexism, white supremacy, imperialism, capitalism, exploitation, and genocide (Battiste, 2000; Datta, 2018; Grenier, 2020; Tuck, 2013; Thambinathan & Kinsella, 2021).

Patriarchy: a social or governmental system where men predominantly hold power, while women are largely excluded from it (Eisenstein, 2004). Facio (2013) further defines patriarchy as

“a form of mental, social, spiritual, economic and political organization/structuring of society produced by the gradual institutionalization of sex-based political relations created, maintained and reinforced by different institutions linked closely together to achieve consensus on the lesser value of women and their roles” (p. 4).

Race: Paradies (2007) defines race as ‘a concept that can be thought of as a social construct that encompasses the notion of essentialized innate difference based on phenotype, ancestry and/or culture, and that intersects in complex ways with other forms of privilege/oppression” (p. 6). However, Statistics Canada (2017) suggests avoiding this word because “race is based primarily upon genetically imparted physiognomic features among which skin colour is a dominant, but not the sole, attribute. Nevertheless, it is possible for a person to be of mixed races…There may also be terminology very much in usage in the common lexicon which is actually offensive to a group in question” (p. 8). As such, I avoid using this term in my research unless it is clearly mentioned as a variable in a study by other authors who I am referencing.

Racialized: persons, other than Indigenous peoples, who are non-white (Ontario Human Rights Commission, 2022). In recognizing the need to disrupt the dominance of white normativity, the term "non-white" will not be employed due to its focus on white individuals as the reference point. Racialization is a complex process leading to a group being labelled as different and belonging to a specific "race", and on that basis, subjected to varied and/or unequal treatment and discrimination (Dalal, 2002). Some scholars, such as Holliday et al., (2010), argue that white individuals are also racialized, highlighting that as long as race is attributed only to “non-white” individuals, and white people are not recognized and labeled racially, white people are perceived as the standard human norm (i.e., without racial distinction), while the “other” is categorized by

their race. However, for this dissertation, I emphasize that although race may not be real, racism does exist (Culley, 2006), and the process of racialization is a direct result of racism (Hochman, 2019). I define racialization as a societal process, devoid of biological or scientific basis, that applies to individuals subjected to racism. Therefore, per this definition, within the context of this dissertation, white persons are not included in the category of "racialized" individuals. It is also important to note that these definitions cannot and should not aim to encapsulate any phenomenon in a standardized, one-size-fits-all, manner since various forms of racism are inherently dynamic and context-specific, dependent on historical, cultural, geographic, and political factors (Garner & Selod, 2015).

Racism: a social determinant of health that occurs when one group has the ability to implement institutionalised discrimination through society's rules and practices while also influencing the cultural beliefs and values that underpin those racist policies and practises (Banton, 1977; Paradies, 2007).

Recent Immigrant: defined as those who have migrated within the last 10-20 years, following the most commonly used definition as proposed by Ng et al., (2012); pertaining to the importance of considering time since immigration.

South Asia: includes the countries of Bangladesh, Sri Lanka, Afghanistan, Pakistan, India, Nepal, and Bhutan.

South Asian Older Adults: older adults who self-identify with belonging to a South Asian country or ancestry. I recognize "South Asian" may be a homogenizing term that may or may not

be reflective of people's lived experiences and individual identities. As such, I will use languages-spoken, rather than country of origin, to recruit participants (Alvi & Zaidi, 2017).

Structural determinants of health: encompass cultural norms, policies, institutions, and practices that influence the distribution or maldistribution of social determinants of health (Crear-Perry, 2021). These structures and systems have roots in the nation's history and economy, founded on principles of racial, class, and gender hierarchy (Kassebaum et al., 2014; Williams, 2019). They significantly impact the allocation of power and resources across the population, leading to health inequities along racial, class, and gender lines, as well as at their intersections (Crear-Perry, 2021; Francis, 2019; Williams, 2019).

Statement of Positionality

Separating researchers from the process and the outcome of research is neither feasible nor desirable because they are an essential component of both (Galdas, 2017). This perspective can, and should, be applied to the interpretation of research as well, i.e., just as no research is neutral and "unbiased", neither is the interpretation of research (Malterud, 2001). By utilizing a positionality statement, in the spirit of reflexivity, my intent is to be reflective of my identity, values, and roles that may impact my perception and interpretation of the literature on the topic of healthcare experiences of South Asian older adults (Bourke, 2014).

I am a 25-year-old South Asian woman, born and raised in Bangladesh. My first brush with discrimination was when I was a teenager and realized that people treated me differently based on my religious background (I belong to a household that practiced both Hinduism and Islam, and I was treated differently based on people's perception of whether I was a religious "insider" or "outsider"). After moving to Canada, I faced racism a handful of times, although not overtly. I have at times been identified as a "brown girl" or "international student" with negative connotations that made me feel like an "outsider" (although I have always taken pride in those two identity-markers). After learning to think critically and formally learning about racism, I look at my past experiences with newfound knowledge. I think critically about the internationalizations I come with and where I learned them from. For instance, when learning the names of various colours in kindergarten, I was instructed to refer to porcelain as "skin colour" (needless to say, shades of "brown" and "black" were signified to be the colours of dirt, not skin-colours). This was not even a country of the Global North where most people looked porcelain or white. In these ways, "white", even in my country, was established and normalized to be the standard. It is only now, through my education and cumulative lived experiences, I realize the

deleterious impacts of such conditioning and how it produces very real and very negative consequences for persons of color all around the globe. My first understanding of the healthcare system, both in Canada and Bangladesh, was through academic means and voluntary positions, where I studied and witnessed the embedded, and often subtle, forms of racism that exist in abundance. I now make it a point to engage in a continual process of being cognisant of the internalizations and conditioning I come with based on my sociocultural "Eastern" up-bringing, my "Western" education, and my lived experiences from both, reflecting on how these identity-making factors impact my approach to research and learning. Finally, I am aware that my positionality influenced the process of collecting data since my identity markers do have an impact on how I was seen and perceived by participants, how they chose to speak to me and what they chose to say in the studies included in this dissertation. Similarly, my positionality also played a role in the data analysis of this dissertation. My research approach, as well as other aspects, was influenced by my identity markers, worldview, and personal characteristics as an individual.

Chapter 1

1.1 Introduction

The first chapter serves as an introduction to the dissertation, which will include brief overviews of the three included manuscripts. It also introduces essential foundational concepts that apply to all subsequent chapters. The introductory chapter also includes a section on the theoretical underpinnings that informed the research, and an outline of the overarching research questions and objectives.

1.2 Background

This brief literature review describes the current research in six areas that are crucial to the purpose of this thesis: 1) healthy immigrant effect 2) immigration and health; 4) consideration of culture in understanding aging; 5) patient and family engagement; and 6) existing literature on South Asian older adults in Canada.

1.2.1 Healthy Immigrant Effect

The "Healthy Immigrant Effect" posits that immigrants have a health advantage over native-born citizens that diminishes with length of residency (Newbold, 2006). Several variables affect whether or not an immigrant's health deteriorates: age at the time of immigration, race, and ethnicity; the health factors being measured, such as the number of chronic illnesses, one's mental health, and one's body weight; socioeconomic status; gender; and the experience of discrimination (de Maio & Kemp, 2010; Gee et al., 2004; McDonald et al., 2010; Zhao et al., 2010). However, much of the research that demonstrates the health advantage that immigrants have over host populations focuses on mortality and physical health outcomes and indicators (such as body mass index, total cholesterol, and diabetes) (Aldridge et al., 2018; Jin et al., 2015;

Vang et al., 2017). Non-physical outcomes, such as mental health and well-being have received less attention (Ng & Zhang, 2020). The "immigrant selection hypothesis", which postulates a positive selection of healthy immigrants into the country of residence at the individual and national levels, has frequently been related to the health advantage observed among immigrants (Vang et al., 2017). This hypothesis, however, does not account for the circumstances of refugees and undocumented immigrants, which frequently do not include positive self-selection on an individual or national level (Elshahat et al., 2021). Others (Berry & Hou, 2016; Gerber et al., 2012; Jass & Massey, 2004; Salant & Lauderdale, 2003) have suggested that the healthy immigrant effect is driven by acculturation, as a result of which immigrants tend to embrace more Canadian attitudes and lifestyle choices (e.g., more sedentary behaviours), which then negatively impact their health (Kobayashi et al., 2008).

1.2.2 Immigration and health

Racialized older adults (over the age of 55) account for 1.4 million of the total Canadian population, with 96% being born outside of Canada (McAlpine et al., 2021). The rapid increase in migration and globalization patterns in the Global North has important implications for health systems, healthcare workers, and the health of individuals (Hamilton & Hagos, 2020; Markides & Rote, 2019). Challenges faced by racialized foreign-born (i.e., immigrant) older adults in North America include greater difficulty accessing health services, lower likelihood of routine services, and an overall lower quality of care (Abbas et al., 2018; Bempong et al., 2019; Butler et al., 2016; Jakab et al., 2015; Kobayashi & Prus, 2012; Sheath et al., 2020). For racialized foreign-born older adults, access and quality of services is of particular concern (Lai & Chau, 2007; Setia et al., 2011). Studies assessing the disparities in health care and health outcomes

among racialized groups, including older adults, compared to non-racialized individuals, have identified racial, ethnic, and cultural variables as predictors of poorer health outcomes (Hamilton & Hagos, 2020; Lai & Chau, 2007; Nair & Adetayo, 2019). Health status disparities result in higher rates of mortality and morbidity among racialized foreign-born older adults even though immigrants report better health outcomes compared to non-foreign-born older adults upon arrival (Gee et al., 2004; Markides & Rote, 2019). Racialized foreign-born older adults in Canada report more difficulties navigating the health care system and obtaining care due to intersecting challenges, such as literacy, language, cultural health beliefs, as well as structural, and geographic inequities (Wang et al., 2019). These challenges are exacerbated by the complexities of family situations, immigrant status, and the healthcare system (Koehn et al., 2013), such as patients concerned that language barriers will prevent them from getting their concerns addressed (Ahmed et al., 2017).

South Asians are one of the largest and fastest-growing racialized groups in Canada, yet the health needs and experiences of this population are not comprehensively studied (Veenstra & Patterson, 2015). Furthermore, several studies have documented poorer health for South Asian-born Canadians compared to their Canadian-born peers (Anand et al., 2000; Chiu et al., 2010; de Maio, 2010; Gupta et al., 2002; Kim et al., 2013; Liu et al., 2010; Omariba, 2015; Veenstra, 2009; Vissandjee et al., 2004). Of the limited information that is currently available, most data on South Asian older adults in Canada have concentrated on mental health, health care access, chronic diseases, and some socioeconomic determinants of health (e.g., Guruge et al., 2015; Koehn et al., 2013; Wang et al., 2019). As a result, there is a notable empirical and theoretical knowledge gap surrounding the health and well-being of South Asian older adults in the Canadian context.

1.2.3 Healthy aging

To support the health and well-being of racialized foreign-born older adults in an equitable and culturally competent manner, it is important to first recognize how this population perceives and understands healthy aging. Therefore, in an era of migration, and global aging, it is important to re-examine the definitions of "healthy aging" (Lu et al., 2018; Rudnicka et al., 2020; Torres & Lawrence, 2012). The term healthy aging is often used synonymously, and critics would argue incorrectly, with successful aging (Torres, 2015). Historically, several definitions of successful aging have been identified, which include concepts such as social and psychological well-being, adapting personal values to face challenges related to older age, as well as definitions that focus on goal achievement and productivity (Bowling, 2007; Baltes & Baltes, 1990; Clark & Anderson, 1967; Gibson, 1995). However, the best known, and arguably the most applied, model to this day is Rowe and Kahn's (1997) model of successful aging (Stowe & Cooney, 2015). A problem with the term "successful" aging, is that it categorizes those who do not fit the model as "unsuccessful," including those who may have aged with a disability (Katz & Calasanti, 2015). Furthermore, the premise of avoiding disease altogether makes this framework of successful aging unrealistic for most older adults (Friedman et al., 2015). On the other hand, healthy aging, which is a related concept, encapsulates the preservation of physical and cognitive capacity, but does not necessitate the avoidance of disease (McLaughlin et al., 2012; Rowe and Kahn, 1997; Wong, 2018). In effect, Wong (2018) differentiates between successful and healthy aging by stating that healthy aging is a concept that is more applicable to the current population of older adults since it is more inclusive than successful aging. Therefore, for the proposal presented here, I have opted to use the term "healthy aging" instead of successful aging, while drawing on the WHO's (2020) definition of healthy aging, but by being

mindful of the fact that healthy aging is not only about function and the absence of disease (Friedman et al., 2015).

1.2.4 The role of culture in shaping the beliefs and behaviours of older adults

Some studies have considered the role culture plays in impacting healthy aging. For instance, a large cross-cultural study conducted in Hong Kong, Philadelphia, Illinois, Ireland, and Botswana reported that the way in which older adults perceived and understood healthy aging is influenced by their countries of origin (Keith et al., 1990). The study found that Americans focused on characteristics such as an ability to be self-sufficient and independence (e.g., living alone) as markers of aging well. Contrarily, older adults in Hong Kong did not equate self-sufficiency with healthy aging, and instead emphasised the involvement of their families (Keith et al., 1990). Torres (1999) suggests that since an individual's cultural background influences their way of life, their values and beliefs system as well as their shared process of meaning-making, including how one approaches and interprets their life, then it inadvertently impacts how individuals construe aging-related constructs, such as healthy aging. Specific to how migrating to a new country impacts healthy aging, Sampaio (2022) suggests the importance of considering local and transnational settings within which identities related to aging are formed, enacted, and restructured. Studying the influences of translational mobility can enable a broader understanding of how aging identities are given meaning and how hybrid cultures of the country of origin and the newer country of migration impact the experience and conceptualization of healthy aging (Sampaio, 2022).

However, most definitions of healthy aging in recent use lack consideration of culture, perhaps owing to the emphasis on the biomedical model of health (Cosco et al., 2014; Depp & Jeste, 2006; Friedman et al., 2019; Martin et al., 2015; Annele et al., 2019). The theoretical

development of healthy aging is largely rooted within an assumed white-centric and biomedical paradigm, despite growing evidence that the definitions, conceptualizations, and individual internalizations of aging are influenced by cultural context (Bar-Tur, 2021). Although everyone has "culture", this body of research tends to equate culture with "otherness", often to those who are racialized or ethnocultural minorities where they presently reside (Torres, 2022). Decades of research have clearly demonstrated that the understanding of health, aging, and well-being are influenced by larger sociodemographic factors (e.g., gender, age, race, ethnicity, culture, socioeconomic status) as well as by individual lived-experiences (Ryff & Singer, 1996; Ryff, 2018). In their examination of psychological well-being, Ryff (2018) noted that the understanding of domains related to positive functioning, including autonomy, purpose in life, and personal growth, vary by cultural context. Specific to older adults, Martin et al., (2015) have noted that the value system that informs the understanding of aging can differ between the Global North and cultures of the global majority. As such, culture largely impacts the way in which individuals make sense of their world and how they assign meaning to themselves and their surroundings (Hannerz, 1992; Torres, 2006). Intercultural differences in perceptions of aging are an important consideration when attempting to define healthy aging, as there is a gap in the literature in understanding how culture (e.g., cultural norms, beliefs, practices, understandings of aging) may impact healthy aging for racialized immigrant older adults.

1.2.5 Patient and family engagement and shared decision-making

As co-producers of their own health, people who use healthcare services play a crucial role in their care, and they are also the only constant in the care continuum (WHO, 2016). Additionally, patients possess the knowledge, and lived experience, necessary to inform process, system, and policy development (WHO, 2016). As such, to increase patient satisfaction with

care, lower treatment costs, and even improve the experience of the care provider, it is important to effectively involve patients in their care (Coulter & Ellins, 2007; Krist et al., 2017). Strong evidence also demonstrates that the engagement of patients and families in primary care decision-making improves chronic disease management and health outcomes (Barello et al., 2012; Hibbard & Greene, 2013; Simmons et al., 2014). Parson et al., (2010) reports that in order to support patient and family engagement, healthcare professionals must receive training and resources to support patient education and awareness, and shared decision-making. Other international studies also reveal that patient involvement decreases health inequities, enhances the standard of care, and increases patient trust (Alegria et al., 2018; Coulter & Ellins, 2007). Despite evidence pointing towards the importance of patient engagement, there have been no Canadian studies that have specifically evaluated patient and family interaction within racialized immigrant older adult communities (Wood et al., 2023). We currently lack an evidence-based understanding of how or if racialized immigrant older adults are engaged in their own healthcare. Furthermore, it is as of yet unknown how patient/family partnership approaches for health systems navigation will operate with an increasingly linguistically and culturally diverse care recipient pool. Moreover, a key component of understanding patient/family partnerships will be to understand shared decision-making approaches in racialized immigrant communities. Shared decision-making, which is a key component of person-centered care, is defined as a collaborative process in which physicians and patients choose treatment and care plans based on a shared understanding of expected outcomes and risks, in line with the patient's values and preferences (Barry & Edgman-Levitan, 2012; Coulter et al., 2011; Elwyn et al., 2010, 2012). However, there is currently a lack of understanding of how family members and caregivers of racialized immigrant older adults fit into and engage in the shared decision-making process (Wood et al.,

2023). Healthcare providers and healthcare service organisations need to be better prepared to support this often vulnerable and marginalized population of racialized immigrant older adults.

1.3 Research Objectives

The aim of the dissertation is to (a) describe how foreign-born South Asian older adults define and conceptualize the notion of healthy aging; (b) understand their approach to patient engagement and healthcare decision-making in the healthcare system; and (c) examine how South Asian older adults navigate the healthcare system and examine the impact of the wider system on the health and overall well-being of South Asian older adults.

The data for this thesis were obtained from two primary studies I conducted as lead researcher: the first study involved 19 interviews and focused on participants' conceptualization of healthy aging, while the second study involved 28 interviews focused on participants' experiences with the health care system (total number of participants, n=47). The first manuscript in the thesis (i.e., Chapter 2) draws on the data collected in the first study, while the second and third manuscripts in the thesis, (i.e., Chapter 3 and Chapter 4), draw on data obtained from the second study. All chapters in this dissertation, apart from the introductory and concluding chapter, are presented in a manuscript format.

My dissertation is embedded in a larger research study [Racialized immigrant older adults' experiences and engagement as patients in the Canadian health care system: A descriptive study in nine languages (Tong et al., 2022)], in which the study team, from the viewpoints of the participant groups (older adults, caregivers, and healthcare providers), have attempted to describe the role that racialized immigrant older adults are/are not taking in managing their own health care. A goal of this work is to develop a co-design process with these participants, creating linguistically and culturally sensitive/aligned tools, resources, or solutions to support engagement

of racialized immigrant older adults in managing their care. My role and contributions to this project are outlined above, and included the recruitment, data collection and analysis of the 28 interviews that formed my second study. Ethics clearance was obtained through the University of Waterloo Office of Research Ethics (ORE #40977). Findings will be disseminated through peer-reviewed publications, presentations, and translated lay summary reports for our community partners and participants.

1.3.1 Philosophical underpinnings

Researchers must clearly state the qualitative paradigms guiding their research. These frameworks encompass both the researcher's beliefs about reality (ontological position) and their understanding of knowledge acquisition (epistemological position) (Breuker & Hoekstra, 2004). The method of collecting and interpreting data is deeply shaped by one's understanding of knowledge and truth (Cordella & Shaikh, 2006). Ontology explores the fundamental nature of reality, while epistemology delves into the ways we can investigate and understand that reality (Al-Saadi, 2014). Though there are numerous approaches to ontology and epistemology, and various terms used in different research fields with distinct paradigms, my current focus is on how I am applying and defining these terms specifically for this research project. Informed by van der Walt's work (2020), my research on racialized foreign-born older adults adopts the interpretivism-constructivism approach to epistemology. Interpretivists-constructivists' view of reality (i.e., their ontology) is rooted in idealism, which states "the human being knows not the world-in-itself but rather the world as rendered-by-the-human mind" (Tarnas 2010, p. 417). Interpretivist-constructivists claim that mind is not a passive mirror that reflects the external world and its inherent order; rather, it actively engages and creates during the process of

perception and cognition (Barret, 2009). Reality, to some extent, is shaped by the mind rather than solely perceived by it and all human understanding involves interpretation (van der Walt, 2020). The underlying concept behind the interpretivism-constructivism approach is also that the researcher is an integral part of the research process and the interpretation of data, and cannot remain entirely objective or removed from the research (van der Walt, 2020). The process of interpretivism and constructivism is not solely influenced by the researcher's personal traits, such as their biases, assumptions, preconceived notions, gender, and age, but also by the theoretical foundations embedded in their theoretical traditions (van der Walt, 2020; Wahyuni, 2012).

1.4 Chapter Summaries

1.4.1 Chapter 2

Understanding how racialized foreign-born older adults perceive healthy aging, and how their perceptions may inform their health behavior and decision-making, is an important yet understudied domain. South Asians are the largest and fastest-growing racialized group in Canada, yet there are limited data on various aspects of health and well-being within this population, including culturally informed perceptions of aging. This manuscript examined how sociocultural influences impact the meaning assigned to healthy aging amongst older South Asians in Canada. In relation to previous work in this field, this study supports the idea that older immigrants are a diverse and heterogeneous population and that their conception of healthy aging is strongly influenced by their country of origin. The findings of this manuscript contribute to existing literature by demonstrating that South Asian-born older adults provide distinct perspectives on the aging process and social theories of aging as a result of their simultaneous immersion in and belonging to cultures of both Global North and Global South.

1.4.2 Chapter 3

Despite evidence pointing towards the importance of patient engagement, there have been no Canadian studies that have specifically evaluated patient and family engagement within racialized immigrant older adult communities (Wood et al., 2023). We currently lack an evidence-based understanding of how or if racialized immigrant older adults are engaging in their own healthcare. This manuscript examines South Asian-born older adults' experiences and approaches to patient engagement, collaborative healthcare decision-making, and the factors that influence patient engagement and healthcare decision-making within this population. The manuscript's contribution includes a thorough understanding of the importance of family, gender, and culture in South Asian older adults' healthcare experiences, as well as how communication extends beyond language. This manuscript challenges previous research that assumes language concordance as well as ethnic matching between patients and healthcare providers are unanimously beneficial.

1.4.3 Chapter 4

In Canada and internationally, the importance of an equitable healthcare system is growing, more so than before. The current biomedical model of healthcare is constructed largely in the Eurocentric tradition of medicine, which often disregards the diverse health perspectives of Canada's racialized immigrant older adults. The healthcare system in Canada, therefore, is structured around Eurocentric approaches of health and well-being. Such an approach ignores that a significant portion Canada's population is racialized. Participants of the study expressed that their approach to well-being and understanding of it did not align with their healthcare providers, resulting in unmet health needs. This study adds to the literature by demonstrating how systemic factors impact individual-level experiences of health and healthcare. The

manuscript also examined access to care, including perceptions of virtual care and the importance of language services. The results of this study can provide valuable guidance to healthcare providers and policymakers in formulating culturally sensitive guidelines that effectively cater to the needs of the South Asian populations in Canada.

1.5 Notes

i. I was responsible for undertaking all the research activity that is described in this dissertation. It is, however, important to note that I conducted the research activities as part of a larger research team within a broader project, as is commonly the case. As a result, I have used the pronoun "we" instead of "I" throughout the dissertation to acknowledge the collaborative nature of research.

ii. Throughout this dissertation, I have opted to follow sociopolitical conventions, rather than stylistic ones, concerning the capitalization of racial categories. While there is, unfortunately, a lack of wide consensus on the capitalization of racial categories (Spears, 2021), "white" is intentionally not capitalized to recognize the historical and on-going oppression rooted in white supremacy and white normativity, while terms such as Black and Indigenous are capitalized to signal their visibility. Whiteness is not the norm or the standard, rather, it was constructed and continually reinforced by individuals and institutions, granting it power and perpetuating thoughts and ideas that positioned white identity at the apex of a false hierarchy (Bailey, 2011). Stewart (2023) succinctly articulates the rationale that echoes with my approach of not capitalizing white, "recognizing the power and privileges that comes with white will hopefully push us to be far more aware of how racialized thinking shaped our past and continues to shape our

present. We should use the term more often and more boldly to reveal this racist hierarchy and to limit the unconscious perpetuation of it in our writing" (p. 7).

iii. Some participants were involved in both studies that contributed to the manuscripts in this dissertation. The pseudonyms used for these participants remain consistent across all the papers.

1.6 References

Abbas, M., Aloudat, T., Bartolomei, J., Carballo, M., Durieux-Paillard, S., Gabus, L., Jablonka, A., Jackson, Y., Kaojaroen, K., Koch, D., Martinez, E., Mendelson, M., Petrova-Benedict, R., Tsiodras, S., Christie, D., Saam, M., Hargreaves, S., & Pittet, D. (2018). Migrant and refugee populations: A public health and policy perspective on a continuing global crisis. *Antimicrobial Resistance and Infection Control*, *7*, 113. https://doi.org/10.1186/s13756-018-0403-4

Adamshick, P. (2010). The lived experience of girl-to-girl aggression in marginalized girls. *Qualitative Health Research*, *20*(4), 541–555. https://doi.org/10.1177/1049732310361611

Ahmed, S., Lee, S., Shommu, N., Rumana, N., & Turin, T. (2017). Experiences of communication barriers between physicians and immigrant patients: A systematic review and thematic synthesis. *Patient Experience Journal*, *4*(1), 122–140. https://doi.org/10.35680/2372-0247.1181

Aldridge, R. W., Nellums, L. B., Bartlett, S., Barr, A. L., Patel, P., Burns, R., Hargreaves, S., Miranda, J. J., Tollman, S., Friedland, J. S., & Abubakar, I. (2018). Global patterns of mortality in international migrants: A systematic review and meta-analysis. *Lancet (London, England)*, *392*(10164), 2553–2566. https://doi.org/10.1016/S0140-6736(18)32781-8

Alegria, M., Nakash, O., Johnson, K., Ault-Brutus, A., Carson, N., Fillbrunn, M., Wang, Y., Cheng, A., Harris, T., Polo, A., Lincoln, A., Freeman, E., Bostdorf, B., Rosenbaum, M., Epelbaum, C., LaRoche, M., Okpokwasili-Johnson, E., Carrasco, M., & Shrout, P. E. (2018). Effectiveness of the DECIDE interventions on shared decision making and perceived quality of care in behavioral health with multicultural patients: A randomized

clinical trial. *JAMA Psychiatry*, *75*(4), 325–335. https://doi.org/10.1001/jamapsychiatry.2017.4585

Al-Saadi, H. (2014). *Demystifying ontology and epistemology in research methods*.

Alvi, S., & Zaidi, A. U. (2017). Invisible Voices: An Intersectional Exploration of Quality of Life for Elderly South Asian Immigrant Women in a Canadian Sample. *Journal of Cross-Cultural Gerontology*, *32*(2), 147–170. https://doi.org/10.1007/s10823-017-9315-7

Anand, S. S., Yusuf, S., Vuksan, V., Devanesen, S., Teo, K. K., Montague, P. A., Kelemen, L., Yi, C., Lonn, E., Gerstein, H., Hegele, R. A., & McQueen, M. (2000). Differences in risk factors, atherosclerosis, and cardiovascular disease between ethnic groups in Canada: The study of health assessment and risk in ethnic groups (SHARE). *Lancet (London, England)*, *356*(9226), 279–284. https://doi.org/10.1016/s0140-6736(00)02502-2

Annele, U., Satu, K. J., & Timo, E. S. (2019). Definitions of successful ageing: A brief review of a multidimensional concept. *Acta Bio Medica : Atenei Parmensis*, *90*(2), 359–363. https://doi.org/10.23750/abm.v90i2.8376

Baah, F. O., Teitelman, A. M., & Riegel, B. (2019). Marginalization: Conceptualizing patient vulnerabilities in the framework of social determinants of health – An integrative review. *Nursing Inquiry*, *26*(1), e12268. https://doi.org/10.1111/nin.12268

Bailey, A. (2011). *On white shame and vulnerability.* (SSRN Scholarly Paper 1958858). https://papers.ssrn.com/abstract=1958858

Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In *Successful aging: Perspectives from the behavioral sciences* (pp. 1–34). Cambridge University Press. https://doi.org/10.1017/CBO9780511665684.003

Banton, M. (1977). *The idea of race*. Routledge.

Barello, S., Graffigna, G., & Vegni, E. (2012). Patient engagement as an emerging challenge for healthcare services: Mapping the literature. *Nursing Research and Practice*, *2012*, e905934. https://doi.org/10.1155/2012/905934

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making—Pinnacle of patient-centered care. *The New England Journal of Medicine*, *366*(9), 780–781. https://doi.org/10.1056/NEJMp1109283

Barrett, S.R. (2009). *Anthropology*. Toronto: University of Toronto Press.

Bar-Tur, L. (2021). Fostering well-being in the elderly: Translating theories on positive aging to practical approaches. *Frontiers in Medicine*, *8*. https://www.frontiersin.org/articles/10.3389/fmed.2021.517226

Battiste, M. (2000). *Reclaiming Indigenous Voice and Vision*. UBC Press; UBC Press. https://www.ubcpress.ca/reclaiming-indigenous-voice-and-vision

Bempong, N.-E., Sheath, D., Seybold, J., Flahault, A., Depoux, A., & Saso, L. (2019). Critical reflections, challenges and solutions for migrant and refugee health: 2nd M8 Alliance Expert Meeting. *Public Health Reviews*, *40*, 3. https://doi.org/10.1186/s40985-019-0113-3

Benuto, L. T., Singer, J., Gonzalez, F., Casas, J., & Ruork, A. (2021). How do clinicians define cultural sensitivity?: A mixed methods study. *International Journal of Mental Health*, *50*(2), 151–167. https://doi.org/10.1080/00207411.2020.1830611

Berry, J. W., & Hou, F. (2003). Immigrant acculturation and wellbeing in Canada. *Canadian Psychology / Psychologie Canadienne*, *57*(4), 254. https://doi.org/10.1037/cap0000064

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*, *29*(6), 697–712. https://doi.org/10.1016/j.ijintrel.2005.07.013

Bourke, B. (2014). Positionality: Reflecting on the Research Process. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2014.1026

Bowling, A. (2007). Aspirations for older age in the 21st century: What is successful aging? *The International Journal of Aging and Human Development*, *64*(3), 263–297. https://doi.org/10.2190/L0K1-87W4-9R01-7127

Boyle, R. C. (2022). We are not 'mixed', we are 'all': Understanding the educational experiences of mixed ethnicity children to enhance learner agency. *Education 3-13*, *50*(4), 471–482. https://doi.org/10.1080/03004279.2022.2052237

Braveman, P. (2014). What Are Health Disparities and Health Equity? We Need to Be Clear. *Public Health Reports*, *129*(Suppl 2), 5–8.

Breuker, J., & Hoekstra, R. (2004). *Epistemology and ontology in core ontologies: FOLaw and LRI-Core, two core ontologies for law*.

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J., Rosser, S., Larson, S., Allen, M., Fu, S., & Kane, R. L. (2016). *Improving cultural competence to reduce health disparities*. Agency for Healthcare Research and Quality (US). http://www.ncbi.nlm.nih.gov/books/NBK361126/

Campbell-Stephens, R. M. (2021). Introduction: Global majority decolonising narratives. In R. M. Campbell-Stephens (Ed.), *Educational leadership and the global majority: decolonising narratives* (pp. 1–21). Springer International Publishing. https://doi.org/10.1007/978-3-030-88282-2_1

Chiu, M., Austin, P. C., Manuel, D. G., & Tu, J. V. (2010). Comparison of cardiovascular risk profiles among ethnic groups using population health surveys between 1996 and 2007.

CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne, *182*(8), E301-310. https://doi.org/10.1503/cmaj.091676

Clark, M., & Anderson, B. G. (1967). *Culture and Aging: An Anthropological Study of Older Americans*. C. C. Thomas.

Cleary, M., Horsfall, J., & Escott, P. (2014). Marginalization and associated concepts and processes in relation to mental health/illness. *Issues in Mental Health Nursing*, *35*(3), 224–226. https://doi.org/10.3109/01612840.2014.883792

Cordella, A., & Shaikh, M. (2006). *From epistemology to ontology: Challenging the constructed truth of ANT*. https://doi.org/10.13140/RG.2.1.1546.5367

Cosco, T. D., Prina, A. M., Perales, J., Stephan, B. C. M., & Brayne, C. (2014). Operational definitions of successful aging: A systematic review. *International Psychogeriatrics*, *26*(3), 373–381. https://doi.org/10.1017/S1041610213002287

Coulter, A., Edwards, A., Elwyn, G., & Thomson, R. (2011). Implementing shared decision making in the UK. *Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen*, *105*(4), 300–304. https://doi.org/10.1016/j.zefq.2011.04.014

Coulter, A., & Ellins, J. (2007). Effectiveness of strategies for informing, educating, and involving patients. *BMJ (Clinical Research Ed.)*, *335*(7609), 24–27. https://doi.org/10.1136/bmj.39246.581169.80

Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. *Journal of Women's Health*, *30*(2), 230–235. https://doi.org/10.1089/jwh.2020.8882

Culley, L. (2006). Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry*, *13*(2), 144–153. https://doi.org/10.1111/j.1440-1800.2006.00311.x

Dalal, F. (2002). New perspectives from group analysis. *Psychoanalysis and Sociology*. Routledge. https://doi.org/10.4324/9780203768679

Datta, R. (2018). Decolonizing both researcher and research and its effectiveness in Indigenous research. *Research Ethics*, *14*(2), 1–24. https://doi.org/10.1177/1747016117733296

De Maio, F. G., & Kemp, E. (2010). The deterioration of health status among immigrants to Canada. *Global Public Health*, *5*(5), 462–478. https://doi.org/10.1080/17441690902942480

Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry*, *14*(1), 6–20. https://doi.org/10.1097/01.JGP.0000192501.03069.bc

Díaz-Venegas, C. (2014). Identifying the confounders of marginalization and mortality in mexico, 2003–2007. *Social Indicators Research*, *118*(2), 851–875. https://doi.org/10.1007/s11205-013-0445-1

Eisenstein, Z. (2004). Constructing a Theory of Capitalist Patriarchy and Socialist Feminism. In *Enriching the Sociological Imagination* (pp. 225–247). Brill. https://doi.org/10.1163/9789047414018_021

Elshahat, S., Moffat, T., & Newbold, K. B. (2021). Understanding the healthy immigrant effect in the context of mental health challenges: A systematic critical review. *Journal of Immigrant and Minority Health*, 1–16. https://doi.org/10.1007/s10903-021-01313-5

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. (2012). Shared decision making: A model for clinical practice. *Journal of General Internal Medicine*, *27*(10), 1361–1367. https://doi.org/10.1007/s11606-012-2077-6

Elwyn, G., Laitner, S., Coulter, A., Walker, E., Watson, P., & Thomson, R. (2010). Implementing shared decision making in the NHS. *BMJ (Clinical Research Ed.)*, *341*, c5146. https://doi.org/10.1136/bmj.c5146

Facio, A. (2013). What is patriarchy. *Translated from the Spanish by Michael Solis*, 1-5.

Flowers, D. L. (2004). Culturally competent nursing care: A challenge for the 21st Century. *Critical Care Nurse*, *24*(4), 48–52. https://doi.org/10.4037/ccn2004.24.4.48

Francis, M. (2019). The Price of Civil Rights: Black lives, white funding, and movement capture: price of civil rights. *Law & Society Review*, *53*, 275–309. https://doi.org/10.1111/lasr.12384

Friedman, S. M., Mulhausen, P., Cleveland, M. L., Coll, P. P., Daniel, K. M., Hayward, A. D., Shah, K., Skudlarska, B., & White, H. K. (2019). Healthy aging: American geriatrics society white paper executive summary. *Journal of the American Geriatrics Society*, *67*(1), 17–20. https://doi.org/10.1111/jgs.15644

Friedman, S. M., Shah, K., & Hall, W. J. (2015). Failing to focus on healthy aging: A frailty of our discipline? *Journal of the American Geriatrics Society*, *63*(7), 1459–1462. https://doi.org/10.1111/jgs.13512

Galdas, P. (2017). Revisiting Bias in Qualitative Research: Reflections on Its Relationship With Funding and Impact. *International Journal of Qualitative Methods*, *16*(1), 1609406917748992. https://doi.org/10.1177/1609406917748992

Garner, S., & Selod, S. (2015). The Racialization of Muslims: Empirical studies of islamophobia. *Critical Sociology*, *41*(1), 9–19. https://doi.org/10.1177/0896920514531606

Gee, E. M., Kobayashi, K. M., & Prus, S. G. (2004). Examining the healthy immigrant effect in mid- to later life: Findings from the Canadian community health survey. *Canadian Journal on Aging = La Revue Canadienne Du Vieillissement*, *23 Suppl 1*, S61-69.

Gerber, M., Barker, D., & Pühse, U. (2012). Acculturation and physical activity among immigrants: A systematic review. *Journal of Public Health*, *20*(3), 313–341. https://doi.org/10.1007/s10389-011-0443-1

Gerlach, A. J. (2015). Sharpening our critical edge: Occupational therapy in the context of marginalized populations. *Canadian Journal of Occupational Therapy. Revue Canadienne D'ergotherapie*, *82*(4), 245–253. https://doi.org/10.1177/0008417415571730

Gibson, R. C. (1995). Promoting successful and productive aging in minority populations. In Bond, L. A., Cutler, S. J. and Grams, A. (Eds.), *Promoting Successful and Productive Aging*. Sage.

Grenier, M.-L. (2020). Cultural competency and the reproduction of White supremacy in occupational therapy education. *Health Education Journal*, *79*(6), 633–644. https://doi.org/10.1177/0017896920902515

Gupta, M., Doobay, A. V., Singh, N., Anand, S. S., Raja, F., Mawji, F., Kho, J., Karavetian, A., Yi, Q., & Yusuf, S. (2002). Risk factors, hospital management and outcomes after acute myocardial infarction in South Asian Canadians and matched control subjects. *CMAJ: Canadian Medical Association Journal*, *166*(6), 717–722.

Guruge, S., Thomson, M. S., George, U., & Chaze, F. (2015). Social support, social conflict, and immigrant women's mental health in a Canadian context: A scoping review. *Journal of Psychiatric and Mental Health Nursing*, *22*(9), 655–667. https://doi.org/10.1111/jpm.12216

Hall, J. M., Stevens, P. E., & Meleis, A. I. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *ANS. Advances in Nursing Science*, *16*(4), 23–41. https://doi.org/10.1097/00012272-199406000-00005

Hamilton, T. G., & Hagos, R. (2020). Race and the healthy immigrant effect. *The Public Policy and Aging Report*, *31*(1), 14–18. https://doi.org/10.1093/ppar/praa042

Hannerz, U. (1992). *Cultural complexity: Studies in the social organization of meaning*. Columbia University Press.

Hibbard, J. H., & Greene, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences; fewer data on costs. *Health Affairs (Project Hope)*, *32*(2), 207–214. https://doi.org/10.1377/hlthaff.2012.1061

Hochman, A. (2019). Racialization: A defense of the concept. *Ethnic and Racial Studies*, *42*(8), 1245–1262. https://doi.org/10.1080/01419870.2018.1527937

Holliday, A., Hyde, M., & Kullman, J. (2010). *Intercultural Communication: An Advanced Resource Book for Students*. Routledge.

Jakab, Z., Severoni, S., Ostlin, P., Verschuuren, M., & Stein, C. E. (2015). Refugee and migrant health: A priority in the WHO European region. *Lancet (London, England)*, *386*(10012), 2477–2478. https://doi.org/10.1016/S0140-6736(15)01102-2

Jass, G., & Massey, D. S. (2004). *Immigrant health: Selectivity and acculturation* (Working Paper 04/23). IFS Working Papers. https://doi.org/10.1920/wp.ifs.2004.0423

Jin, K., Ding, D., Gullick, J., Koo, F., & Neubeck, L. (2015). A Chinese immigrant paradox? Low coronary heart disease incidence but higher short-term mortality in western-dwelling Chinese immigrants: A systematic review and meta-analysis. *Journal of the American Heart Association*, *4*(12), e002568. https://doi.org/10.1161/JAHA.115.002568

Kassebaum, N. J., Bertozzi-Villa, A., Coggeshall, M. S., Shackelford, K. A., Steiner, C., Heuton, K. R., Gonzalez-Medina, D., Barber, R., Huynh, C., Dicker, D., Templin, T., Wolock, T. M., Ozgoren, A. A., Abd-Allah, F., Abera, S. F., Abubakar, I., Achoki, T., Adelekan, A., Ademi, Z., … Lozano, R. (2014). Global, regional, and national levels and causes of maternal mortality during 1990–2013: A systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, *384*(9947), 980–1004. https://doi.org/10.1016/S0140-6736(14)60696-6

Katz, S., & Calasanti, T. (2015). Critical perspectives on successful aging: Does it "appeal more than it illuminates"? *The Gerontologist*, *55*(1), 26–33. https://doi.org/10.1093/geront/gnu027

Kealy, D., & Ogrodniczuk, J. S. (2010). Marginalization of borderline personality disorder. *Journal of Psychiatric Practice*, *16*(3), 145–154. https://doi.org/10.1097/01.pra.0000375710.39713.4d

Keith J., Fry, C. L., & Ikels, C. (1990) Community as context for successful aging. In Sokolovsky, J. (ed.), *The Cultural Context of Agin*g. Bergin and Garvey.

Khan, T., Abimbola, S., Kyobutungi, C., & Pai, M. (2022). How we classify countries and people—And why it matters. *BMJ Global Health*, *7*(6), e009704. https://doi.org/10.1136/bmjgh-2022-009704

Kim, I.-H., Carrasco, C., Muntaner, C., McKenzie, K., & Noh, S. (2013). Ethnicity and postmigration health trajectory in new immigrants to Canada. *American Journal of Public Health*, *103*(4), e96–e104. https://doi.org/10.2105/AJPH.2012.301185

Kobayashi, K. M., & Prus, S. G. (2012). Examining the gender, ethnicity, and age dimensions of the healthy immigrant effect: Factors in the development of equitable health policy.

International Journal for Equity in Health, *11*(1), 8. https://doi.org/10.1186/1475-9276-11-8

Kobayashi, K. M., Prus, S., & Lin, Z. (2008). Ethnic differences in self-rated and functional health: Does immigrant status matter? *Ethnicity & Health*, *13*(2), 129–147. https://doi.org/10.1080/13557850701830299

Koehn, S., Neysmith, S., Kobayashi, K., & Khamisa, H. (2013). Revealing the shape of knowledge using an intersectionality lens: Results of a scoping review on the health and health care of ethnocultural minority older adults. *Ageing & Society*, *33*(3), 437–464. https://doi.org/10.1017/S0144686X12000013

Kopec, J. A., Williams, J. I., To, T., & Austin, P. C. (2001). Cross-cultural comparisons of health status in Canada using the Health Utilities Index. *Ethnicity & Health*, *6*(1), 41–50. https://doi.org/10.1080/13557850125061

Krist, A. H., Tong, S. T., Aycock, R. A., & Longo, D. R. (2017). Engaging patients in decision-making and behavior change to promote prevention. *Studies in Health Technology and Informatics*, *240*, 284–302.

Krohn, M. D., Schmidt, N. M., Lizotte, A. J., & Baldwin, J. M. (2011). The impact of multiple marginality on gang membership and delinquent behavior for Hispanic, African American, and White male adolescents. *Journal of Contemporary Criminal Justice*, *27*(1), 18–42. https://doi.org/10.1177/1043986211402183

Lai, D. W. L., & Chau, S. B. Y. (2007). Predictors of health service barriers for older Chinese immigrants in Canada. *Health & Social Work*, *32*(1), 57–65. https://doi.org/10.1093/hsw/32.1.57

Lee, B. A., Ogunfemi, N., Neville, H. A., & Tettegah, S. (2023). Resistance and restoration: Healing research methodologies for the global majority. *Cultural Diversity and Ethnic Minority Psychology*, *29*(1), 6–14. https://doi.org/10.1037/cdp0000394

Lees, N. (2021). The Brandt Line after forty years: The more North–South relations change, the more they stay the same? *Review of International Studies*, *47*(1), 85–106. https://doi.org/10.1017/S026021052000039X

Liu, R., So, L., Mohan, S., Khan, N., King, K., & Quan, H. (2010). Cardiovascular risk factors in ethnic populations within Canada: Results from national cross-sectional surveys. *Open Medicine*, *4*(3), e143–e153.

Lu, W., Pikhart, H., & Sacker, A. (2019). Domains and measurements of healthy aging in epidemiological studies: A review. *The Gerontologist*, *59*(4), e294–e310. https://doi.org/10.1093/geront/gny029

Malterud, K. (2001). Qualitative research: Standards, challenges, and guidelines. *Lancet (London, England)*, *358*(9280), 483–488. https://doi.org/10.1016/S0140-6736(01)05627-6

Markides, K. S., & Rote, S. (2019). The healthy immigrant effect and aging in the United States and other Western countries. *The Gerontologist*, *59*(2), 205–214. https://doi.org/10.1093/geront/gny136

Marmamula, S., Barrenkala, N. R., Challa, R., Kumbham, T. R., Modepalli, S. B., Yellapragada, R., Bhakki, M., Friedman, D. S., & Khanna, R. C. (2020). Falls and visual impairment among elderly residents in "homes for the aged" in India. *Scientific Reports*, *10*(1), 13389. https://doi.org/10.1038/s41598-020-70066-2

Martin, P., Kelly, N., Kahana, B., Kahana, E., Willcox, B. J., Willcox, D. C., & Poon, L. W. (2015). Defining successful aging: A tangible or elusive concept? *The Gerontologist*, *55*(1), 14–25. https://doi.org/10.1093/geront/gnu044

McAlpine, A. A., George, U., Kobayashi, K., & Fuller-Thomson, E. (2022). Physical health of older Canadians: Do intersections between immigrant and refugee status, racialized status, and socioeconomic position matter? *The International Journal of Aging and Human Development*, *95*(3), 326–348. https://doi.org/10.1177/00914150211065408

McDonald, J. T., Queen's University (Kingston, Ont.), & Metropolis Project (Eds.). (2010). *Canadian immigration: Economic evidence for a dynamic policy environment*. School of Policy Studies, Queen's University.

McLaughlin, S. J., Jette, A. M., & Connell, C. M. (2012). An examination of healthy aging across a conceptual continuum: Prevalence estimates, demographic patterns, and validity. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, *67*(7), 783–789. https://doi.org/10.1093/gerona/glr234

Monteiro, L., & Haan, M. (2022). The life satisfaction of immigrants in Canada: Does time since arrival matter more than income? *Journal of International Migration and Integration*, *23*(3), 1397–1420. https://doi.org/10.1007/s12134-021-00899-x

Morris, N. (2021). *Mixed/Other: Explorations of Multiraciality in Modern Britain*. Orion.

Nair, L., & Adetayo, O. A. (2019). Cultural competence and ethnic diversity in healthcare. *Plastic and Reconstructive Surgery Global Open*, *7*(5), e2219. https://doi.org/10.1097/GOX.0000000000002219

Newbold, B. (2005). Health status and health care of immigrants in Canada: A longitudinal analysis. *Journal of Health Services Research & Policy*, *10*(2), 77–83. https://doi.org/10.1258/1355819053559074

Newbold, K. B. (2006a). Self-rated health within the Canadian immigrant population: Risk and the healthy immigrant effect. *Social Science & Medicine (1982)*, *60*(6), 1359–1370. https://doi.org/10.1016/j.socscimed.2004.06.048

Newbold, K. B. (2006b). Chronic conditions and the healthy immigrant effect: evidence from Canadian immigrants. *Journal of Ethnic and Migration Studies*, *32*(5), 765-784.

Ng, E., Lai, D. W., Rudner, A. T., & Orpana, H. (2012). What do we know about immigrant seniors aging in Canada? A demographic, socio-economic and health profile. *CERIS working papers*, 88-90.

Ng, E., Wilkins, R., Gendron, F., & Berthelot, J. M. (2006). Dynamics of immigrants' health in Canada: Evidence from the national population health survey. Statistics Canada. http://www.statcan.gc.ca/pub/82-618-%20m/2005002/pdf/4193621-eng.pdf)

Ng, E., & Zhang, H. (2020). The mental health of immigrants and refugees: Canadian evidence from a nationally linked database. *Health Reports*, *31*(8), 3–12. https://doi.org/10.25318/82-003-x202000800001-eng

Omariba, D. W. R. (2015). Immigration, ethnicity, and avoidable mortality in Canada, 1991-2006. *Ethnicity & Health*, *20*(4), 409–436. https://doi.org/10.1080/13557858.2014.995155

Ontario Human Rights Commission. (2022). *Racial discrimination (brochure)*. Racial discrimination (brochure) | Ontario Human Rights Commission. Retrieved December 5, 2022, from https://www.ohrc.on.ca/en/racial-discrimination-brochure

Paradies, Y. C. (2007). Defining, conceptualizing and characterizing racism in health research. *Critical Public Health*, *16*(2), 143–157. https://doi.org/10.1080/09581590600828881

Parsons, S., Winterbottom, A., Cross, P., & Redding, D. (2010). *The quality of patient engagement and involvement in primary care*. 100.

Porta, M., & Last, J. (2018). A dictionary of public health. In *A Dictionary of Public Health*. Oxford University Press.

Prasad, K., Dwivedi, S. N., Kant, S., Vibha, D., Pandit, A. K., Karthikeyan, G., Tripathi, M., Srivastava, A. K., Nehra, A., Vivekanandhan, S., Garg, A., Chutani, A. M., Verma, V., Kumar, S., Kumar, A., Gulati, K., Gulati, A., Makharia, G., Seth, T., … Tiemeier, H. (2022). Cohort Profile: The LoCARPoN-a population-based prospective cohort study in middle-aged and older adults in India. *International Journal of Epidemiology*, *51*(1), 29–30m. https://doi.org/10.1093/ije/dyab078

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, *37*(4), 433–440. https://doi.org/10.1093/geront/37.4.433

Rudnicka, E., Napierała, P., Podfigurna, A., Męczekalski, B., Smolarczyk, R., & Grymowicz, M. (2020). The World Health Organization (WHO) approach to healthy ageing. *Maturitas*, *139*, 6–11. https://doi.org/10.1016/j.maturitas.2020.05.018

Ryff, C. D. & Singer, B. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics*, *65*, 1, 14–23. https://doi.org/10.1159/000289026

Ryff, C. D. (2018). Well-being with soul: Science in pursuit of human potential. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science, 13*(2) 242–8. https://doi.org/10.1177/1745691617699836

Salant, T., & Lauderdale, D. S. (2003). Measuring culture: A critical review of acculturation and health in Asian immigrant populations. *Social Science & Medicine*, *57*(1), 71–90. https://doi.org/10.1016/S0277-9536(02)00300-3

Sampaio, D. (2022). Ageing, agency and work: Brazilian older adults building spaces of opportunity in the United States. *Social & Cultural Geography*, *0*(0), 1–17. https://doi.org/10.1080/14649365.2022.2121983

Sampson, L., Dasgupta, K., & Ross, N. A. (2014). The association between socio-demographic marginalization and plasma glucose levels at diagnosis of gestational diabetes. *Diabetic Medicine: A Journal of the British Diabetic Association*, *31*(12), 1563–1567. https://doi.org/10.1111/dme.12529

Sasao, T., & Sue, S. (1993). Toward a culturally anchored ecological framework of research in ethnic-cultural communities. *American Journal of Community Psychology*, *21*(6), 705–727. https://doi.org/10.1007/BF00942244

Setia, M. S., Quesnel-Vallee, A., Abrahamowicz, M., Tousignant, P., & Lynch, J. (2011). Access to health-care in Canadian immigrants: A longitudinal study of the National Population Health Survey. *Health & Social Care in the Community*, *19*(1), 70–79. https://doi.org/10.1111/j.1365-2524.2010.00950.x

Sheath, D., Flahault, A., Seybold, J., & Saso, L. (2020). Diverse and complex challenges to migrant and refugee mental health: Reflections of the M8 alliance expert group on migrant health. *International Journal of Environmental Research and Public Health*, *17*(10), 3530. https://doi.org/10.3390/ijerph17103530

Simmons, L. A., Wolever, R. Q., Bechard, E. M., & Snyderman, R. (2014). Patient engagement as a risk factor in personalized health care: A systematic review of the literature on chronic disease. *Genome Medicine*, *6*(2), 16. https://doi.org/10.1186/gm533

Spears, A. K. (2021). White supremacy and antiblackness: Theory and lived experience. *Journal of Linguistic Anthropology*, *31*(2), 157–179. https://doi.org/10.1111/jola.12318

Statistics Canada. (2017). *Previous standard—Race (ethnicity)*. https://www.statcan.gc.ca/en/concepts/definitions/previous/preethnicity

Statistics Canada. (2021, October 25). *Census in Brief: Ethnic and cultural origins of Canadians: Portrait of a rich heritage*. https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016016/98-200-x2016016-eng.cfm

Stewart, W. N. (2023). White/white and/or the absence of the modifier. *Journal of the Early Republic*, *43*(1), 101–108. https://doi.org/10.1353/jer.2023.0006

Sternberg, E. (2015). Defining Capitalism. *Economic Affairs*, *35*(3), 380–396. https://doi.org/10.1111/ecaf.12141

Stowe, J. D., & Cooney, T. M. (2015). Examining Rowe and Kahn's concept of successful aging: Importance of taking a life course perspective. *The Gerontologist*, *55*(1), 43–50. https://doi.org/10.1093/geront/gnu055

Tarnas, R. (2010). *The passion of the western mind: Understanding the ideas that have shaped our world view*. Random House.

Thambinathan, V., & Kinsella, E. A. (2021). Decolonizing methodologies in qualitative research: Creating spaces for transformative praxis. *International Journal of Qualitative Methods*, *20*, 16094069211014766. https://doi.org/10.1177/16094069211014766

Thomson, M. D., & Hoffman-Goetz, L. (2009). Defining and measuring acculturation: A systematic review of public health studies with Hispanic populations in the United States. *Social Science & Medicine*, *69*(7), 983–991. https://doi.org/10.1016/j.socscimed.2009.05.011

Torres, S. (1999). A culturally-relevant theoretical framework for the study of successful ageing. *Ageing & Society*, *19*(1), 33–51. https://doi.org/10.1017/S0144686X99007242

Torres, S. (2006). Elderly immigrants in Sweden: 'Otherness' under construction. *Journal of Ethnic and Migration Studies*, *32*(8), 1341–1358. https://doi.org/10.1080/13691830600928730

Torres, S. (2015). Expanding the gerontological imagination on ethnicity: Conceptual and theoretical perspectives. *Ageing & Society*, *35*(5), 935–960. https://doi.org/10.1017/S0144686X14001330

Torres, S., & Lawrence, S. (2012). An introduction to 'the age of migration' and its consequences for the field of gerontological social work. *European Journal of Social Work*, *15*(1), 1–7. https://doi.org/10.1080/13691457.2012.661562

Torre, S. (2022). Ethnicity, race and migrancy: Advancing the gerontological imagination in theoretically astute ways. *British Society of Gerontology, Virtual Conference*.

Trefzer, A., Jackson, J. T., McKee, K., & Dellinger, K. (2014). Introduction: The global South and/in the global North: Interdisciplinary investigations. *The Global South*, *8*(2), 1–15. https://doi.org/10.2979/globalsouth.8.2.1

Tuck, E. (2013). Commentary: Decolonizing Methodologies 15 years later. *AlterNative: An International Journal of Indigenous Peoples*, *9*(4), 365–372. https://doi.org/10.1177/117718011300900407

Turcotte, M. (2012). Profile of seniors' transportation habits. *Canadian Social Trends*, *93*, 1-16.

van der Walt, J. L. (2020). Interpretivism-constructivism as a research method in the humanities and social sciences – More to it than meets the eye. *International Journal of Philosophy and Theology, 8*(1), 59–68. https://doi.org/10.15640/ijpt.v8n1a5

Vang, Z. M., Sigouin, J., Flenon, A., & Gagnon, A. (2017). Are immigrants healthier than native-born Canadians? A systematic review of the healthy immigrant effect in Canada. *Ethnicity & Health*, *22*(3), 209–241. https://doi.org/10.1080/13557858.2016.1246518

Veenstra, G. (2009). Racialized identity and health in Canada: Results from a nationally representative survey. *Social Science & Medicine*, *69*(4), 538–542. https://doi.org/10.1016/j.socscimed.2009.06.009

Veenstra, G., & Patterson, A. C. (2015). South Asian-White health inequalities in Canada: Intersections with gender and immigrant status. *Ethnicity & Health*, *21*(6), 639–648. https://doi.org/10.1080/13557858.2016.1179725

Vissandjee, B., Desmeules, M., Cao, Z., Abdool, S., & Kazanjian, A. (2004). Integrating ethnicity and migration as determinants of Canadian women's health. *BMC Women's Health*, *4 Suppl 1*, S32. https://doi.org/10.1186/1472-6874-4-S1-S32

Wahyuni, D. (2012). *The research design maze: Understanding paradigms, cases, methods and methodologies* (SSRN Scholarly Paper 2103082). https://papers.ssrn.com/abstract=2103082

Wang, Q., Davis, P. B., Gurney, M. E., & Xu, R. (2021). COVID-19 and dementia: Analyses of risk, disparity, and outcomes from electronic health records in the US. *Alzheimer's & Dementia*, *17*(8), 1297–1306. https://doi.org/10.1002/alz.12296

Williams, D. R., Lawrence, J., & Davis, B. (2019). Racism and Health: Evidence and needed research. *Annual Review of Public Health*, *40*, 105–125. https://doi.org/10.1146/annurev-publhealth-040218-043750

Wong, R. Y. (2018). A new strategic approach to successful aging and healthy aging. *Geriatrics*, *3*(4), 86. https://doi.org/10.3390/geriatrics3040086

Wood, J., Stolee, P., & Tong, C. (2023). Understanding the patient experience of foreign-born older adults: A scoping review of older immigrants receiving health care in Canada. *Canadian Journal on Aging = La Revue Canadienne Du Vieillissement*, 1–11. https://doi.org/10.1017/S0714980823000235

World Health Organization. (2016). *Patient engagement*. https://apps.who.int/iris/handle/10665/252269

World health Organization (2021) *Ageing and health*. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

Zhao, Y., Dupre, M. E., Qiu, L., & Gu, D. (2017). Changes in perceived uselessness and risks for mortality: Evidence from a National sample of older adults in China. *BMC Public Health*, *17*(1), 561. https://doi.org/10.1186/s12889-017-4479-1

Chapter 2

"Think positive and don't die alone" - Foreign-born, South Asian older adults' perceptions on healthy aging

Keywords: Culture, Immigrant, Qualitative, Successful aging, Ethnogerontology, Well-being

Abstract

South Asians are the largest and fastest-growing racialized group in Canada, yet there are limited data on various aspects of health and well-being within this population. This includes the South Asian older adults' ethnoculturally informed perceptions of aging. The study aimed to understand how social and cultural forces impact the meaning assigned to healthy aging amongst older South Asians in Canada. We recruited with purposeful and snowball sampling strategies in Southern Ontario. We conducted in-depth focus group and individual interviews (n=19) in five South Asian languages, employing a multilingual and cross-cultural qualitative approach. In our analysis, we identified three central themes: (a) taking care of body (b) taking care of mind and heart and (c) healthy aging through the integration of mind and body. Our study demonstrates that older immigrants are a diverse and heterogeneous population and that their conception of healthy aging is strongly influenced by their country of origin. This study also demonstrates how racialized foreign-born older adults might provide distinctive perspectives on the aging process and on social theories of aging due to their simultaneous immersion in and belonging to global majority and global minority cultures. This research also adds to the limited body of literature on the theories of aging, despite migration trends, still has a white-centric lens.

2.1 Introduction

Like other nations in the Global North, Canada is experiencing two notable changes in the demographic landscape: increased immigration and a growing population of older adults (Warnes et al., 2004; Zubair & Norris, 2015). Among the older adult population are growing numbers of immigrants who are racialized (Statistics Canada, 2021). This warrants further exploration of racialized foreign-born older adults' heterogenous nature of experiencing old age (Blakemore, 1999; Torres, 2006a; Reich et al., 2020; Vincent et al.,2006). Currently, the experiences of foreign-born older adults are not well-understood, on account of both theoretically- and empirically-limited work (Torres 2020; Torres 2022). South Asians are the largest and fastest-growing racialized group in Canada, yet the culturally unique health needs of this population are not comprehensively studied (see reviews from Koehn et al., 2013; Lin, 2021; Quay et al., 2017; Wang et al., 2019). Of the limited information available, the bulk of empirical data on South Asian older adults in Canada has typically focused on mental health, health care access, and some chronic diseases (see Guruge et al., 2015; Koehn et al., 2013; Wang et al., 2019); to our knowledge there is no published data, empirical or theoretical, on the culturally informed perceptions of aging amongst South Asian older Canadians (or any racialized older Canadians). This study aims to understand how social and ethnocultural influences impact the meaning assigned to healthy aging amongst older South Asians in Canada, adding the voices of racialized older adults to the discussions on healthy aging.

2.2 Background

2.2.1 Defining and differentiating successful and healthy aging

In an era of migration, and global aging, it is important to re-examine the definitions of "healthy aging", given their implications for health and social care delivery and planning (Behr

et al., 2023: Lu et al., 2018; Rudnicka et al., 2020; Torres & Lawrence, 2012). Similar to the companion concept of "successful aging" (Cosco et al., 2014; Rowe & Kahn, 1998; Rubinstein & de Medeiros, 2015), conceptualizing and operationalizing healthy aging has long been the subject of vigorous inquiry and debate in gerontology (Abud et al., 2022; Bousquet et al., 2015; McLaughlin et al., 2012). Because both health and aging are multi-dimensional concepts, capturing the depth of the meanings associated with "healthy aging" within one universal definition is an elusive task. Various gerontological paradigms and studies have introduced successive terminologies to define the process of aging, including successful aging, active aging, and healthy aging, amongst others (Cosco et al., 2014; Depp & Jeste, 2006; Friedman et al., 2019; Martin et al., 2015; Urtamo et al., 2019; Wong, 2018). For instance, the World Health Organization (WHO) defines healthy aging as "the process of developing and maintaining the functional ability that enables wellbeing in older age" (World Health Organization, 2020), while Friedman and colleagues (2015) point out the widespread use of the biomedical model for defining healthy aging, where a key focus is on the absence of disease. Conversely, the psychosocial lens on healthy aging highlights general life satisfaction, social functioning, and psychological resources as key components (Friedman et al., 2015; Wong, 2018).

The term healthy aging is often used synonymously, and critics would argue incorrectly, with successful aging (Torres, 2015; Wong, 2018). Historically, several definitions of successful aging have been identified, which include concepts such social and psychological well-being, adapting personal value to face challenges related to older age, as well as definitions that focus on goal achievement and productivity (Gibson, 1995; Clark & Anderson, 1967; Baltes & Baltes, 1990). However, the best known, and arguably the most applied, model to this day is Rowe and Kahn's (1997) model of successful aging (Stowe & Cooney, 2015). This model of successful

aging posits the absence of disease and disability as well as an emphasis on individual well-being and personal satisfaction (Rowe & Kahn, 1997). Despite being the predominantly accepted definition of healthy aging, successful aging has been the subject of much criticism. For instance, McLaughlin et al., (2010) showed that only 11.9 percent older adults were "successfully" aging according to the definition of successful aging proposed by Rowe and Kahn's (1997) conceptualization (McLaughlin et al., 2010; Meng & D'Arcy, 2014). Furthermore, the premise of avoiding disease altogether makes this framework of successful aging unrealistic for most older adults (Friedman et al., 2015; Stowe & Cooney, 2015). On the other hand, healthy aging, which is a related concept, encapsulates preservation of physical and cognitive capacity, but does not necessitate the avoidance of disease (McLaughlin et al., 2012; Rowe & Kahn, 1997; Wong, 2018). In effect, Wong (2018) differentiates between successful and healthy aging by stating that healthy aging is a concept that is more applicable to the current population of older adults since it is more inclusive than successful aging. Therefore, for the research presented here, we have opted to use the term "healthy aging" instead of successful aging, while drawing on the World Health Organization's (WHO) (2020) definition of healthy aging and being mindful of the fact that healthy aging extends beyond function and the absence of disease (Friedman et al., 2015).

2.2.2 Culture and ethnicity

The terms culture and ethnicity are often used interchangeably (Torres, 2015), with both terms often employed as euphemisms for race (Bell, 2015). However, with an increase in international migration and growing communities of diverse older adults, such concepts merit attention as they are frequently conflated to mark distinctions amongst social groups. Several authors have discussed the concepts of culture and ethnicity in gerontology (e.g., Castles, 2000; Cornell & Hartmann, 1998; Jenkins, 1997), therefore, an in-depth examination of all the current

and historic definitions is beyond the scope of this paper. Renfrew (1996) points out that a common approach to defining ethnicity focuses on genetic, linguistic, and geographical variables, which often deems ethnic identity as bounded and monolithic despite being socially contingent (Smith & Wilkinson, 2007). Conversely, although the most used definition of ethnicity revolves around a mixture of physical, behavioral, and cultural attributes (Pfeffer, 1998), Jenkins (1997) offers a nuanced definition of ethnicity in differentiating it from culture, i.e., ethnicity is a product of culture that involves shared meaning through both social interaction and self-identification. Torres (2015) furthers this notion by describing ethnicity as a background variable to which a person "belongs" and culture as a variable that adds meaning to the "belonging". Therefore, similar to culture, ethnic identity can be a subjective social marker that is determined situationally (Torres, 2015; Culley, 2006). The relationship between culture and ethnicity can be summarised by Nagel's shopping cart analogy: "ethnic boundary construction determines the shape of the shopping cart (size, number of wheels), and 'ethnic culture' is composed of the things we put into the cart such as food, music, dress, religion, beliefs, symbols, and customs. Culture is not a shopping cart that comes to us already loaded with a set of goods; rather, we construct culture by picking and choosing items from the shelves of the past and the present (Nagel, 1994). Cultures change, "they are borrowed, blended, rediscovered and reinterpreted" (Nagel, 1994, p 162). Therefore, particularly for older immigrants, both their countries of origin and their country of residence impact the cultural markers they possess, giving rise to a resultant hybridized cultural identity that is complex, ever changing, and fluid, as opposed to being an immutable characteristic (Ford & Harawa, 2010; Malik, 1996; May, 1999).

Culture is dynamic and multidimensional (Asad & Kay, 2015; Raeff et al., 2020; Sue, 2001). Consequently, the term is viewed through several lenses, often dictated by the respective

disciplines of those involved (Cai, 2016; Truong et al., 2014). Several definitions of culture exist in the literature, including defining it as an integrated pattern of human behaviour, a dynamic accumulation of socially and geographically-derived human experience, and the manifestation of distinct social, economic, and political contexts (Cross, 1989; Raeff et al., 2020; Truong et al., 2014). For the purposes of our study, we employ Torres's (2015) definition of culture, which is specific to the field of ethno-gerontology. In this definition, culture is the dynamic interplay between race, ethnicity, and human experience, and provides a sense of belonging to one's ethnic group (Torres, 2015). What healthy aging means to older adults may thus vary depending on their lived experiences, personal circumstances, and social backgrounds. Therefore, just as anthropologists understand culture as open, heterogenous, and changing, understanding healthy aging can also be seen as malleable and fluid (Perkinson & Solimeo, 2014).

2.2.3 The role of culture in shaping the beliefs and behaviours of older adults

Some studies have considered the role culture plays in impacting healthy aging. For instance, a large cross-cultural study conducted in Hong Kong, Philadelphia, Illinois, Ireland, and Botswana reported that the way in which older adults perceived and understood healthy aging is influenced by their countries of origin (Keith et al., 1990). The study found that Americans focused on characteristics such as an ability to be self-sufficient and independent (e.g., living alone) as markers of aging well. Contrarily, older adults in Hong Kong did not equate self-sufficiency with healthy aging, and instead emphasised the involvement of their families (Keith et al., 1990). One reason suggested for this discrepancy was the culture of intergenerational living in Chinese families, where the ability to depend on the younger generation is seen as a marker of "good old age" (Keith et al., 1990, p. 314). Torres (1999) and Fung (2013) suggests that since an individual's cultural background influences their way of life,

their value and belief system, as well as their shared process of meaning-making, including how one approaches and interprets their life, inadvertently impacts how individuals construe aging-related constructs, such as healthy aging. Specific to how migrating to a new country impacts healthy aging, Sampaio (2021) suggests the importance of considering local and transnational settings within which identities related to aging are formed, enacted, and restructured. Studying the influences of translational mobility can enable a broader understanding of how aging identities are given meaning and how hybrid cultures of the country of origin and the newer country of migration impacts the experience and conceptualization of healthy aging (Sampaio, 2021).

However, most of the recent definitions of health aging lack a consideration of culture, perhaps owing to the emphasis on the biomedical model of health (Abud et al., 2022; Cosco et al., 2014; Depp & Jeste, 2006; Friedman et al., 2019; Martin et al., 2015; Urtamo et al., 2019). The theoretical development of healthy aging is largely rooted within an *assumed* white-centric, Eurocentric paradigm, despite growing evidence that the definitions, conceptualizations, and individual internalizations of aging are influenced by cultural context (Bar-Tur, 2021). Although everyone has "culture", this body of research tend to equate culture with "otherness" (Torres, 2022). Decades of research has clearly demonstrated that the understanding of health, aging, and well-being are influenced by larger sociodemographic factors (e.g., gender, age, race, ethnicity, culture, socioeconomic status) as well as by individual lived experiences (Ryff & Singer, 1996; Ryff, 2018). In their examination of psychological well-being, Ryff (2018) noted that the understanding of domains related to positive functioning, including autonomy, purpose in life, and personal growth, vary by cultural context. Other studies that have contextualized well-being based on work or familial environment have also suggested the potential influence of culture on

the understanding of such core aspects of living (Bloch-Jorgensen et al., 2018). Sheldon and colleagues' (2004) analysis of subjective well-being has suggested that well-being is impacted by culture, including whether a culture is considered more collectivist or individualist. Similarly, Oishi (2000) reported that goals related to independence and self-expression are often deemed less beneficial within collectivist cultures compared to individualist cultures. Specific to older adults, Martin et al., (2015) have noted that the value system that informs the understanding of aging can differ between cultures of the Global North and the Global South. As such, culture largely impacts the way in which individuals make sense of their world and how they assign meaning to themselves and their surroundings (Hannerz, 1992; Ketay et al., 2009; Torres, 2006b). Intercultural differences in perceptions of aging are an important consideration when attempting to define healthy aging, as there is a gap in the literature in understanding how culture (e.g., cultural norms, beliefs, practices, understandings of aging) may impact the experience of aging for racialized immigrant older adults. As Torres (1999) states, "culturally-specific knowledge is necessary if we are to discover what lies behind its many existing constructions" (p. 7).

2.2.4 South Asian older adults in Canada

The rapid increase in migration and globalization patterns in the developed world has important implications for health systems, healthcare workers, and the health of individuals (Hamilton & Hagos, 2020; Markides & Rote, 2019). South Asians account for 28.4 percent of the racialized population in Canada and 7.1 percent of the entire population (Statistics Canada, 2021). Large groups of South Asian immigrants, particularly from countries such as India, Pakistan, Bangladesh, and Sri Lanka, reside in Toronto, the capital of Ontario, and surrounding regions, namely the Greater Toronto Area (Islam et al., 2017). The vast majority of those from

South Asian origin are foreign-born (68%) (Chui et al., 2006). Despite South Asians being one of the largest and fastest-growing racialized groups in Canada, the health and wellbeing of this subpopulation is not well understood (Veenstra & Patterson, 2016), with most work focusing on differences and disadvantages in comparison to the reference group (i.e., those who are Canadian-born and non-racialized) (e.g., Anand et al., 2000; Chiu et al., 2010; Gupta et al., 2002; Kim et al., 2013; Liu et al., 2010; Omariba, 2015; Veenstra, 2009; Veenstra & Patterson, 2016). The lack of data on various aspects of health and well-being of this population, including culturally informed perceptions of aging, mask possible differences in health attitudes, norms, and practices. To support the health and well-being of racialized foreign-born older adults in an equitable and culturally sensitive manner, it is important to first recognize how this population perceives and understands healthy aging. Similar to the many possible definitions of culture and ethnicity, it is also important to consider terminologies that are used to describe people belonging to specific cultures and ethnicities. Pfeffer (1998) stresses the need to be aware of the meaning that is retained of the words and terms when used for individuals in isolation and in collective contexts. A common critique of using certain terms is that they lack specificity. For instance, the term "Asian" can constitute people from several different countries, differentiated in their ethnocultural background, such as India, Pakistan, China, or Korea to name a few (Pfeffer, 1998). Similarly, the term "white" can also cover a range of people, such as those of Jewish or Irish origin (Pfeffer, 1998; Sheldon and Parker, 1992). Another key criticism of using terminologies to describe specific populations is that it may lead to homogenization of individuals or communities of diverse national, linguistic, religious, and ethno-cultural backgrounds (Rahemtullah, 2010). Regarding the term "South Asian", Rahemtullah (2010) states that, although the term seemingly unifies the ethno-racial group, not acknowledging the historic

and ethnocultural specificities can be problematic. Moreover, Carsignol (2014) criticizes the "South Asian" category for having monolithic and homogenizing connotations that historically has led to maintenance of unequal power relations between immigrant and non-immigrant groups. In the Canadian context, "South Asian" is a term commonly used to encompass people from a large diversity of ethno-cultural backgrounds, including Bangladeshi, Indian, Pakistani, Nepali, and Sri Lankan ancestry (Statistic Canada, 2021). Thus, while several different terminologies are used by authors to describe their participants, it is important to provide an explanation for why a specific term was chosen over others, at the very least, for comparison purposes with other studies (Pfeffer, 1998).

The purpose of this study is to describe how foreign-born (i.e., immigrant) South Asian older adults in Canada define and conceptualize the notion of "healthy aging", thus contributing to the healthy aging literature which (despite calls for a more culturally responsive lens, e.g., Torres, 1999) has overemphasized a white-centric- lens (Fung, 2013).

2.3 Methods

To understand how foreign-born South Asian older Canadians define healthy aging, we conducted focus group and in-depth individual interviews in five South Asian languages, employing a strengths-based, multilingual, and cross-cultural qualitative approach (Liamputtong, 2010). The chosen methodology for this study is qualitative description, the objective of which is to provide a comprehensive summary of particular events experienced by individuals or groups of individuals (Kim et al., 2017). A cross-cultural qualitative approach is used to examine and interpret cultural phenomena, behaviors, beliefs, or experiences across diverse cultural contexts (Chan, 2008; Liamputtong, 2010). Researchers aim to comprehend and compare the commonalities and distinctions among various cultural groups, employing qualitative techniques

such as interviews, observations, focus groups, and content analyses (Jackson & Niblo, 2003). The primary objective is to gain insights into how culture impacts individuals and societies, leading to a greater understanding of how cultural elements influence attitudes, behaviors, and perceptions (Jackson & Niblo, 2003; Liamputtong, 2010). Identification of existing strengths to create positive, long-lasting change is the main tenet of a strengths-based strategy (Reed et al., 2008; Saleebey, 2006). According to Fast and Chapin (2002), the foundation of a strengths-based approach is based on the innate capacity of people to develop, heal, and learn, as well as on their capacity to recognise wants, the positive aspects of the individual and environment, as well as their sense of autonomy, individuality, and uniqueness.

2.3.1 Setting, context, and recruitment

We conducted this research in the Southern region of Ontario, Canada, one of the major destinations for all immigrants to Canada and representing a range of diverse South Asian communities (Statistics Canada, 2023). We recognize the term "South Asian" may be homogenizing term that may or may not be reflective of people's lived experiences and individual identities. As such, we used languages-spoken, rather than country of origin, to recruit participants. While the chosen languages reflected the most spoken languages in South Asia, this approach allowed us to identify culture-sharing groups bound by language, instead of colonially drawn borders (Alvi & Zaidi, 2017). Eligible participants were South Asian older adults (60+ years), able to provide informed consent and able to complete the interview in Hindi, Punjabi, Tamil, Urdu, Bangla, or English. The languages used in the study represent the most commonly spoken languages in the region. Because we are working with immigrant populations, we employed the WHO's cut-off of age 60 for older adults, which is consistent with how the term

"older adult" has been used in other studies with individuals in South Asia (Marmamula et al., 2020; Prasad et al., 2021; WHO, 2021).

Upon ethics approval from the University of Waterloo's Research Ethics Board (#40977), we recruited participants through several South Asian community organizations, utilizing a combination of email, recruitment posters, and word of mouth within the communities. Several of the initial participants then went on to voluntarily assist with snowball sampling (Sadler et al., 2010), sharing our recruitment materials with friends and family who met the eligibility criteria. Consent forms were sent in advance of the interviews or focus groups, via email. As a token of appreciation for their time, interview participants received an honorarium in the form of a $20 CAD gift card.

2.4 Data collection

Data were collected during the fourth wave of COVID-19 in Canada (May-June, 2021), and consequently all interviews and focus groups were completed either via the telephone or video call, at a time of the participants' choosing. Participants were asked to select either the individual or focus group interview option; in total we spoke to 19 South Asian older adults (See Table 2-1 for participant characteristics), providing us with enough data to answer the research questions sufficiently. As such, our sample size was informed by Malterud and colleagues' concept of information power (2016), in which sample size is determined during data collection, based on the richness of the data obtained and the availability of existing theory to build on from the current body of literature. Eight participants requested a spousal dyad interview, five completed an individual one-on-one interview, and six participated in two separate focus groups. The same interview guide was used for focus groups, dyad, and one-on-one interviews – the wordings of the questions were adjusted to fit each interview type; focus groups ran longer than

the dyad and one-on-one interviews to ensure the same questions were asked. Participants were given pseudonyms to protect anonymity (Table 2-3 links each pseudonym to demographic information, the language of the interview, the type of interview, etc.).

We developed the interview guide to start with general questions about healthy aging, followed by specific probes and follow-up questions. For example, if a person mentioned that food or nutrition was important to healthy aging- a common response, we would then follow with queries such as: what does food mean to you? How does food support healthy aging? Data was collected by the first author (DC), who speaks English, Hindi, Punjabi, Urdu, and Bangla (she is a native of Bangladesh and formally studied South Asian languages), and a trained research assistant fluent in Tamil and English. Interviews were often completed in a combination of English and one or more South Asian languages, and were audio recorded. Both interviewers completed comprehensive field notes within 24 hours, and regularly debriefed with one another. Qualitative researchers have recognized the challenges inherent in interpreting and translating, particularly in multilingual (i.e., more than two languages) studies (Inhetveen, 2012). Given the complex and multilingual nature of this data collection, each interviewer was also charged with translating to English and producing an English-language transcript for analysis, using the written translation approach outlined by Inhetveen (2012). The research team met regularly throughout data collection to discuss the interview guide, translation queries, and preliminary findings; these team meetings were recorded.

2.4.1 Analysis and strategies for rigour

Transcripts were cleaned, anonymized, and uploaded into NVivo 12 for analysis, along with field notes and meeting notes. The interviewers and co-authors met on several occasions to develop the coding structure. We utilized an iterative process of proposing codes and then adding

new codes as needed, through line-by-line analysis of the data, which was led by the first author (DC). Our iterative coding strategy is further detailed in Table 2-2. Strategies for rigour included: reflexive memoing while coding (Birks et al., 2008); team meetings throughout the data collection and analysis process (Guest & MacQueen, 2008); team-based analysis with members representing different disciplines and cultural groups, including "insiders" and "outsiders" (Morse, 2010); and the careful examination of outliers (Saldaña, 2021). Outliers typically refer to participants and/or themes that are unique and distinct from the bulk of the data set (Saldaña, 2021); in this study there was one notable outlier, a participant with notably high socioeconomic status, whose data largely focused on finances and legacy. We used shared memos and team-based analysis meetings to distill and discuss final central themes and address discrepancies in interpretation of the data.

Table 2 - 1

Participant Demographics

Interview and focus group sample (n=19)	
Age	71.2 mean (min: 60, max: 86)
Gender	
Men	10
Women	9
Country of origin	
India	5
Bangladesh	6
Sri Lanka	6
Pakistan	2
Years in Canada	26.4 mean (min: 2, max: 52)

Table 2 - 2

Inductive, Evolving Coding Structure

Initial Codes	Codes added during further reading of transcripts	Codes less salient, either removed or collapsed; not highlighted in the results	Final, high-level clustering of themes and sub-themes, as presented in the results
			
Physical activity Nutrition Mental activity Good genes Healthy habits and lifestyle	Yoga Food as tradition & custom Canadian health care Financial security	Avoiding alcohol and smoking Sleep and rest Good environment (home, community, nature, etc.)	**Taking care of body and being** • Food: nutrition and sustenance • Physical activity • Healthcare system**s**
Psychological health and outlook socialization Family connections and relationships Spirituality, faith & religion	Adaptation death and dying independence and autonomy collective/community perceptions on aging	Pets as companions	**Taking care of mind and heart** • Outlook: positivity, Adaptation, and disposition • Religion and spirituality • Social interaction • Family
	Yoga- mind and body Holistic approach to aging		**Integration of mind and body** • Food: sustenance and tradition • Physical activity and spirituality

2.5 Results

At the opening of each interview, most participants consistently commented on the importance of food, fitness, and friends when asked about what is important to their health and well-being. Participants also highlighted that the three core concepts – social interaction, food, and physical activity – are inter-related. For instance, when asked about the importance of one of the core components over the others, participants highlighted how each factor informs the other:

> *I think social support, physical activity and nutrition are all interdependently important. You can't have physical exercise alone, without having good healthy eating. And you cannot be doing all these things if you are isolated because that may make you feel down.*
>
> - Divya, female, 71 years old

Our analysis illuminated three central themes related to healthy aging: (a) *taking care of body and being (*b) *taking care of mind and heart;* and (c) *healthy aging through the integration of mind and body*. Additional details about the participants can be found in Table 2-3, at the end of this section.

2.5.1 Taking care of body

According to participants, healthy aging requires the ability to look after the body, through food, physical activity, and adequate access to health care.

2.5.1.1 Food: nutrition and sustenance

Of the three core factors (food, fitness, and friends), the importance of the association between food and healthy aging was emphasised by most participants. This claim was often accompanied by the notion that food and nutrition were more important than any other factors related to aging and health:

I would say diet is the most important. If you don't have healthy body and organs, then you can't do anything at all. If I eat well, then I can exercise better, and then I have more energy to socialize better as well…so, it's the most basic need.

- Mahmud, male, 83 years old

Participants also described, with a particular emphasis on older bodies, that eating high quality, "age appropriate" food, at appropriate times, was essential.

With food…not eating a lot and eating on time are important. We need to eat early. That is something that you can digest quickly. People who are older need to eat early in the morning, in the afternoon, and night…if they eat like that, they will feel healthy.

- Ashini, female, 73 years old

Many participants discussed the fluctuating nature of the relationship between age and food. This idea of how people's relationship with food changes based on their age and life circumstances was further highlighted by Prisha when discussing her status as a widow:

This [food restrictions for widows] is a custom. After my father died, my mother only ate one meal a day because her husband was no more. She couldn't eat any fish, meat, or onions. She would eat only vegetarian dishes. When my husband passed away, I used to do the same thing back home, and it made me weak physically, since I had no protein. But now that I'm in Canada, my children told me to eat more and not restrict myself the same way, so now I eat everything. I don't have the same level of restrictions here in Canada as my mother did back home [in Bangladesh].

- Prisha, female, 63 years old

Prisha's quote exemplifies how food-related lifestyle choices and habits change for some participants not only in response to age, but also social circumstances and life events. Prisha further explained that moving away from her country of origin led her to ease off on her food restrictions despite widowhood, which also improved the quality of her diet. It is worth noting

that Prisha's decision to ease her food restrictions in Canada was also influenced by her children, underscoring the significant role children can play in their parents' dietary choices. Their encouragement played a part in her decision to make changes to her diet, illustrating the impact of familial dynamics on food habits in a new environment. Similarly, other participants have also noted that they ate better after moving to Canada; this was attributed to both a higher food quality and a lower need to follow social conventions, such as food restrictions for widows, after migrating.

2.5.1.2 Physical activity

All participants categorized physical activity as an important component of healthy aging. Some participants also expressed the view that the primary marker for "being healthy" is having the ability to be physically active. Furthermore, many participants indicated that the need to be physically active is higher for older adults compared to other age groups because physical fitness allows them to be independent for longer. When asked about how physical activity may impact healthy aging, Nivaan explained:

> *Age is no barrier if you are physically fit, you can move about you're not dependent on anybody for all activities of daily living, like eating, grooming, taking a bath, or taking a walk… To me, especially in Canada, being physically active is very important so that I will still be able to drive myself. Because you don't have chauffeurs here like in India.*
>
> - Nivaan, male, 86 years old

Some participants did not equate physical activity with exercise. Instead, they considered it to be able to work and contribute financially to themselves and their family, as stated by Swapan:

> *If you are not physically active, then you cannot earn…you have to depend on your family for money. But if I can work then I can make money and use it. And even give it to my children if they need it. This can impact the family dynamic too - we are*

immigrants…I will be a burden if I come [immigrate] here and keep asking them for money.

- Swapan, male, 64 years old

While physical activity was cited as an important component of healthy aging, interviews also showed how this facet of healthy aging is closely related to the immigrant experience and concepts of independence, autonomy, and self-sufficiency.

2.5.1.3 Healthcare system

The previous sub-themes portrayed participants' actions in self-care (i.e., eating healthy and exercising), however, participants also emphasized the healthcare system as an additional resource to support them when medical assistance is needed to provide care for their health. The vast majority of older adults stated that a good quality healthcare system is a key component of an environment that supports healthy aging. Participants frequently used a comparative lens to contrast the Canadian healthcare system to the one they had in their country of origin. Although they recognised a number of limitations (e.g., wait times, language issues, lack of culturally competent long-term care options), participants largely expressed positive views and perceptions towards the Canadian healthcare system. Prisha, who is a newcomer to Canada, expressed her views on why she preferred the Canadian healthcare system over the one in her country of origin:

Even if you don't have people with you [in Canada], you can call 911 and medical services will come to get you. But back home you don't have the luxury of that, even if you have money. You need family for that. Or here, you can go to long-term care homes if you can't live with family. But back home you don't have long term care homes that are as good as the ones here.

- Prisha, female, 63 years old

Prisha's quote is an example of the positive assessments that many participants voiced. Her quote also demonstrates that the shortcomings of the healthcare system in their country of origin may lead immigrants to positively view the healthcare system in Canada. When asked about what impacts his quality of life, Kanish noted:

> *What I feel is the medical care that we get is one of the main reasons why our people are living longer here [in Canada], than in our own country [Sri Lanka]. If we don't go, the doctors keep on phoning in and asking us to come for a follow up… So, it is the ongoing support and healthcare that we get here is enabling our people to live longer.*
>
> - Kanish, male, 72 years old

2.5.2 Taking care of mind and heart

In their discussions on healthy aging, participants emphasized the importance of nourishing spiritual and emotional well-being, taking care of the mind and heart, and noted various avenues through which this could be accomplished.

2.5.2.1 Outlook: the importance of positivity, adaptability, and disposition

The need to be resilient, adaptive and hone a positive mindset as one ages was frequently expressed by participants. Participants stressed that a positive outlook helps cope better with daily affairs of life and is particularly important for older adults since it allows them to adjust to changes, both mental and physical, that occur with age. Ashish noted how a positive outlook greatly helps with overcoming challenges:

> *An ability to bounce back…comes with an open mind and positive attitude. If you fall, and you break your leg, you definitely want to believe that you'll be able to walk one day… if you give up hope then you will never get better…Being resilient is difficult, but there is no way you can keep on brooding. The worst has come but you have to live with your fate with a positive attitude.*

- Ashish, male, 88 years old

Just as Ashish mentions how being resilient can be difficult, many participants have also noted that maintaining a positive attitude can be particularly challenging when one ages. As a solution, many participants voiced that the way to adapt with age, keep a positive outlook, and be resilient was through the removal of expectations. Sanjay explains this from his perspective,

> *It [staying positive] can become very difficult sometimes when you are old, because when you are young, you could just brush off so many things in life because there is still a long journey in front of you. But as people grow old, they're coming towards the end of the journey…so, there is the tendency of overthinking or becoming emotional. For example, when I was young…I took care of my parents…And now I look back and see how my kids are taking care of me. If there is any gap in the expectation, then it can be hard…then it definitely contributes to feeling bad. So, keeping positivity intact is very, very difficult sometimes… but it is important.*
> - Sanjay, male, 62 years old

Sanjay's quote highlights that an individual's mentality and outlook can fluctuate over their lifespan. Similarly, other participants noted that when faced with an obstacle, it is difficult but important to adjust and evolve accordingly, in order to age well and stay well.

2.5.2.2 Religion and spirituality

Most interview and focus group participants deemed religion an important component of healthy aging. Tarala notes her perspective on the purpose of religion for aging well,

> *Religion is the thing that gives you support to go through all your problems. And as you get older, you take solace in the fact that these problems are given by God… we have to go through these and you pray to God, and you think he will give you an answer. So, you leave it to God every day when you get up…in the morning, you say your prayer and*

leave everything to God and that takes the weight off your head. Even if you fall ill, you take it as God's will.

- Tarala, female, 78 years

In this quote, Tarala explains that religion promotes her mental well-being not only by allowing her to gain comfort during times of distress, but by also holding religion as an explanation for the distress.

Participants, regardless of their faith system, commonly expressed the belief that one's soul or spirit persists after biological death. In this regard, participants brought up the notion that as they age and near the end of their lives, the inclination towards religion increases as a means to understand what may happen to them in the afterlife. Aruna took this notion one step further to explain that her decision to follow religion comes down to the possibility of an afterlife:

We think of the afterlife as we grow older. You know, what will happen to me after I die? I think of it as a gamble. If praying might grant me a good afterlife, then I'll just pray… just to be safe. But perhaps it's for nothing. Who knows?

- Aruna, female, 79 years old

Many participants highlighted that religion is a prominent source of positivity that impacts their mental and emotional well-being. For instance, Zarina explained that death is not a negative phenomenon because her religion teaches her so:

Aging and death is a positive thing as long as you follow what God says. But yes, everyone will die. That's a fact. You have no control over that, but what happens to you after that, is dependent on your actions. …So, we don't see death and aging as a negative thing, but rather as the beginning of a more permanent life.

- Zarina, female, 60 years old

Although most participants voiced similar ideas and the belief that death is not the end, some other participants disagreed. Of the participants who asserted that religion is of little or no importance for healthy aging, most made a distinction between religion and spirituality:

> *Religion is an institution - it dictates. It is manmade and ritualistic. And you are told to believe in one particular type of God. You cannot go beyond one group and community. But spirituality has no limits*.
>
> - Sanjay, male, 62 years old

The quotes above highlight the view that, although typically used as interchangeable terms, religion and spirituality may represent different ideas. Participants shared the view that religion is rooted in collective thinking at the level of community and organization, while spirituality operates on a more personalised level. However, despite the differences or similarities between the two concepts, participants agreed that both play a critical role in healthy aging, as a means of providing mental clarity as well as emotional and social support.

2.5.2.3 Social interaction

Participants largely identified social interaction as a means of promoting and fostering positive mental health and well-being. It was also emphasized that social interaction becomes increasingly important as one ages. For instance, Mahmud highlighted that social interaction was a way to lessen the state of isolation that increases with age:

> *Socialization is so important. You need people to talk to and interact with, or else you will become very lonely. You can have everything right – food, exercise, or money – but if you don't have anyone to speak with or spend time with, then everything feels like it doesn't matter. Especially as you age…you want to socialize more.*
>
> - Mahmud, male, 83 years old

Several participants have stated that social interaction is particularly challenging for foreign-born older adults because having immigrated, aside from their spouse and children, they lack other familial connections. Commenting on why social interaction for foreign-born older adults can be particularly challenging, Geeta noted:

> *As you get older, active social life is a problem. Humans are social animals… but isolation is the biggest problem with old people here. Isolation is a big problem for them, and social gathering is very difficult for them. Even your very own children… have no time. And especially for immigrants, it's a big problem because in our country of origin we don't have to go out to reach out to others. They come here into your house… your relatives, your children, your neighbors. But here, you don't know your very next-door neighbor.*
>
> - Geeta, female, 82 years old

Similar to Geeta, Irfaan noted how the frequency of socialization was greater for him in his country of origin:

> *Back home the culture of socializing would be different. We would be with family a lot more. Here we don't have that many relatives or family members…we have more friends here. The dynamic of socializing would be different if we were back home and not here [in Canada]. We also meet people less here. Back home we would socialize more*.
>
> - Irfaan, male, 68 years old

2.5.2.4 Family

Most participants spoke of their family, particularly their children and spouse, as the primary source of emotional and social support, both of which were identified as important components of healthy aging. As noted by Aparna:

> *You need family for emotional support. No other place to get that but from your families.*
>
> - Aparna, female, 76 years old

Apart from emotional and social support, the notion of dependence and reliance was also frequently associated with family, particularly with participants' children. Aruna, who has been in Canada for 15 years, noted:

> *I can't do anything without my family. I don't even know my address or where the next street is. So, I am completely dependent, because I don't have an option but to rely on them.*
>
> - Aruna, female, 79 years old

This notion of reliance on family for practical and emotional support was particularly emphasized by newer immigrants. For example, when probed about why the importance of family is greater in Canada, Aashi noted:

> *Family is more important here than back home because family is all we have here. Back home we would have relatives and friends who could provide more support to us. But since we came to Canada, we have only one source for that.*
>
> - Aashi, female, 60 years old

2.5.3 The integration of mind and body

Participants discussed healthy aging as having multiple dimensions. Facets of healthy aging work together to add meaning to the lives of the participants. Some notable examples of these overlaps were related to the meaning of food and the meaning of exercise.

2.5.3.1 Food: sustenance and tradition

Participants regarded food not only as nutrition, but also as a source of tradition, culture, and connection. Tradition was highlighted by participants as a key form of community-bonding and the primary way of upholding the collective values of their sociocultural background. Therefore, tradition was an additive component to their mental health and emotional well-being. For

instance, Prisha explained how food is a form of tradition that allowed her to gain an increased sense of belonging:

> *Food is a form of tradition. When we eat with my family, my son, and my daughter-in-law, eating is a lot more meaningful. So, those times, when we eat together, I don't feel like I am older than them or that I am part of a different age group. I feel like one of them. I think that's important…just eating good nutritious food doesn't just cut it. It's important to have that sincerity and togetherness when we eat.*
>
> - Prisha, female, 63 years old

Many participants voiced how food is largely the focal point of much of South Asian celebrations, religious events, and cultural ceremonies:

> *In terms of tradition, food is a big part of our culture. We have food in all big events, and we like to eat a lot too.*
> - Irfaan, male, 68 years old
>
> *Food is for sure a tradition. It's also a matter of eating healthy ethnic food. Food is also a big part of celebrations, gatherings, and invitations that we receive.*
> - Zarina, female, 60 years old

The quotes above highlight participants' view of how the impact and role of food goes beyond bodily functionality, as it impacts mental, emotional and social well-being as well. Aashi's comment, "*This is just our culture*", stresses the complex relationship that participants have with food and how integral food can be to their culture.

2.5.3.2 Physical activity and spirituality

Participants highlighted the integration of the mind and body, particularly when discussing spiritual/religious practices and physical activity. The most frequently cited example of this was the practice of yoga. Participants, primarily those who immigrated from India, commonly spoke of yoga as their primary form of physical activity as well as their way of practicing their

spirituality and connecting to a higher power. When asked to elaborate about how yoga helps with healthy aging, Jay noted,

> *Yoga is all about the mind and the body and how the two are connected. From a medical-neurological standpoint, yoga has so many benefits… it reduces my stress on so many levels and helps me keep active… But at the same time, yoga and its principles have also has gotten me closer to God and taught me to see the beauty in God's creations.*
> - Jay, male, 75 years old

Jay's comments illustrate how the domains of mental and physical health can be interconnected. Participants who had similar insights also frequently referred to Hinduism as the underlying basis of yoga. Other participants have also specified that their main source of mental clarity, cognitive well-being, stress management, spirituality, as well as exercise, was through the practice of yoga.

Another example of the integration between physical activity and religion/spirituality was through the practice of Islamic prayers, termed "namaaz". Participants, not only exclusive to the Islamic faith, have emphasized that namaaz, which is a process that requires extensive body movements, including standing, sitting, and bending in a repetitive motion, is a way to cater not only to their mental well-being, but also their physical health. When asked about the role of exercise for healthy aging, Mahmud noted:

> *I pray [namaaz] five times a day. And I think that contributes to healthy aging. This is because not only am I getting exercise while praying namaaz, but I also get peace of mind because… I devote myself to God- it brings me peace. Reminds me of a higher purpose of life…and helps me mentally.*
> - Mahmud, male, 83 years old

Similar to the practice of yoga, Mahmud's explanation of namaaz also portrays how mind and body can integrate to form a cohesive understanding of the participants' view of healthy aging.

This also highlights how integral cultural influences are to activities that participants choose to do to keep themselves mentally and physically healthy.

Table 2 - 3

Interview/Focus Group Participant Pseudonyms and Demographic Information

Pseudonym	Age	Gender	Country of Origin	Religion/Faith System	Length of time in Canada (Years)	Type of Interview Conducted	Language interview conducted in
Ashish	88	Male	Bangladesh	Hinduism	29	Individual	English
Sanjay	62	Male	Bangladesh	Hinduism	29	Individual	Bengali
Aruna	79	Female	Bangladesh	Hinduism	15	Focus group	Bengali
Prisha	63	Female	Bangladesh	Hinduism	6	Focus group	Bengali
Aparna	76	Female	India	Hinduism	51	Focus group	English
Nivaan	86	Male	India	Hinduism	47	Focus group	English
Zarina	60	Female	Pakistan	Islam	20	Dyad	Urdu
Irfaan	68	Male	Pakistan	Islam	21	Dyad	Urdu
Mahmud	83	Male	Bangladesh	Islam	2	Individual	Bengali
Jay	75	Male	India	Hinduism	52	Individual	English
Divya	71	Female	India	Hinduism	45	Individual	English
Ikshan	77	Male	Sri Lanka	Hinduism	26	Dyad	Tamil
Danvir	78	Male	Sri Lanka	Hinduism	31	Dyad	Tamil
Ashini	73	Female	Sri Lanka	Hinduism	25	Dyad	Tamil
Kanish	72	Male	Sri Lanka	Hinduism	27	Dyad	Tamil
Tarala	78	Female	Sri Lanka	Hinduism	28	Focus group	Tamil
Geeta	82	Female	Sri Lanka	Hinduism	28	Focus group	English
Swapan	64	Male	Bangladesh	Hinduism	9	Dyad	Bengali
Aashi	60	Female	India	Hinduism	10	Dyad	Hindi

2.6 Discussion

The present study explored how foreign-born South Asian older adults in Canada perceive and define the concept of healthy aging. Three primary interrelated dimensions of healthy aging were highlighted by the participants: (A) taking care of body; (B) taking care of mind and heart; and (C) the integration of mind and body. The multi-faceted views of the participants within each dimension illuminated the influence of culture that remains central to, and informs, their conceptualization of healthy aging. This finding is consistent with previous research on racialized foreign-born older adults. For instance, in their study with foreign-born Chinese and South Asian older adults, Tong and colleagues' (2020) noted that culture is a prominent driver of health behaviours. Similarly, Napier et al., (2014) states that, "ideas about health are… cultural" (p. 17), pointing towards how perspectives on physiological and psychosocial wellbeing differ substantially across and within cultures and societies.

Participants believed that healthy aging extends beyond simply the absence of disease and longevity. The quality of life, including the quality of food, social connection, and the environment, was highlighted as a key determinant of healthy aging. Participants also heavily emphasized the importance of attitude, mindset, and outlook that impacts all facets of the process and experience of aging. This finding is distinct from the biomedical model of aging that still predominates in the understanding and practise of healthy aging in the Global North. Rowe and Kahn's (1997) model, which despite considerable academic criticism is widely cited and influential, highlights three components of successful aging: avoidance of disease and disability, the maintenance of high physical and cognitive function, and being engaged socially and productively. In contrast, our findings indicate that healthy aging consists of broader and more holistic domains. Although participants did voice the importance of avoiding disease and

disability and having the ability to function well in order to age well, it was not limited to those areas. For instance, participants, to a large extent, highlighted the importance of familial connection and social interaction as well as religion and spirituality as core components of healthy aging. As such, the findings of this study are consistent with the life course perspective, which posits the importance of the larger historical, social, and cultural context of aging (Hanson et al., 2016; Kuh et al., 2014). More specifically, the life course approach considers how sociocultural forces and individual agency as well as lived experiences interact to shape the outcomes and experiences of aging (Dannefer, 2012; Kuh et al., 2014). An example of this in our study is provided by Prisha, a widow who, after moving to Canada, altered her diet due to the greater ease in social restrictions within her new social environment.

Cartesian dualism, a concept credited to 17th century philosopher Rene Descartes, largely dominates the white-centric biomedical understanding of health and aging, suggesting that physical health (body) and mental health (mind) are separate and distinct (Descartes et al.,1952; Thibaut, 2018). This view of mind and body dichotomy was not shared by many participants in this study. Instead, participants voiced that not only do mind and body inform each another, but that they are, in many instances, integrated. The participants brought up two particularly prominent examples of this: (a) viewing food as sustenance as well as a fundamental source of tradition and social connection, and (b) perceiving physical activity as exercise as well as a means of practicing one's spirituality and/or religion. Participants explained that although food and physical activity are important for the body, they are just as important for the mind. Although there are several research studies that associate physical activity with mental well-being, such studies focus on the indirect causal pathway that results from exercise, attributed to release of certain hormones and chemical changes that may work to prevent mental disorders

(Bize et al., 2007; Peluso & Guerra de Andrade, 2005). Similarly with food, there is substantial evidence that supports how consumption of healthy and nutritious food may prevent disease burden, such as with obesity and heart disease, which may then consequently promote mental well-being (Owen & Corfe, 2017; van der Pols, 2018). However, this is distinct from the findings of our study because participants emphasised that, as opposed to being a product of eating well and exercising, the very act of doing so, in and of itself, contributes to their mental, spiritual, and social well-being. Participants have attributed this understanding of health to their cultural and social upbringing. In support, Mehta (2011) states that the dichotomous view of mind and body persists because our understanding of health is rooted within a dualistic biomedical culture. However, as exemplified by the participants of this study, it is important to acknowledge the dynamic nature of human beings that results from different cultures and environments and endorse a holistic view of healthy aging (Ernst, 2007).

Our findings highlighted the significance of family and the predominance of a family-oriented approach to aging and well-being for our participants. While some participants, particularly those who were newcomers, emphasised their reliance on family for needs such as their emotional well-being and healthcare decision-making, several participants also stressed the importance of fostering interdependence. Prior studies with racialized immigrant older adults that report similar findings on the role of family point towards the understanding that collectivist societies, such as South Asian communities, have a heightened level of importance accorded to family (Conkova & Lindenberg, 2020; Beyene et al., 2002; Nieboer et al., 2021). For instance, a key finding by Choudhry and colleagues' (2002) study on South Asian women in Canada reported that participants placed the needs of their family before their own needs – a thought similarly expressed by participants of our study. Another study by Beyene et al., (2002) showed

that for Latino older adults in the United States, successful aging was closely related to and influenced by familial relationships and the fulfillment of culturally embedded expectations from family members, particularly their children. Participants of our study added a step further to explain that the conscious removal of such expectations through the adaptation of their mindset and outlook is a way of reducing stress and upholding their mental and emotional well-being as they age. Barbaranelli et al., (2019) reports the importance of outlook in encouraging people to view their own lives in a positive way, while numerous articles have emphasised the value of optimism in fostering health, happiness, and preventing maladjustment (Alessandri et al., 2012; Caprara et al., 2016). Participants also added that countries in the Global North such as Canada tend to focus more on nuclear families, whereas their countries of origin place a much higher emphasis on communal living, community, and extended social networks beyond immediate family members. As such, our findings are consistent with previous studies that found autonomous or independent control to be less valued and filial piety and familial bonding to be regarded as significant in collectivist immigrant communities (Nieboer et al., 2021; Huang & Fioco, 2020).

Furthermore, participants conveyed that the influence and impact of their families was not limited to the social domain of healthy aging. A key example of this brought forth by participants represented an intersection between nutrition, family, religion, and gender. Some female participants emphasized widowhood as a prominent identity marker which influenced not only their social dynamics (e.g., being given less importance and less of a voice since the death of their husband) but also their eating habits. Certain South Asian communities impose restrictions and external markers upon women to indicate their transition to widowhood (Jacobsen & Myrvold, 2018). Participants of our study highlighted that such impositions that are

placed to uphold religious and societal norms have negatively impacted their health and experience of aging. For instance, following the death of their husbands, participants experienced physical weakness on account of a limited diet. However, some participants also conveyed that after immigrating, their children, who brought them to Canada, talked them into easing off on previously imposed dietary restrictions. This reflects a shift in familial dynamics post immigration where the children start to take precedence over their late husbands. Unlike our findings, a study by Vesnaver et al., (2015) that focused on non-immigrant older women from Caucasian or European descent, found that widowhood resulted in re-adjustment of food behaviours that led to more satisfactory personal food systems. Additionally, contradictory to our findings, previous studies that looked at non-immigrant older women reported that with the removal of food-related obligations as a wife, women had more freedom to choose their own food preferences during widowhood (Quandt et al., 2000; Johnson, 2002). Although studies have looked at the relationship between food and widowhood, to our knowledge, this is the first to discuss this relationship between food and widowhood amongst South Asian-born older adults in Canada, which could explain the disparity in findings.

Finally, the results of our analyses also suggested that immigration largely shaped the participants' experiences and understanding of healthy aging. Participants recurrently viewed aging, health, and well-being through the lens of an immigrant, highlighting several challenges, such as decreased opportunities for social interaction, and benefits, such as less stringent cultural norms, that resulted from migrating to Canada. These findings highlight the large influence that immigration has on health behaviours and perceptions of aging-related constructs among racialized foreign-born older adults. This also suggests that the process of immigrating to a country with different cultures and social norms can influence the understanding and practice of

one's own culture of origin, which then impacts their health behaviours, perceptions, and overall approach to well-being. For instance, in our study we saw that migrating to Canada led to lesser food restrictions for widows. Moreover, Torres (2001) reported similar findings while studying successful aging amongst Iranian immigrants, noting that individuals often redefine concept of aging well after immigration. This is particularly so when individuals immigrate to a culture that is different in fundamental ways from their culture of origin, such as migrating from a collectivist society to one that is individualistic (Torres, 2001), as in the case for our study. This was further evidenced by participants of this study who emphasised the need to adapt and evolve their approach and attitude towards everyday life, including health and aging, to one that was compatible with norms of the Global North, such as with dietary changes and social compliance. Therefore, not only is culture interwoven within all dimensions of well-being, but the approach to and understanding of healthy aging is contingent upon the individuals' culture of origin, the culture that is acquired after immigrating to a new country, and a hybrid culture that is a product of the two (Torres, 1999; Torres, 2006b).

2.7 Implications for Future Research

Our team has employed an interpretive lens, drawing on our own knowledge of South Asian culture and academic literature to hypothesize some of the ways in which this culture may inform perceptions of aging amongst immigrants to Canada. Shooshtari et al., (2020) found that there are differences between conceptualizations of healthy aging among ethnocultural group. Our study expands on these findings by examining what those specific differences may be for the South Asian population, which is one of Canada's largest ethnocultural group. Finally, the results of our study have strong implications for future research that focus on the meaning associated with food not only as sustenance but also an important component of culture and sense of

identity for South Asian communities. We had limited opportunity to speak to widows belonging to South Asian communities. Future studies are needed to further study the interaction of widowhood and aging in a foreign land.

Before creating resources that can support racialized immigrant older adults, it would be important to first understand how health and well-being is conceptualized by this population. This study can be used as a starting point to inform future development and implementation of interventions to support culturally competent, person-centered care of racialized immigrant older adults. For example, currently, there is limited evidence regarding the nature of patient engagement, and the role that family members play within this interaction, for racialized foreign-born older adults (Culhane-Pera et al., 2010). This study can shed light on how racialized foreign-born older adults conceptualize the importance of family, and in turn, help in understanding the role that family can play in the experience of aging. This understanding of the family's significance in the aging experience could serve as a foundation for understanding how family might influence healthcare experiences and navigation among racialized foreign-born older adults.

2.8 Implications for Practice and Policy

Our research contributes to the current implications of practice and policy related to the health and well-being of and services for racialized immigrant older adults. This research can assist health practitioners, government organizations, and policy makers in understanding aspects of health that are important to older adults from South Asian backgrounds. For instance, government programs that are designed to cater to the health of the older adults tend to focus majorly on the physical aspects of health (Clarke et al., 2003); our research points to the importance of considering health beyond the physical and initiating programs that consider not

only mental health but the mind in tandem with the body. The results of this study can also contribute to assessing the efficiency and competence of existing services and programs for South Asian older adults in Ontario. Similarly, understanding how South Asian older adults conceptualize healthy aging can enable health practitioners to understand their approach to health management, health behaviour, and healthcare decision making, which has important implications for healthcare provision and patient-provider engagement. Therefore, the findings of this study can be used to advance scholarship in work related to promoting healthy aging for older adults from diverse ethnic and linguistic backgrounds by informing policy and practice change at local and possibly national levels (Lin, 2021).

2.9 Limitations

In North American research on ethnocultural groups, the term 'South Asian' has primarily represented those from India (e.g., Koehn et al., 2016; Oliffe et al., 2009; Tong et al., 2020). It is a strength of our work to have also reached older adults from Bangladesh, Pakistan and Sri Lanka; however, we recognize that our sample does not include individuals from Afghanistan, Bhutan, Maldives or Nepal and cannot be generalized to the experiences of all South Asians aging in Canada. Future research, both of our team and others, should be cautious of the term 'South Asian' when only representing a portion of the region in our recruitment and data collection. Also, in our experiences both here and in prior work (e.g., Tong et al., 2019), we note that it can be incredibly challenging for people to articulate notions of culture and cultural norms in interviews.

2.10 Conclusion

Understanding how racialized foreign-born older adults perceive healthy aging, and how their perceptions may inform their health behavior and decision-making, is an important yet

understudied domain (Montoya-Williams et al., 2020). Our study is one of only a few studies (e.g., Keith et al., 1990; Oishi, 2000; Sampaio, 2021) focusing on how racialized immigrant older adults perceive and conceptualize healthy aging. Further, our study reinforces the notion that immigrant older adults are a diverse and heterogenous population, and that the culture of their country of origin is heavily infused in their conceptualization of healthy aging. This study also highlights that being immersed in and belonging to both a global majority and a global minority culture simultaneously, racialized foreign-born older adults can offer unique perspectives on the aging process and on social theories of aging. With the increasingly diverse geriatric population in migrant-receiving, Global North nations, it is now more important than ever to recognize these unique perspectives and understand how intersecting statuses of "ethnic-minority" and "immigrant" can impact older adults' health and well-being.

2.11 Acknowledgments

We sincerely thank the research participants who generously shared their experiences and perspectives with us. This work was supported by the Canadian Institutes of Health Research (grant number: 452873) and a University of Waterloo International Doctoral Scholarship Award granted to DC.

2.12 References

Abud, T., Kounidas, G., Martin, K. R., Werth, M., Cooper, K., & Myint, P. K. (2022). Determinants of healthy ageing: A systematic review of contemporary literature. *Aging Clinical and Experimental Research*, *34*(6), 1215–1223. https://doi.org/10.1007/s40520-021-02049-w

Alessandri, G., Vecchione, M., Tisak, J., Deiana, G., Caria, S., & Caprara, G. V. (2012). The utility of positive orientation in predicting job performance and organisational citizenship behaviors. *Applied Psychology*, *61*(4), 669–698.

Alvi, S., & Zaidi, A. U. (2017). Invisible voices: An intersectional exploration of quality of life for elderly South Asian immigrant women in a Canadian sample. *Journal of cross-cultural gerontology*, *32*(2), 147-170.

Anand, S. S., Yusuf, S., Vuksan, V., Devanesen, S., Teo, K. K., Montague, P. A., Kelemen, L., Yi. C., Lonn, E., Gerstein, H., Hegele, R. A., & McQueen, M. (2000). Differences in risk factors, atherosclerosis, and cardiovascular disease between ethnic groups in Canada: the Study of Health Assessment and Risk in Ethnic groups (SHARE). *Lancet (London, England)*, *356*(9226), 279–284.

Asad, A. L., & Kay, T. (2015). Toward a multidimensional understanding of culture for health interventions. *Social Science & Medicine*, *144*, 79-87. https://doi.org/10.1016/j.socscimed.2015.09.013

Baltes, P. B., & Baltes, M. M. (eds) (1990). *Successful Aging: Perspectives from the Behavioural Sciences*. Cambridge University Press.

Barbaranelli, C., Paciello, M., Biagioli, V., Fida, R., & Tramontano, C. (2019). Positivity and behaviour: The mediating role of self-efficacy in organisational and educational settings.

Journal of Happiness Studies: An Interdisciplinary Forum on Subjective Well-Being, *20*(3), 707–727. https://doi.org/10.1007/s10902-018-9972-4

Bar-Tur, L. (2021). Fostering Well-Being in the Elderly: Translating Theories on Positive Aging to Practical Approaches. *Frontiers in Medicin*e, *8*, 200. https://doi.org/10.3389/fmed.2021.517226

Behr, L. C., Simm, A., Kluttig, A., & Grosskopf Großkopf, A. (2023). 60 years of healthy aging: On definitions, biomarkers, scores and challenges. *Ageing Research Reviews*, *88*, 101934. https://doi.org/10.1016/j.arr.2023.101934

Bell, E. (2015). Ethnicity versus Culture. *In The Wiley Blackwell Encyclopedia of Race, Ethnicity, and Nationalism* (eds A.D. Smith, X. Hou, J. Stone, R. Dennis and P. Rizova). https://doi.org/10.1002/9781118663202.wberen578

Beyene, Y., Becker, G., & Mayen, N. (2002). Perception of aging and sense of well-being among Latino elderly. *Journal of Cross-cultural Gerontology*, *17*(2), 155–172. https://doi.org/10.1023/a:1015886816483

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing, 13*(1), 68-75.

Bize, R., Johnson, J. A., & Plotnikoff, R. C. (2007). Physical activity level and health-related quality of life in the general adult population: a systematic review. *Preventive Medicine*, *45*(6), 401-415.

Blakemore, K. (1999). International migration in later life: social care and policy implications. *Aging & Society*, *19*(6), 761-774.

Bloch-Jorgensen, Z. T., Cilione, P. J., Yeung, W. W., & Gatt, J. M. (2018). Centeredness Theory: Understanding and Measuring Well-Being Across Core Life Domains. *Frontiers in Psychology*, *9*, 610. https://doi.org/10.3389/fpsyg.2018.00610

Bousquet, J., Kuh, D., Bewick, M., Standberg, T., Farrell, J., Pengelly, R., Joel, M. E., Rodriguez, Mañas. L., Mercier, J., Bringer, J., Camuzat, T., Bourret, R., Bedbrook, A., Kowalski, M. L., Samolinski, B., Bonini, S., Brayne, C., Michel, J. P., Venne J, Viriot-Durandal P. (2015) Operational Definition of Active and Healthy Aging (AHA): A Conceptual Framework. *The Journal of Nutrition, Health & Aging*, *19*(9), 955–960. https://doi.org/10.1007/s12603-015-0589-6

Cai, D. (2016). A concept analysis of cultural competence. *International Journal of Nursing Sciences*, *3*(3), 268-273. https://doi.org/10.1016/j.ijnss.2016.08.002

Caprara, G. V., Eisenberg, N., & Alessandri, G. (2016). Positivity: The dispositional basis of happiness. *Journal of Happiness Studies*, *18*, 1–19.

Castles, S. (2000). *Ethnicity and Globalization: From Migrant Worker to Transnational Citizen*. Sage.

Carsignol, A. (2014). *The Construction, Mobilization and Limits of South Asianism in North America*. South Asia Multidisciplinary Academic Journal.

Chan, A. (2008). Measuring cross-cultural values: A qualitative approach. *Proceedings of Ninth International Business Research Conference, Held in Melbourne, Vic., November 2008*. https://researchdirect.westernsydney.edu.au/islandora/object/uws%3A7684/

Chiu, M., Austin, P. C., Manuel, D. G., & Tu, J. V. (2010). Comparison of cardiovascular risk profiles among ethnic groups using population health surveys between 1996 and 2007.

CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne, 182(8), E301–E310. https://doi.org/10.1503/cmaj.091676

Chui, T., Tran, K., & Maheux, H. (eds) (2006). Canada's ethnocultural mosaic, census (catalogue no. 97-562-XIE2006001). *Statistics Canada*. Available online at https://www12.statcan.gc.ca/census-recensement/2006/as-sa/97-562/p2-eng.cfm

Choudhry, U. K., Jandu, S., Mahal, J., Singh, R., Sohi-Pabla, H., & Mutta, B. (2002). Health promotion and participatory action research with South Asian women. *Journal of Nursing Scholarship*, *34*(1), 75-81.

Clark, M., & Andersson, B. G. (1967). *Culture and Aging : an Anthropological Study of Older Americans*. Charles C. Thomas.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003). Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine. *American Sociological Review*, *68*(2), 161–194. https://doi.org/10.2307/1519765

Conkova, N., & Lindenberg, J. (2020). The Experience of Aging and Perceptions of "Aging Well" Among Older Migrants in the Netherlands. *The Gerontologist*, *60*(2), 270–278. https://doi.org/10.1093/geront/gnz125

Cornell, S., & Hartmann, D. (1998). *Ethnicity and Race: Making Identities in a Changing World*.

Cosco, T. D., Prina, A. M., Perales, J., Stephan, B. C., & Brayne, C. (2014). Operational definitions of successful aging: a systematic review. *International Psychogeriatrics*, *26*(3), 373–381. https://doi.org/10.1017/S1041610213002287

Cross, T. L. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.* ERIC.

Culhane-Pera, K. A., Allen, M., Pergament, S. L., Call, K., Adawe, A., de la Torre, R., Hang, M., Jama, F., Navas, M., Ortega, L., Vue, P., & Yang, T. T. (2010). Improving health through community-based participatory action research. Giving immigrants and refugees a voice. *Minnesota medicine*, *93*(4), 54–57.

Culley, L. (2006). Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry*, *13*(2), 144–153. https://doi.org/10.1111/j.1440-1800.2006.00311.x

Dannefer, D. (2012). Enriching the tapestry: expanding the scope of life course concepts. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *67*(2), 221–225. https://doi.org/10.1093/geronb/gbr148

Descartes, R., De Spinoza, B., & Hutchins, R. M. (1952). *Great Books of the Western World*. Encyclopaedia Britannica.

Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: a comprehensive review of larger quantitative studies. *The American Journal of Geriatric Psychiatry : Official Journal of the American Association for Geriatric Psychiatry*, *14*(1), 6–20. https://doi.org/10.1097/01.JGP.0000192501.03069.bc

Ernst, E. (2007). Holistic health care? *The British Journal of General Practice : The Journal of the Royal College of General Practitioners*, *57*(535), 162–163.

Fast, B. , & Chapin, R (2002). The strengths model with older adults: Critical practice components. In Saleebey, D. (Ed.), The strengths perspective in social work practice (3rd ed.; pp. 143–162). New York: Longman.

Ford, C., & Harawa, N. T. (2010). A new conceptualization of ethnicity for social epidemiologic and health equity research. *Social science & medicine (1982)*, *71*(2), 251–258. https://doi.org/10.1016/j.socscimed.2010.04.008

Friedman, S. M., Mulhausen, P., Cleveland, M. L., Coll, P. P., Daniel, K. M., Hayward, A. D., Shah, K., Skudlarska, B., & White, H. K. (2019). Healthy Aging: American Geriatrics Society White Paper Executive Summary. *Journal of the American Geriatrics Society*, *67*(1), 17–20. https://doi.org/10.1111/jgs.15644

Friedman, S. M., Shah, K., & Hall, W. J. (2015). Failing to Focus on Healthy Aging: A Frailty of Our Discipline?. *Journal of the American Geriatrics Society*, *63*(7), 1459–1462. https://doi.org/10.1111/jgs.13512

Fung, H. H. (2013). Aging in culture. *The Gerontologist, 53*(3), 369-377.

Gibson, R. C. (1995). *Promoting successful and productive aging in minority populations*. In Bond, L. A., Cutler, S. J. and Grams, A. (eds) Promoting Successful and Productive Aging. Sage.

Guest, G., & MacQueen, K. M. (eds) (2008). *Handbook for Team-based Qualitative Research*. Rowman Altamira.

Gupta, M., Doobay, A. V., Singh, N., Anand, S. S., Raja, F., Mawji, F., Kho, J., Karavetian, A., Yi, Q., & Yusuf, S. (2002). Risk factors, hospital management and outcomes after acute myocardial infarction in South Asian Canadians and matched control subjects. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *166*(6), 717–722.

Guruge, S., Birpree,t B., & Samuels-Dennis, J. A. (2015). Health status and health determinants of older immigrant women in Canada: a scoping review. *Journal of Aging Research*.

Hamilton, T. G., & Hagos, R. (2020). Race and the Healthy Immigrant Effect. *The Public Policy and Aging Report, 31(*1), 14–18. https://doi.org/10.1093/ppar/praa042

Hanson, M. A., Cooper, C., Aihie, Sayer. A., Eendebak, R. J., Clough, G. F., & Beard, J. R. (2016). Developmental aspects of a life course approach to healthy aging. *The Journal of Physiology*, *594(*8), 2147–2160. https://doi.org/10.1113/JP270579

Hannerz, U. (1992). *Cultural complexity: Studies in the Social Organization of Meaning.* Columbia University Press.

Huang, V., & Fiocco, A. J. (2020). Measuring Perceived Receipt of Filial Piety among Chinese Middle-Aged and Older Adults. *Journal of Cross-cultural Gerontology, 35(*2), 195–208. https://doi.org/10.1007/s10823-019-09391-7

Inhetveen, K. (2012) Translation Challenges: Qualitative Interviewing in a Multi-Lingual Field. *Qualitative Sociology Review*, *8(*2), 28-45. https://doi.org/10.18778/1733-8077.8.2.03

Islam, F., Multani, A., Hynie, M., Shakya, Y., & McKenzie, K. (2017). Mental health of South Asian youth in Peel Region, Toronto, Canada: a qualitative study of determinants, coping strategies and service access. *BMJ Open*, 7(1), e018265.

Jackson, M., & Niblo, D. (2003). The role of qualitative methodology in cross-cultural research. *Qualitative Research Journal*. https://www.semanticscholar.org/paper/The-role-of-qualitative-methodology-in-research-Jackson-Niblo/89481f606e79c0b24d2c20bd6f972f2ea02649d4

Jacobsen, K. A., & Myrvold, K. (2018). *Religion and Technology in India: Spaces, Practices, and Authorities*. Routledge.

Jenkins, R. (1997). *Rethinking Ethnicity: Arguments and Explorations*. Sage, London.

Johnson, C. S. (2002). Nutritional considerations for bereavement and coping with grief. *The Journal of Nutrition, Health & Aging*, **6**, 3, 171–176.

Keith, J., Fry, C. L., & Ikels, C. (1990). Community as context for successful aging. In Sokolovsky, J. (ed) *The Cultural Context of Aging*. Bergin and Garvey.

Ketay, S., Aron, A., & Hedden, T. (2009). Culture and attention: Evidence from brain and behavior. *Progress in Brain Research*, *178*, 79–92. https://doi.org/10.1016/S0079-6123(09)17806-8

Kim, I. H., Carrasco, C., Muntaner, C., McKenzie, K., & Noh, S. (2013). Ethnicity and postmigration health trajectory in new immigrants to Canada. *American Journal of Public Health*, *103*(4), e96–104. https://doi.org/10.2105/AJPH.2012.301185

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of Qualitative Descriptive Studies: A Systematic Review. *Research in Nursing & Health*, *40*(1), 23–42. https://doi.org/10.1002/nur.21768

Koehn, S., Neysmith, S., Kobayashi, K., & Khamisa, H. (2013). Revealing the shape of knowledge using an intersectionality lens: Results of a scoping review on the health and health care of ethnocultural minority older adults. *Aging & Society*, *33*(3), 437–464.https://doi.org/10.1017/S0144686X12000013

Koehn, S., Habib, S., & Bukhari, S. (2016). S4AC case study: Enhancing underserved seniors' access to health promotion programs. *Canadian Journal on Aging/La Revue Canadienne du Vieillissement, 35(*1), 89-102.

Kuh, D., Karunananthan, S., Bergman, H., & Cooper, R. (2014). A life-course approach to healthy aging: maintaining physical capability. *The Proceedings of the Nutrition Society*, *73*(2), 237–248. https://doi.org/10.1017/S0029665113003923

Liamputtong, P. (2010). *Performing Qualitative Cross-cultural Research.* Cambridge University Press.

Lin, S. (2021). Access to health care among racialised immigrants to Canada in later life: A theoretical and empirical synthesis. *Aging and Society*, 1-25. https://doi.org/10.1017/S0144686X20001841

Liu, R., So, L., Mohan, S., Khan, N., King, K., & Quan, H. (2010). Cardiovascular risk factors in ethnic populations within Canada: results from national cross-sectional surveys. *Open Medicine: A Peer-reviewed, Independent, Open-access Journal*, **4**, 3, e143–153.

Lu, W., Pikhart, H., & Sacker, A. (2018). Domains and Measurements of Healthy Aging in Epidemiological Studies: A Review. *The Gerontologist,* **59**, 4. https://doi.org/10.1093/geront/gny029

Malik, K. (1996). *The meaning of race*. Basingstoke: Macmillan.

Marmamula, S., Barrenkala, N. R., Challa, R., Kumbham, T. R., Modepalli, S. B., Yellapragada, R., Bhakki, M., Friedman, D. S., & Khanna, R. C. (2020). Falls and visual impairment among elderly residents in 'homes for the aged'in India. *Scientific Reports*, *10(*1), 1-8.

Markides, K. S., & Rote, S. (2019). The Healthy Immigrant Effect and Aging in the United States and Other Western Countries. *The Gerontologist*, *59(*2), 205–214. https://doi.org/10.1093/geront/gny136

Martin, P., Kelly, N., Kahana, B., Kahana, E., Willcox, B. J., Willcox, D. C., & Poon, L. W. (2015) Defining successful aging: a tangible or elusive concept?. *The Gerontologist*, *55(*1), 14–25. https://doi.org/10.1093/geront/gnu044

May, S. ed (1999). *Critical multiculturalism and cultural difference: Avoiding essentialism*. In Critical multiculturalism, ed. S May, 11– 41. Falmer Press.

McLaughlin, S. J., Connell, C. M., Heeringa, S. G., Li, L. W., & Roberts, J. S. (2010). Successful aging in the United States: prevalence estimates from a national sample of

older adults. *The journals of gerontology. Series B, Psychological Sciences and Social Sciences*, *65*B(2), 216–226. https://doi.org/10.1093/geronb/gbp101

McLaughlin, S. J., Jette, A. M., & Connell, C. M. (2012). An examination of healthy aging across a conceptual continuum: prevalence estimates, demographic patterns, and validity. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, *67(*7), 783–789. https://doi.org/10.1093/gerona/glr234

Mehta, N. (2011). Mind-body Dualism: A critique from a Health Perspective. *Mens Sana Monographs, 9(*1), 202–209. https://doi.org/10.4103/0973-1229.77436

Meng, X., & D'Arcy, C. (2014). Successful aging in Canada: Prevalence and predictors from a population-based sample of older adults. *Gerontology*, *60*(1), 65–72. https://doi.org/10.1159/000354538

Montoya-Williams, D., Fuentes-Afflick, E., & Wallis, K. (2020). The Case for Research-Informed Immigrant Health Policies Within Health Care Systems. *JAMA Network Open*, 3, 4. doi:10.1001/jamanetworkopen.2020.3022

Morse, J. M. (2010). How different is qualitative health research from qualitative research? Do we have a subdiscipline? *Qualitative Health Research*, *20(*11), 1459-1464.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, *26.(*13), 1753-1760.

Nagel, J. (1994). Constructing ethnicity: Creating and recreating ethnic identity and culture. *Social Problems 41,* 152–176.

Napier, A. D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., Guesnet, F., Horne, R., Jacyna, S., Jadhav, S., Macdonald, A., Neuendorf, U., Parkhurst, A., Reynolds, R., Scambler, G., Shamdasani, S., Smith, S. Z., Stougaard-Nielsen, J.,

Thomson, L., Tyler, N., Woolf, K. (2014). *Culture and Health. Lancet (London, England)*, *384*(9954), 1607–1639. https://doi.org/10.1016/S0140-6736(14)61603-2

Nieboer, A. P., van den Broek, T., & Cramm, J. M. (2021). Positive and negative aging perceptions account for health differences between older immigrant and native populations in the Netherlands. *BMC Geriatrics*, *21(*1), 190. https://doi.org/10.1186/s12877-021-02119-8

Oishi, S. (2000). Goals as cornerstones of subjective well-being: Linking individuals and cultures. In E. Diener & E. Suh(Eds), Culture and subjective well-being (pp. 87-112). *Cambridge, MA: MIT Press.*

Oliffe, J. L., Grewal, S., Bottorff, J. L., Hislop, T. G., Phillips, M. J., Dhesi, J., & Kang, H. B. K (2009). Connecting masculinities and physical activity among senior South Asian Canadian immigrant men. *Critical Public Health, 19*(3-4), 383-397.

Omariba, D. W. (2015). Immigration, ethnicity, and avoidable mortality in Canada, 1991-2006. *Ethnicity & Health*, *20*(4), 409–436. https://doi.org/10.1080/13557858.2014.995155

Owen, L., & Corfe, B. (2017). The role of diet and nutrition on mental health and wellbeing. *The Proceedings of the Nutrition Society*, *76*(4), 425–426. https://doi.org/10.1017/S0029665117001057

Peluso, M. A., & Guerra, de Andrade, L. H. (2005). Physical activity and mental health: the association between exercise and mood. *Clinics (Sao Paulo, Brazil), 60*(1), 61–70. https://doi.org/10.1590/s1807-59322005000100012

Perkinson, M. A., & Solimeo, S. L. (2014). Aging in cultural context and as narrative process: Conceptual foundations of the anthropology of aging as reflected in the works of Margaret Clark and Sharon Kaufman. *The Gerontologist*, *54*(1), 101-107.

Pfeffer, N. (1998). Theories in Health Care and Research: Theories of Race, Ethnicity and Culture. *BMJ: British Medical Journal*, *317*(7169), 1381–1384. http://www.jstor.org/stable/25180994

Prasad, K., Dwivedi, S. N., Kant, S., Vibha, D., Pandit, A. K., Karthikeyan, G., Tripathi, M., Srivastava, A. K., Nehra, A., Vivekanandhan, S., Garg, A., Chutani, A. M., Verma, V., Kumar, S., Kumar, A., Gulati, K., Gulati, A., Makharia, G., Seth, T., Dhingra, K., Mandal, P. K., Mishra, N. K., Ikram, K., & Tiemeier, H. (2021). Cohort profile: The LoCARPoN—a population-based prospective cohort study in middle-aged and older adults in India. *International Journal of Epidemiology*. *51*(1), 29-30m.

Quandt, S. A., McDonald, J., Arcury, T. A., Bell, R. A., & Vitolins, M. Z. (2000). Nutritional self-management of elderly widows in rural communities. *The Gerontologist*, *40*(1), 86–96. https://doi.org/10.1093/geront/40.1.86

Quay, T. A., Frimer, L., Janssen, P. A., & Lamers, Y. (2017). Barriers and facilitators to recruitment of South Asians to health research: A scoping review. *BMJ Open*, *7*(5), e014889. https://doi.org/10.1136/bmjopen-2016-014889

Raeff, C., Fasoli, A. D., Reddy, V., & Mascolo, M. F. (2020). The concept of culture: Introduction to spotlight series on conceptualizing culture. *Applied Developmental Science*, *24*(4), 295–298. https://doi.org/10.1080/10888691.2020.1789344

Rahemtullah, O. S. (2010). Interrogating 'indianness': Identity and diasporic consciousness among twice migrants. *Anthurium: A Caribbean Studies Journal*, *7*(1), 3-13.

Reed, J., Richardson, E., Marais, S., & Moyle, W. (2008). Older people maintaining well-being: An International Appreciative Inquiry study. *International Journal of Older People Nursing*, *3*(1), 68–75. https://doi.org/10.1111/j.1748-3743.2007.00111.x

Reich, A. J., Claunch, K. D., Verdeja, M. A., Dungan, M. T., Anderson, S., Clayton, C. K., Goates, M. C., & Thacker, E. L. (2020). What does "successful aging" mean to you? - Systematic review and cross-cultural comparison of lay perspectives of older adults in 13 countries, 2010-2020. *Journal of Cross-Cultural Gerontology*, *35*(4), 455–478. https://doi.org/10.1007/s10823-020-09416-6

Renfrew, C. (1996). *Prehistory and the Identity of Europe. Cultural Identity and Archaeology: The Construction of European Communities.* Routledge, 125-137.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, *37*(4), 433–440. https://doi.org/10.1093/geront/37.4.433

Rowe, J. W., & Kahn, R. L. (1998). *Successful Aging*. Pantheon Books.

Ryff, C. D., & Singer, B. (1996). Psychological well-being: meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics*, *65*(1), 14–23. https://doi.org/10.1159/000289026

Ryff, C. D. (2018). Well-Being With Soul: Science in Pursuit of Human Potential. *Perspectives on Psychological Science : A Journal of the Association for Psychological Science, 13*(2), 242–248. https://doi.org/10.1177/1745691617699836

Rubinstein, R. L., & de Medeiros. K. (2015). "Successful aging," gerontological theory and neoliberalism: A qualitative critique. *The Gerontologist*, *55*(1), 34-42.

Rudnicka, E., Napierała, P., Podfigurna, A., Męczekalski, B., Smolarczyk, R., & Grymowicz, M. (2020). The World Health Organization (WHO) approach to healthy aging. *Maturitas, 139*, 6–11. https://doi.org/10.1016/j.maturitas.2020.05.018

Sadler, G. R., Lee, H. C., Lim, R. S. H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing & Health Sciences, 12*(3), 369-374.

Saldaña, J. (2021). The coding manual for qualitative researchers. *Thousand Oaks: Sage Publications.*

Saleebey, D. (2006). *The Strengths Perspective in Social Work Practice*. Pearson/Allyn & Bacon.

Sampaio, D. (2021). Ageing, agency and work: Brazilian older adults building spaces of opportunity in the United States. *Social & Cultural Geography*, *0*(0), 1–17. https://doi.org/10.1080/14649365.2022.2121983

Sheldon, T. A., & Parker, H. (1992). Race and ethnicity in health research. *Journal of Public Health Medicine*, *14*(2), 104–110.

Sheldon, K. M., Elliot, A. J., Ryan, R. M., Chirkov, V., Kim, Y., Wu, C., Demir, M., & Sun, Z. (2004). Self-Concordance and Subjective Well-Being in Four Cultures. *Journal of Cross-Cultural Psychology*, *35(*2), 209–223. https ://doi.org/10.1177/0022022103262245

Shooshtari, S., Menec, V., Swift, A., & Tate, R. (2020). Exploring ethno-cultural variations in how older Canadians define healthy aging: The Canadian Longitudinal Study on Aging (CLSA). *Journal of Aging Studies*, *52*, 100834. https://doi.org/10.1016/j.jaging.2020.100834

Smith, S. T., & Wilkinson, T. (2007). *Ethnicity and Culture*. Routledge.

Statistics Canada (2021). Key results from the 2021 Census. Available at: https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025b-eng.htm

Statistics Canada. (2023, June 28). *Immigrants' sense of belonging to Canada by province of residence*. https://www150.statcan.gc.ca/n1/pub/36-28-0001/2023006/article/00003-eng.html

Stowe, J. D., & Cooney, T. M. (2015). Examining Rowe and Kahn's concept of successful aging: Importance of taking a life course perspective. *The Gerontologist*, *55*(1), 43–50. https://doi.org/10.1093/geront/gnu055

Sue, D. W. (2001). Multidimensional Facets of Cultural Competence. *The Counseling Psychologist*, *29*(6), 790–821. https://doi.org/10.1177/0011000001296002

Thibaut, F. (2018). The mind-body Cartesian dualism and psychiatry. *Dialogues in Clinical Neuroscience*, *20*(1), 3. https://doi.org/10.31887/DCNS.2018.20.1/fthibaut

Tong, C. E., McKay, H. A., Martin-Matthews, A., Mahmood, A., & Sims-Gould, J. (2020). "These Few Blocks, These Are My Village": The Physical Activity and Mobility of Foreign-Born Older Adults. *The Gerontologist, 60*(4), 638–650. https://doi.org/10.1093/geront/gnz005

Tong, C. E., McKay, H. A., Martin-Matthews, A., Mahmood, A., & Sims-Gould, J. (2019). "these few blocks, these are my village": The physical activity and mobility of foreign-born older adults. *The Gerontologist*. https://doi.org/10.1093/geront/gnz005

Torres, S. (1999). A culturally-relevant theoretical framework for the study of successful aging. *Aging & Society*, *19(*1), 33–51. https://doi.org/10.1017/S0144686X99007242

Torres, S. (2001). Understandings of successful aging in the context of migration: The case of Iranian immigrants in Sweden. *Aging & Society*, *21(*3), 333–355. https://doi.org/10.1017/S0144686X01008261

Torres, S. (2006a). Different Ways of Understanding the Construct of Successful Aging: Iranian Immigrants Speak About What Aging Well Means to Them. *Journal of Cross-Cultural Gerontology*, *21(*1), 1–23. https://doi.org/10.1007/s10823-006-9017-z

Torres, S. (2006b). Elderly immigrants in Sweden:'Otherness' under construction. *Journal of Ethnic and Migration Studies*, *32*(8), 1341-1358.

Torres, T. (2015). Expanding the gerontological imagination on ethnicity: conceptual and theoretical perspectives. *Aging and Society*, *35*(5), 935-960. https://doi.org/10.1017/S0144686X14001330

Torres, S. (2020). *Ethnicity and older age: Expanding our imagination*. Policy Press.

Torres, S. (2022). Ethnicity, race and migrancy: Advancing the gerontological imagination in theoretically astute ways. *British Society of Gerontology*. Available at https://www.britishgerontology.org/events-and-courses/past-conferences-content/2022-conference-content/plenary-speakers/professor-sandra-torres

Torres, S., & Lawrence, S. (2012). An introduction to 'the age of migration' and its consequences for the field of gerontological social work, *European Journal of Social Work*, *15(*1), 1-7, https://doi.org/10.1080/13691457.2012.661562

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research*, *14(*1), 1-17. https://doi.org/10.1186/1472-6963-14-99

Urtamo, A., Jyväkorpi, S. K., & Strandberg, T. E. (2019). Definitions of successful aging: a brief review of a multidimensional concept. *Acta Bio-medica : Atenei Parmensis*, *90(*2), 359–363. https://doi.org/10.23750/abm.v90i2.8376

Wang, L., Guruge, S., & Montana, G. (2019). Older immigrants' access to primary health care in Canada: A scoping review. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *38*(2), 193-209.

Warnes, A. M., Friedrich, K., Kellaher, L., & Torres, S. (2004). The diversity and welfare of older migrants in Europe. *Aging & Society*, *24*(3), 307–326. https://doi.org/10.1017/S0144686X04002296

Wong, R. Y. (2018). A New Strategic Approach to Successful Aging and Healthy Aging. *Geriatrics (Basel, Switzerland)*, *3*(4), 86. https://doi.org/10.3390/geriatrics3040086

World Health Organization (2020). Healthy aging and functional ability. https://www.who.int/philippines/news/q-a-detail/healthy-aging-and-functional-ability

World health Organization (2021). Aging and health. Available online at https://www.who.int/news-room/fact-sheets/detail/aging-and-health

van der Pols, J. C. (2018). Nutrition and mental health: bidirectional associations and multidimensional measures. *Public Health Nutrition, 21*(5), 829–830. https://doi.org/10.1017/S1368980017003974

Veenstra, G. (2009). Racialized identity and health in Canada: results from a nationally representative survey. *Social Science & Medicine (1982)*, *69*(4), 538–542. https://doi.org/10.1016/j.socscimed.2009.06.009

Veenstra, G., & Patterson, A. C. (2016). South Asian-White health inequalities in Canada: intersections with gender and immigrant status. *Ethnicity & Health*, *21*(6), 639–648. https://doi.org/10.1080/13557858.2016.1179725

Vesnaver, E., Keller, H. H., Sutherland, O., Maitland, S. B., & Locher, J. L. (2015). Food behavior change in late-life widowhood: A two-stage process. *Appetite*, *95*, 399–407. https://doi.org/10.1016/j.appet.2015.07.027

Vincent, J. A., Phillipson, C., & Downs, M. (Eds.) (2006). *The Futures of Old Age*. SAGE Publications Ltd, https://dx.doi.org/10.4135/9781446211533

Zubair, M., & Norris, M. (2015). Perspectives on aging, later life and ethnicity: Aging research in ethnic minority contexts. *Aging and Society*, *35*(5), 897–916. https://doi.org/10.1017/S0144686X14001536

Chapter 3

"And who would question God?": Patient engagement and healthcare decision-making of South-Asian older adults in the Canadian healthcare system

Key words: patient engagement, shared decision making, person-centered care, racialized immigrant older adults.

Abstract

With the increase in ethnocultural diversity in the Canadian demographic landscape, it is imperative for healthcare providers and policy makers to understand the needs and preferences of racialized immigrant older adults. Previous research has shown that to increase patient satisfaction with care and lower treatment costs it is important to effectively involve patients in their care. However, we currently lack the understanding of how racialized immigrant older adults want to engage as patients, the factors that influence their involvement in their own care, and who they want involved in the decisions surrounding their care. To address this gap in the literature specifically for the South Asian community, one of Canada's largest and fastest growing populations, our study aimed to understand South Asian older adults' experiences with and approaches to patient engagement and shared decision making. We conducted in-depth individual and dyadic interviews (n=28) in six languages, utilizing a multilingual cross-cultural qualitative approach. Our findings highlight the nuances of language and how miscommunication can arise even when patients and providers are conversing in the same language. Patient engagement and shared decision making, including the desire for family involvement, is heavily influenced by both culture and gender. Additionally, perceptions of patients regarding the status of physicians can have a notable influence on patient engagement, leading to an increased tendency for patients to agree with the physicians' approach to care. These findings suggest that effective engagement between providers and patients require a tailored approach that extends beyond white-centric approaches to decision-making and communication.

3.1 Introduction

To provide effective and appropriate care, healthcare professionals must be aware of the heterogeneity in culture, language, health beliefs, and other characteristics that are present, and continuously shifting, amongst ethnocultural communities. Engaging patients and their families in the healthcare process, and thus allowing for a tailored and person-centered care approach, may offer a path to higher-quality, more effective care for racialized immigrant older adults (Carman et al., 2013). Shared decision-making, which has been called "the pinnacle of person-centered care," (Barry & Edgman-Levitan, 2012) involves care providers and recipients collaborating to determine the best course of action while considering the patients' values and preferences (Armstrong et al., 2016). Patient engagement, which is a pre-requisite for shared decision-making, involves meaningfully engaging patients in various aspects of the care delivery process to increase their capacity to make evidence-informed decisions about their own health (Galletta et al., 2022; Kambhampati et al., 2016; Weingart et al., 2011). In the Canadian context, patient engagement holds significant importance due to two interrelated aspects: the aging population and the growing diversity primarily driven by migration.

3.2 Background

3.2.1 The importance of patient engagement and shared decision making

The biomedical “Western” medical model of healthcare has historically been firmly rooted in the idea that, in certain instances, it is permissible to overlook a person's opinions in favour of advancing their health (Emanuel & Emanuel, 1992; Gallagher, 1998; Gillon, 1985; Moore, 1995; Siegler, 1985). This practice, termed paternalism, is based on the assumption that patients need to be safeguarded since they are ill-equipped to determine what is ideal for them (Cody, 2003; Nys, 2008). Medical and health research has now abandoned this notion,

recognizing that while healthcare providers may be experts in medical knowledge, patients are the experts in their own health. As explained by Bournes (2000), “to judge people as not knowing what is best for their lives is a way of labelling that is antithetical to the basic assumptions of human becoming” (p 19). Patients are now widely acknowledged to be the only constant in the care continuum and it is critical to recognise each patient's unique lived experiences and how it impacts the care they want (Coulter & Ellins, 2007; Krist et al., 2017).

Research indicates that as healthcare options have become more abundant and complex, patients who have a stronger connection with their healthcare providers and receive ongoing support throughout the treatment journey tend to express higher levels of satisfaction with the care they receive (Ong et al., 1995; Cervantes-Ortega et al., 2020; Thind et al., 2010). This involves evaluating the values, objectives, abilities, and preferences of patients in order to reach consensus on treatment plans that are mutually agreed upon (Cervantes-Ortega et al., 2020). There is also strong evidence that the engagement of patients in primary care decision-making improves chronic disease management and health outcomes (Barello et al., 2012; 2014; Hibbard & Greene, 2013; Simmons et al., 2014). Other international studies also reveal that patient involvement decreases health inequities, enhances the standard of care, and increases patient trust (Alegria et al., 2009; 2018; Coulter & Ellins, 2007).

3.2.2 Patient engagement and shared decision making in the context of older adults

Patient engagement is of particular significance for marginalized populations who face challenges in accessing healthcare services and are frequent users of the healthcare system (Nguyen et al., 2010; Markle-Reid et al., 2021). One such cohort is older adults (Holdroyd-Leduc et al., 2016; McNeil et al., 2016). With the aging population and the growing prevalence of comorbid and chronic conditions, an increasing number of older adults will encounter the

complexities of making ongoing healthcare decisions (Boyd et al., 2005, 2019; Chiu et al., 2016; Hogan et al., 2001). Current evidence indicates that older adults who actively participate as partners in their care have the capacity to enhance health outcomes by embracing health-promoting behaviors and, therefore, reducing health disparities (Cosgrove et al., 2013; Coulter, 2005; Glasgow et al., 2008; Hibbard & Cunningham, 2008; Hibbard & Greene, 2013; Jordan et al., 2008; Shah & Siegel, 2015). More specifically, active involvement of individuals in their healthcare are more likely to experience better physical (Laurence et al., 2014; Sacks et al., 2017) psychological (James et al., 2013) interpersonal results (Shay & Lafata, 2015). Other studies also report organisational results, such as cost reductions, with increase in patient engagement (Greene et al., 2015). Overall, it is more important for older adults, along with their families, to take an active role in their healthcare given all their responsibilities and decisions (Boyd et al., 2005; Menichetti et al., 2018). However, several studies have found lower decision control preferences, i.e., the level of control patients desire over their medical decisions, amongst older adults (Chung et al., 2012; Nolan et al., 2005; Rodriguez et al., 2008; Zhang et al., 2005; Levinson et al., 2005). Eldh (2008) found that not having sufficient information (e.g., not being given appropriate details) and not being acknowledged (e.g., not being heard or recognized as an individual with unique needs and concerns) were important factors contributing to patient non-participation. Moreover, non-participation involved encountering healthcare systems that prioritized organizational interests over patient-centered care and feeling uncertain during healthcare interactions (Eldh, 2008). It has also been observed that individuals, including older adults, with lower education levels and those with minority status tend to have lower preferences for decision making (Blackhall et al., 1995; Levinson et al., 2005; Patel & Bakken, 2010; Sulmasy et al., 2007). Authors such as Sogaard et al., (2021) recommend that with the increase

in the aging population and the rising prevalence of multiple chronic conditions, it is imperative to proactively engage in systematic and timely discussions with patients regarding the future scenarios related to their health and well-being as well as their priorities.

3.2.3 Patient engagement and shared decision making in the context of racialized immigrant older adults

Decision making in a variety of clinical and healthcare contexts can be especially challenging because it is entangled with sociocultural beliefs and value matrices that differ for care provider and care recipient (Bito et al., 2007). Consequently, a disparity may arise between the communication approach adopted by healthcare providers, which plays a vital role in decision-making and patient engagement, and the preferred approach desired by patients. For instance, currently, a fundamental value within Eurocentric decision-making models in healthcare is patient autonomy (Beauchamp & Childress, 2001; Bito et al., 2007). However, several ethnocultural groups have historically held alternative paradigms for the decision-making process (Blackhall et al., 1995). An illustration of this can be seen in a study conducted by Blackhall and colleagues (1995), which demonstrated that older adults of Korean and Mexican origin residing in the United States expressed a preference for their family members to be responsible for making important healthcare decisions, such as those concerning the use of life support, rather than making those decisions themselves. A separate study examining Southeast Asian communities highlights that the collaborative communication approach promoted in literature of the Global North may not be directly applicable to other cultures, and notably, it may not be the most suitable style for the specific context of racially immigrant communities (Claramita et al., 2013). Additional research has investigated the notion of "equity," which plays a pivotal role in a collaborative communication approach and has found that it is not inherent in

the established norms, values, and beliefs of certain Asian cultures that are deeply rooted in a hierarchical social structure (Harmsen et al., 2007; Geertz, 1976; Ramirez et al., 2003). To mitigate such a mismatch between patients and providers, culturally and linguistically diverse communities may require additional attention during the process of healthcare decision making, owing to their unique experiences related to language and cultural values (Broom et al., 2012; Kirby et al., 2018). Also, specific to racialized patients, Cooper-Patrick and colleagues (1999) have noted that healthcare providers may involve white patients in decision-making processes more than non-white individuals. A subsequent study by Levinson et al., (2005) found that although the factors contributing to racial disparities are multifaceted, individuals from racial minority groups are more inclined towards a physician-directed approach, even when socioeconomic status and education are taken into account. Newer immigrant populations may experience these difficulties to a greater extent, including challenges such as communication barriers and a feeling of isolation from the broader community (Barclay et al., 2007; Rao et al., 2006).

While the majority of the attention in the literature on healthcare communication has been focused on patient-physician interactions, family members and their input in making healthcare decisions has received far less attention (Alden et al., 2018; Laidsaar-Powell et al., 2013). The participation of family members in medical decision-making is a significant cultural factor (Agoritsas et al., 2015; Charles et al., 2006) that can impact the exchange of information and shared decision-making during healthcare consultations (Edwards et al., 2009). Studies indicate that individuals' comprehension of health and illness within a familial context is shaped by a combination of personal experiences and shared cultural beliefs and practices (Brown et al., 2013; Fang et al., 2016). Cultural elements can impact the dynamics among patients, their

families, and healthcare providers, potentially influencing satisfaction levels and adherence to medical recommendations (Alden et al., 2018). Current literature indicates that patients from cultures that place a larger importance on family responsibilities, solidarity, and harmony are also more likely to prefer higher levels of family engagement (Cherry, 2015; Clayman et al., 2005; Epstein, 2012; Searight & Gafford, 2005). Few studies have examined family involvement in the care context of racialized immigrant older adults, and how these older adults often depended on social support from their family, as well as how their family members play a significant part in their decision-making about their health care (Park et al., 2018; Sagong & Yoon, 2021). However, family engagement, although acknowledged as a crucial component of patient-centered care (Wolff et al., 2015), is poorly understood, especially across cultural boundaries (Alden et al., 2018).

Despite evidence pointing towards the importance of patient engagement, there have been no Canadian studies that have specifically evaluated patient and family involvement within racialized immigrant older adult communities (Wood et al., 2023). We currently lack an evidence-based understanding of how or if racialized immigrant older adults are engaged in their own healthcare. Furthermore, it is yet unknown how patient/family partnership approaches for health systems navigation will operate with an increasingly linguistically and culturally diverse care recipient pool. According to Parson and colleagues (2010), healthcare providers need training and resources to assist with patient education, awareness, and shared decision-making to encourage patient and family engagement. However, there is no research on what this may look like for specific ethnocultural populations, including the South Asian community, which is one of Canada's largest and fastest growing sub-populations. A key component of understanding patient and family engagement will be to understand shared decision-making approaches utilized

in the racialized immigrant communities. Therefore, the present study was designed to (1) examine South Asian older adults' experiences and approaches to patient engagement, (2) understand what collaborative healthcare decision-making looks like for this community, and (3) understand factors that influence patient engagement and healthcare decision-making in this population.

3.3 Methods

Our study is embedded in a larger research study (Tong et al., 2022) which is aimed at describing the role that racialized immigrant older adults are/are not taking in managing their own health care from the viewpoints of the participant groups (older adults, caregivers, and healthcare providers). The second phase of this work will be to develop a co-design process with these participants, creating linguistically and culturally sensitive/aligned tools, resources, or solutions to support engagement of racialized immigrant older adults in managing their care.

3.3.1 Research design and approach

In-depth individual and dyadic interviews were conducted in multiple South Asian languages employing a multilingual and cross-cultural qualitative approach, with an emphasis on solutions-oriented inquiry (Liamputtong, 2010). An integrated knowledge translation method (Boland et al., 2020) was used, collaborating with community partners as we constructed the research questions and established our chosen methodological approach (Kothari et al., 2017). The chosen methodology for this study is qualitative description (Kim et al., 2017). While the description of this work seems linear, it is crucial to remember that these are iterative processes in which we worked with the community partners and participants to continuously learn and improve (Gauthier et al., 2005).

We actively collaborated with racialized immigrant older adults during all research phases. To support relationship-building prior to the interviews, I participated in 167 hours of online community events (e.g., community yoga and deep-breathing sessions), in place of the in-person community engagement that we had planned prior to the pandemic. Prior to conducting the interviews, this active engagement with participants allowed the research team to establish rapport and trust with the participants. The research team intentionally adopted this collaborative approach to enhance the rigor and quality of the data collection process and to enable reciprocity between participants and researchers to avoid extractive research practices. In the extractive approach to research, communities are excluded from the process of defining the research's scope and determining the credibility of its findings (Corntassel & Gaudry, 2018; Igwe et al., 2022; Kouritzin & Nakagawa, 2018). Chambers (2012) characterizes this as a situation where outsiders, i.e., researchers, obtain information for their own gain, rather than for the benefit of the groups and communities the research is conducted with and for. Ethics clearance was obtained through the University of Waterloo Office of Research Ethics (ORE #43297).

3.3.2 Study setting, study population, and sample

We conducted this research in the South-Western region of Ontario, Canada, which is one of the major destinations for all immigrants to Canada and which includes a range of diverse South Asian communities. The use of the term "South Asian" can oversimplify and generalize a diverse group of people, potentially disregarding their unique lived experiences and individual identities. To address this, instead of relying on the term "South Asian" or country of origin, we chose to recruit participants based on the languages they spoke. This method enabled us to identify groups that shared a common culture through language rather than being constrained by arbitrarily drawn colonial borders (Alvi & Zaidi, 2017).

The study included participants who were older adults (60 years or older) from the South Asian community, residing in Southern Ontario. To be eligible, individuals needed to be capable of giving informed consent and able to conduct the interview in one of the following languages: Bangla, English, Hindi, Punjabi, Tamil, or Urdu. These languages were chosen as they are the most commonly spoken South Asian languages in the region. As we were working with immigrant populations, we adopted the World Health Organization's (WHO) age cut-off of 60 for defining older adults, which aligns with how the term "older adult" has been used in previous studies involving individuals from South Asia (Marmamula et al., 2020; Prasad et al., 2021; WHO, 2021).

3.3.3 Recruitment

Participants were recruited using purposeful sampling to provide richness to the data set (Palinkas et al., 2015; Patton, 2014). The use of purposeful sampling was chosen because it can be used to recruit participants with in-depth knowledge of the phenomenon of interest (Palinkas et al., 2015; Patton, 2014). To ensure inclusivity, participants were recruited from various South Asian community organizations, employing a combination of email, recruitment posters, and word-of-mouth methods within these communities. Furthermore, some of the initial participants voluntarily engaged in snowball sampling (Sadler et al., 2010) by sharing the recruitment materials with their friends and family members who met the eligibility criteria. This collaborative approach helped expand the participant pool. Apart from personal and professional networks, community outreach and engagement were on-going processes throughout all the research phases. All participants received a letter of information clarifying their involvement in the project and describing the nature of the study. Letters of information were sent in advance of

the interviews or dyad interviews via email and verbal consent was taken and recorded (with timestamp) at the beginning of the interview. Following the completion of the interviews, the participants received an honorarium (a $20 gift card of their choice).

3.4 Data Collection

Data collection took place during the ongoing COVID-19 pandemic, necessitating adaptations in the interview process. As a result, all interviews were conducted remotely, either through telephone or video calls, ensuring the safety and convenience of the participants. The interviews were scheduled at a time of the participants' choosing. Participants were asked to select either the individual or dyadic interview option. The determination of the sample size followed the principle of information power, as proposed by Malterud and colleagues (2016). According to this concept, the sample size was dynamically determined during the data collection process, taking into account the depth and richness of the data obtained. Twenty-eight interviews were conducted in the following languages: Bangla, Hindi, Urdu, Punjabi, and English. I speak the listed languages (other than Tamil), and conducted all the interviews in Bangla, Hindi, Urdu, Punjabi and English. The Tamil interviews were conducted by a multilingual Research Assistant proficient in Tamil and a member of the Tamil community in Canada. Interviews lasted an average of 84 minutes (min: 32, max: 120). Refer to Table 3-1 for sample characteristics.

A consistent interview guide was utilized for both dyad (spousal) and one-on-one interviews, although the wording of the questions was tailored to suit each interview format. For instance, dyad interviews were designed to be longer than one-on-one interviews to ensure that all participants were asked the same set of questions. The interview guide started with general questions about participants' healthcare experiences, followed by specific probes and follow-up

questions. For example, if a person mentioned that their children are involved in their healthcare decision-making, the interviewer then followed up with queries such as: how do your children help you make those decisions? Are any other family members also involved in this process? Please refer to Table 3-3 for a sample of the interview guide questions. Interviews were audio recorded and field notes were taken within 24 hours. The field notes contained non-textual and auditory insights into interviews, which were valuable in understanding the participants' intended meanings (Phillippi & Lauderdale, 2018). To protect the anonymity of participants, pseudonyms were assigned to them during the analysis process (refer to Table 3-2 for the pseudonyms assigned to each participant). During the data collection phase, the broader research team held regular meetings to discuss various aspects, including the interview guide, translation inquiries, and initial findings. These team meetings were documented through recordings.

Table 3 - 1

Participant Demographics

Interview Sample (n=28)	
Age	Mean: 74 (min: 60, max: 88)
Gender	
Men	13
Women	15
Country of Origin	
India	11
Bangladesh	6
Sri Lanka	7
Pakistan	4
Years in Canada	Mean: 34 (min: 10, max: 62)

Education	
Secondary	3
Undergraduate	14
Graduate	11
Marital Status	
Married	25
Widowed	1
Divorced	2
Lives with	
Spouse	8
Spouse & children	14
Spouse, children, & grandchildren	3
Alone	3
Has family doctor	
Yes	26
No	2
English Proficiency (self-reported)	
Reading	
Poor	1
Well	2
Very well	25
Writing	
Poor	0
Well	2
Very well	26
Speaking	
Poor	2
Well	0
Very well	26

Table 3 - 2

Interview Participant Pseudonyms and Demographic Information

Pseudonym	Age	Gender	Country of Origin	Religion/Faith System	Length of time in Canada (Years)	Type of Interview Conducted	Language interview conducted in

Ashish	88	Male	Bangladesh	Hinduism	29	Individual	English
Rajib	74	Male	Bangladesh	Hinduism	12	Dyad	Bengali
Aarini	62	Female	Bangladesh	Hinduism	15	Dyad	Bengali
Prisha	63	Female	India	Hinduism	51	Individual	Hindi
Shivanya	76	Female	India	Hinduism	51	Individual	Tamil
Shankar	86	Male	India	Hinduism	52	Individual	English
Zarina	60	Female	Pakistan	Islam	17	Single	Urdu
Irfaan	68	Male	Pakistan	Islam	21	Dyad	Urdu
Aaron	75	Male	India	Christian	57	Dyad	English
Aileen	68	Female	India	Christian	52	Dyad	English
Prithvish	71	Male	India	Hinduism	45	Individual	Tamil
Shastik	77	Male	Sri Lanka	Hinduism	26	Dyad	Tamil
Gayatri	78	Female	Sri Lanka	Hinduism	31	Dyad	Tamil
Sharvaa	73	Female	Sri Lanka	Hinduism	25	Dyad	Tamil
Abhijeet	75	Male	India	Hinduism	45	Dyad	Tamil
Tarala	78	Female	Sri Lanka	Hinduism	28	Single	English
Sarath	82	Male	Sri Lanka	Hinduism	28	Dyad	English
Amit	86	Male	India	Hinduism	53	Single	English
Shalini	67	Female	India	Hinduism	42	Dyad	Hindi
Jamal	60	Male	Pakistan	Islam	16	Dyad	Urdu
Beena	73	Female	India	Hinduism	34	Single	English
Ananya	61	Female	India	Hinduism	32	Single	Hindi
Janaia	64	Female	India	Hinduism	10	Single	English
Sharad	87	Male	India	Hinduism	62	Single	English
Shujata	77	Female	Bangladesh	Hinduism	34	Single	Bengali
Malini	83	Female	India	Hinduism	10	Single	Punjabi
Ravi	72	Male	India	Hinduism	45	Single	Hindi

Table 3 - 3

Sample Interview Questions

Primary Questions	**Probe**
Have you ever disagreed with your healthcare provider and/or their decisions regarding your health?	If so, could you tell me how you dealt with that?

When you want to know more about your health, where do you go for information?	Family, internet, news, social media, talking with friends, relatives overseas, etc.
What role do family members play in your health care?	Do they join you for appointments? Drive you to appointments? Do they help with translation? Do they get medications for you? Prepare special meals? What does this support mean to you?
What would you like health care providers to know/understand about your culture?	How does that impact your health?

3.4.1 Translation

Qualitative researchers have recognized the challenges inherent in interpreting and translating, particularly in multilingual (i.e., more than two languages) studies (Inhetveen, 2012). The translation of qualitative data encompasses not only the linguistic aspect but also the cultural context in which the data were gathered (Chen & Boore, 2010). Given the complex and multilingual nature of this data collection, DC translated the interviews to English using the written translation approach outlined by Inhetveen (2012). The written translation approach, which was done soon after the interview, provided a more thorough translation ensuring that no details were overlooked. It also enabled our team to get closer to a lexical equivalent of the original phrasing (Inhevteen, 2012). Following the guidelines outlined by McKenna (2022), DC also followed a forward translation method, in which the original source language was translated into the language in which the analysis and reporting will be conducted. After translating all transcripts into English, DC analyzed them as a comprehensive dataset (McKenna, 2022). DC

also translated the interviews early in the research process to enable easy accessibility of the dataset for other members of the research team (Santos et al., 2015).

3.5 Data Analysis

The transcripts underwent a process of cleaning and anonymization before being uploaded into NVivo 12 for analysis. In addition to the transcripts, field notes and meeting notes were also included in the analysis software. Because of its theoretical flexibility and capacity to provide rich and detailed data without losing complexity, Braun and Clarke's (2006) thematic analysis was chosen as the analytical technique for analyzing the data associated with this research. The steps of Braun and Clarke's (2006) thematic analysis technique include becoming acquainted with the data, developing preliminary codes, searching for themes, reviewing the topics, and identifying and labelling the themes. Interviews were transcribed verbatim and included detailed notes in the case of video-call interviews in order to preserve voice cues, tone of voice, and non-vocal signals and body language, such as facial expressions and hand gestures in order to help readers understand the data. Important information was noted both during transcription and in the form of fieldnotes during the interview. Our study involved a combination of two coding techniques. The first one is a priori coding, which was guided by the research questions and the chosen theoretical models (listed below) (Morse, 2015; Ritchie et al, 2003). The second one was emergent coding, which was used to identify significant themes raised in the interviews with participants (Cresswell & Poth, 2013; Lofland et al., 2006; Morse, 2015; Ritchie et al., 2003). After becoming familiar with the data, line-by-line coding was used to create initial codes. From the raw data, these codes were utilised to extract crucial information about the experiences and perspectives of the participants (Braun & Clarke, 2006; Ritchie et al., 2003). As per the theoretical frameworks guiding this research, some of the coding structures

were developed *a priori* (Blair et al., 2015) as well, following Bronfenbrenner's (1979) and Lin's (2022) theoretical models (further described below). We then used an iterative process of proposing codes and then adding new codes as needed, through line-by-line analysis of the data. Please refer to Table 3-4 for an illustration of the evolving coding structure.

3.5.1 Theoretical models that inform analysis

This research is guided two theoretical models, namely the socio-ecological model (Bronfenbrenner, 1979) and the multilevel eco-social framework (Lin, 2022) to understand racialized immigrant older adults' access to healthcare.

3.5.1.1 Bronfenbrenner's Socio-Ecological Model

The "socio-ecological model" was created in the late 1970s to acknowledge the fact that people are impacted by a wide variety of social influences and nested environmental interactions (Bronfenbenner, 1979). According to Bronfenbrenner's (1979) paradigm, human development is a dynamic, reciprocal interaction between people, objects, and symbols in their contexts that regularly occurs over time. This model also explains how interactions between system structures, such as family, cultural, socioeconomic, political, and psychological domains, have an impact on human development, which ultimately shapes our behaviour, life decisions, and well-being over the course of a lifetime (Backonja et al., 2014; Bronfenbrenner, 1979). The initial ecological system model was put forth to explain how 'person-context interconnection' is represented by a succession of nested structures (Bronfenbrenner, 1979). The interactions between people and their environments were divided by Bronfenbrenner into four concentric circles of ecological systems: micro, meso, exo, and macro.

According to Bronfenbrenner (1979), a person's role might change depending on "role demands, tensions, and supports emanating from other settings" (p 7). This postulates that racialized immigrant older adults' assessments of their capacity to navigate the healthcare system and their perceptions of their health condition will determine whether they can function effectively in these roles (Levesque et al., 2013). The availability of health care and social services, the presence of supportive environments in the community, and the prevalence of inclusive societal ideals, are just a few of the external factors/settings that may influence these assessments (Sallis & Owen, 2015). The effect of these external settings is dependent on more general policies, laws, and regulations that have a structural impact on older adults and their overall health and well-being (Sallis & Owen, 2015). As such, Bronfenbrenner's ecological formulation provides a "systems approach" in addition to the incorporation of contextual variables and healthcare environmental aspects for assessing the experiences and perceptions of racialized immigrant older adults concerning their health and healthcare.

3.5.1.2 Multilevel Eco-Social Framework

The multilevel eco-social framework (see Lin, 2021, p. 10) expands on the socio-ecological model by emphasising the relationship between racialized older immigrants and healthcare access as a complex social process involving individual and contextual factors that exist between older immigrants' health needs and healthcare providers (Lin, 2021). In Bronfenbrenner's ecological theory, the process of racialized immigrants seeking health care involves an ecological transition and person-environment interaction across multi-layered overlapping systems where patients' health demands and health care services are integrated (Bronfenbrenner, 1979). The multilevel eco-social framework furthers this conceptualization by noting the structural determinants specific to racialized and marginalized communities that shape

the health-care experiences of older immigrants (Lin, 2021). For instance, concerning the micro-level, Lin (2021) highlights social and economic difficulties in a post-migration environment and socio-cultural variations in clinical settings (Lin, 2021). For the meso- and exo-system, Lin (2021) highlights capital and labour as well as accessibility and sensitivity within healthcare organisations. Finally, immigration/social policies, as well as societal values/ideologies, are emphasised as macro-level, structural elements that influence all other levels.

3.5.2 Strategies for rigour

Strategies for rigour included reflexive memoing while coding (Mahbub al., 2017); team meetings throughout the data collection and analysis process (Guest et al., 2012); team-based analysis with members representing different disciplines and cultural groups, including “insiders” and “outsiders” (Morse, 2010); and the careful examination of outliers (Saldaña, 2021). An individual conducting research is deemed an "insider" when they possess specific attributes and identity markers that align with those of the study participants. Conversely, a researcher is regarded as an "outsider" when they do not belong to the same groups as the participants (Bukamal, 2022; Braun & Clarke, 2013). Outliers typically refer to participants and/or themes that are unique and distinct from the bulk of the data set (Saldaña, 2021).

The Scholastic point of view, coined by Pierre Bourdieu, considers how our academic training, past experiences, and social processes shape our way of seeing the world, leading to epistemological errors in social science practices (Schirato & Webb, 2003; Lash, 2000). Reflexivity is seen as a response to that bias, as a deliberate and conscious check for blind spots during qualitative research, in order to be aware of one's experiences, backgrounds, personal interests, culture, and social context, all of which influence how an individual perceives the world (Lash, 2000). Although researchers cannot be completely free of these influences, they can

be aware of how these influences affect their interpretation (Lash, 2000). An intentional engagement in a reflexive approach throughout all stages of this research, allowed for awareness of the biases and subjectivities that result from the authors' academic training as well as their non-academic experiences (Braun & Clark, 2019). More specifically, our approach to reflexivity is guided by Ellis and Bochner's (2000) approach to reflexivity, which entails tuning out the voices in our heads in order to avoid reporting the first thing that comes to mind and assuming it is true. We intended to recognise that what we may consider to be rooted in reality and truth may be the result of specific ways of reasoning that we have become accustomed to, influenced by our structural, social, and academic contexts (Ellis & Bochner, 2000). For more information on the lead author, DC's, specific positionality, please refer to the "Statement of Positionality" section.

Table 3 - 4

A priori & Emergent, Evolving Coding Structure

Initial Codes from the Multi-level Eco-social Framework	**Codes added during further reading of transcripts**	**Codes less salient, either removed or collapsed; not highlighted in the results**	**Final, high-level clustering of themes and sub-themes, as presented in the results**
	⊕	⊖	→
Enabling Resources: Patient-provider dyad	Language Culture Gender	Provider-caregiver dyad	**The intricacies of language** • Nuanced nature of language and the • Language and communication **The role of culture and gender** • Social restrictiveness

			• Gender norms rooted in cultural upbringing
Enabling Resources: Patient-caregiver dyad	Family engagement & decision-making	Support from friends	**The role of family in healthcare decision-making** • Family members' engagement with the patients' care journey • Level of involvement of children and spouses in healthcare decision-making
	Perceptions of patients regarding physicians' status	Prejudice of healthcare providers	**Reverence or deference to the physician's role.** • Power of the physicians' status • Patient characteristics that influences the interaction between provider and patient

3.6 Results

Through the analysis we identified four themes pertaining to patient engagement and healthcare decision making of South Asian older adults in Canada: 1) the intricacies of language, 2) the role of gender and culture, 3) the role of family in healthcare decision making, and 4) reverence or deference to the physician's role. The first theme emphasized the nuanced nature of language and the potential for miscommunication to occur even when patients and healthcare providers are conversing in the same language. The results also highlighted that the extent of patient engagement and shared decision-making, along with the preference for family involvement, are greatly influenced by cultural and gender factors. Lastly, the final theme

demonstrated that the position and perceptions of physicians play a significant role in shaping patient engagement, often resulting in patients being more inclined to agree with the healthcare providers' approach to care.

3.6.1 The intricacies of language

The participants in our study explained the importance of language when interacting with their healthcare providers, particularly highlighting language concordance, which refers to patients and healthcare providers being able to effectively communicate in a shared language (Hsueh et al., 2019). Participants noted that the lack of linguistic concordance will have an especially negative impact on newer immigrants who are unfamiliar with the Canadian healthcare system, making healthcare navigation particularly challenging. Ashish, for instance, explained his perspective on the importance of language:

> *When our people come in from overseas, they have a language barrier. They can't explain exactly what the problem is, and if the doctor does not understand the problem, how can he cure it?*
>
> - Ashish, male, 88 years old

On the other hand, Jamal noted another aspect of language barriers between physician and patient that is associated with technical terms and medical jargon:

> *See, so long as the doctor speaks in simple language, people will understand. The moment he tells you medical terms, they will find it difficult to digest.*
>
> - Jamal, male, 60 years old

The quote above highlights that there is more to language than having a conversation in a shared language. Similarly, Zarina explained from a different perspective how communication goes beyond language concordance:

I had to go to a specialist for my knee a few months ago. I have chronic knee pain for the past few years and doctor just gave me an appointment…he [doctor] said I should use medication and physiotherapy and maybe surgery. He said that a surgery would make his job easier {laughs}. I thought he was serious! I got worried, I said to myself "he is not a good doctor". But my son explained after the appointment that he was trying to be funny. I do know English but I don't get these things, these 'mazaak' (Urdu word for joking or sarcasm) - you know? I know now. But I am glad my son went with me. I thought I had to get a new specialist! {laughs}. Doctors back in Pakistan are more professional and to-the-point, you know?

- Zarina, female, 60 years old

Zarina's comment emphasises the subtleties of language and how miscommunication can occur even when two individuals converse in the same language. Zarina, who has been in Canada for seventeen years and speaks very little English, also mentions her son's role in her engagement with her healthcare provider, demonstrating a way in which family members can be helpful beyond acting as translators.

3.6.2 The role of gender and culture

Gender played a significant role in the interviews with both male and female participants. Our study showed that the gender of the healthcare providers can impact the interaction between the care-provider and the care-recipient. For example, many participants stated that they would feel more at ease talking to a healthcare provider who is their own gender. However, the participants acknowledged that finding a physician of the same gender as them is not an aspect of their care they can control, particularly in Canada, where finding a physician is difficult in and of itself. Abhijeet elaborated on this point, explaining how the experience of seeking, or needing a physician of the same gender can differ in Canada compared to his country of origin:

I find, yeah, doctors are very, very liberal and they will just go into their things with the ladies in Canada when they have problems. In India, it's quite different. You know, like, I

know my family members back in India, the ladies seek, and they go for a lady gynecologist, for example. Here, you don't have that option, you get a gynecologist, you get a gynecologist. So that might be a bit shocking to people that's coming from that country, Bangladesh or India. Over here some of my family members say, "oh my god, you know, I have a male doctor who is going to check me out". Uncomfortableness is the word to use here, I guess. That's how they feel.

- Abhijeet, male, 75 years old,

Abhijeet's quote emphasises the perceived need for individuals who come to Canada to adjust to the differences in how the healthcare system operates there compared to their home countries. Although the majority of participants who expressed their discomfort in discussing sensitive topics with healthcare providers of the opposite gender were female, it is worth noting that some male participants also highlighted this concern. Irfaan is one such example,

There are so many health issues that come up in my old age now. It's uncomfortable to speak with female doctors about all of them. I would prefer a male doctor who I can talk about those more personal topics about my health. I don't feel comfortable talking to female doctors about everything.

- Irfaan, male, 68 years old

While some participants have also stated they would prefer to have a physician who not only is the same gender as them but also shares the same ethnocultural background, others have stated the opposite as true for them. Beena, who has lived in Canada for the majority of her life, described her interactions with her family physician, a man from the same ethnocultural background as her, in the following way:

I think there are two sides to some people wanting a doctor from the same culture as them, because I've seen people saying they want to find a preferably Indian doctor or Pakistani, you know, South Asian doctor. But in my experience, when we came to Canada

we saw that doctors are difficult to get... So, one of my first things after we came was to find a doctor, in case my children became sick. But I had a hard time finding a doctor. But then one of my friends said oh there was a doctor who was accepting new patients and the way she pronounced her name, I didn't realize it's an Indian gentleman. I was just so happy to get a doctor, and then figured out he is Indian later. And because of that I know him socially, he went to the parties around my neighbourhood. I thought to myself, if I'd known earlier and had a choice, I would choose a different doctor. For example, I didn't know about pap smears, and it was not comfortable talking to him about it, like he is male and also Indian. He was also friends with my mom. I felt like if I left him to find another doctor it would be a difficult situation, you know, socially. I never had the courage to leave him. But then I found out he was planning to retire, so I was very happy!

- Beena, female, 73 years old

Beena's quotes highlight that having a healthcare provider from the same culture as themselves is not inherently positive to their healthcare experience. Beena further discusses how an individual's upbringing and education might influence how they interact with their healthcare providers:

If it's like, a doctor of the opposite gender, then it can be a little bit more uncomfortable at times, especially if you come from like, more conservative, cultural background. That's exactly my story, right? Education and upbringing matter I think, since I was born and raised in India, I am still following those norms and rules here in Canada. But since I received my higher education here, I am more adjusted to how Canadians work. It doesn't bother the same way anymore. But, I do know that a lot of people do want to see doctors from the same gender.

- Beena, female, 73 years old

Beena's comment above exemplifies how the intersection of culture and gender can influence the healthcare experience of older adults in Canada. Beena also highlighted that in her community,

women must adhere to certain levels of social restrictiveness as well as certain "sociocultural rules of interaction," when communicating with men. Beena and several other female participants noted that the stigma and societal restrictions stemmed from their cultural upbringing, which is why many of them said they would prefer a female doctor. In this way, Beena states that her approaches to engagement are rooted in their cultural upbringing, while education as well as time spent in Canada impacts how those approaches to healthcare engagement and decision-making evolve over time.

3.6.3 The role of family in healthcare decision making

The importance of family members' engagement in the process of the participants' healthcare decision making was a prominent theme. Aaron explains the role his children play when it comes to making a decision regarding his health:

> *I expect my children to weigh in with their opinion. When we are older, they are the ones who will take care of me and my wife, so their input now is important to us.*
>
> - Aaron, male, 75 years old

According to Aaron, the children's input is important because they are expected to be Aron's caregivers in the future. Similarly, Ananya, an older adult who also acts as a caregiver to her father-in-law explained how decisions are made in their household:

> *Say for example, there was this decision about adding a new medication, because my father-in-law has a prostate condition. So, we discussed with him, but he usually leaves the decision to my husband and myself. So, we decide that it would be a better option, because surgery is not an option for him at this age. So, we decided to go this route and so most of the decisions are done like that... Even though we asked him, we discuss with him, but he usually leaves it to us.*
>
> - Ananya, female, 61 years old

Ananya's quote explains that not only does her father-in-law involve her and her husband in the decision-making process, but he leaves the decision up to them. On the other hand, Shalini explains that she consults her spouse when it comes to making a decision, but not her children:

> *After the doctor, I will talk to my husband about it. After we discuss it, I may ask my friend who is a doctor in India about it. But usually just my husband and I make the decision together. I don't bother my children with it, they have their own problems.*
> - *Shalini, female, 67*

Other participants in our study, particularly longer-term immigrants and male participants, on the other hand, stated that their families were not as involved in their healthcare decision making, and that they made their own decisions, independently, based on their physicians' medical advice.

3.6.4 Reverence or deference to the physicians' role

Most participants in our study expressed satisfaction with their care, good experiences with their family doctors, and trust in the Canadian healthcare system. They did not, however, report being actively engaged in their own care. When questioned about her approach and process for making healthcare decisions, Malini expressed,

> *Usually, I will just do as the doctor says. Sometimes I will consult my husband if it's a big issue – I had to do a small surgery a few years back, so my husband and children came with me to discuss it with the doctor. But I tend to be an easy-going person. The doctor usually gives prescription to buy medication for something and I'll just go and get it.*
> - Malini, female, 83 years old

When questioned about instances when participants had disagreed with the doctor, a frequent response echoed Malini's comments about being laid-back and easy-going. Participants indicated that they entrusted decision-making authority to the doctors and expressed agreement with their decisions. When inquired about the reasons behind their tendency to agree with the doctor, Aarini stated:

> *I tend to agree with the doctor because I feel that each one has his or her own expertise. I'm not a doctor and I don't have that knowledge. So I let them do what needs to be done.*
>
> - Aarini, female, 62 years old

As seen in the above quote, a common explanation provided by participants for their inclination to agree with the doctor was owing to the doctor's medical experience and expertise. However, some participants, such as Rajib, discussed additional factors that may be influencing the dynamics between physicians and patients:

> *I am not a shy person so I will voice my opinion if I think the doctor is doing something wrong. But for immigrant populations, there is a power dynamic where if the doctor is white and the patient is not, it can be harder to disagree.*
>
> - Rajib, male, 74 years old

Rajib's quote highlights two key factors that may influence the interaction between the care provider and the care recipient. Firstly, the quote highlights that a patient's approach and personal characteristics can be a factor that impacts the care they receive. Rajib also draws attention to the significance of both the patient's and the physician's identity, emphasizing that it can influence the extent to which a patient expresses disagreement with the healthcare provider. This, in turn, may restrict the patient's level of engagement in their own care. Another participant, Tarala, explains the influences which led her to align with her doctor's viewpoint,

> *"In our culture and Hindu scriptures, for example, a physician is seen as God. And who would question God?"*
>
> - Tarala, female, 78 years old

Other participants in the study also raised the perspective that, based on their religious or cultural teachings, care providers are regarded with a status akin to "God". Consequently, it can be deemed uncomfortable, disrespectful, or impolite to express disagreement with them. While

some participants referred to the role of a “healer” as being important in religious scripture, most participants referred specifically to “doctors” or “physicians” being given higher importance over other healthcare professionals.

3.7 Discussion

The significance of language in society, and thus in healthcare, cannot be overstated (Franz & Murphy, 2018). Several participants highlighted the need to know the language spoken by the care-provider (i.e., English) in order to explain their existing medical issues. Participants, however, emphasised that language often goes beyond simply knowing the words. Language serves as a vehicle for social and cultural expression as a way of conveying understandings and assumptions held by groups (Al-Amer et al., 2014). Similarly, language is a means of communicating one's identity and representing one's sense of self (Squires et al., 2008). Linguists classify language competency into four categories: grammatical, discourse, sociolinguistic, and strategic (Larson, 1998; Savignon, 1976). The sociolinguistic category is especially relevant in healthcare providers' interactions and engagement with their linguistically diverse patient populations. The sociolinguistic category refers to the capacity to communicate and negotiate word and phrase meanings in terms of the culture in which the language is used, incorporating knowledge of cultural norms into communication processes (Savignon, 1976; Squires et al., 2008). An example of this in our study was seen through Zarina’s interaction with her specialist. Understanding the sociolinguistic category may help explain why language and communication are not always synonymous, and why knowing what is said in English (which is often used as a marker for language concordance) does not always imply that the care-provider and recipient are communicating. Several studies report the impact of gender, class, and education on the sociolinguistic understanding of language (French et al., 1984; Kiełkiewicz-Janowiak, 2012;

Verhoeven, 2017; Wodak & Benke, 2017). While sociolinguistics is often taken into account for cross-cultural research and communication between researcher and participant, it is often overlooked in the interaction between healthcare providers and patients (Helmich et al., 2017; Squires et al., 2008).

Studies have also found that language barriers can impede access to health care and challenges related to navigating the complex system of care in Canada (de Moissac & Bowens, 2017; Bowens, 2021; Shamsi et al., 2020). Participants in our study expressed similar concerns, indicating that if the doctor does not understand what is being said, they will be unable to help their patients. However, as pointed out by Schwei and colleagues (2016), researchers should start concentrating their efforts on understanding how language concordance affects patient outcomes and their healthcare experiences rather than just stating that language barriers exist. Previous studies have indicated that patients generally perceive language concordance and ethnic-matching between doctors and patients as beneficial (Cooper-Patrick et al., 1999; Perez-Stable et al., 1997; Saha et al., 1999; Sue et al., 1995). For instance, one study found that Black participants who had Black doctors and Hispanic patients who had Hispanic physicians were more likely to express high satisfaction with their overall healthcare experience and more inclined to rate their physicians as excellent (Saha et al., 1999). However, contrary to previous findings, our research revealed that, while having a healthcare provider who speaks the same language and belongs to the same ethnocultural background as the patient has advantages, especially for newer immigrants who often face language barriers, there are some drawbacks. The participants of the study emphasised that linguistic concordance sometimes means that the physician is a member of their community social circles, which presents some challenges, such as discussing personal matters. For instance, one participant, Beena, noted that because her

family physician, who spoke Hindi (her language spoken at home), was frequently invited to the same gatherings and functions in their community, she found it challenging to interact with her doctor in a social, in-formal setting while still needing to discuss person health concerns such as gynaecological care or sexual health issues. Quotes from participants, such as Beena, highlight that speaking with a male healthcare provider from the same ethnocultural background requires adherence to certain sociocultural rules which may impede open communication. Our study, therefore, shows that healthcare experiences can be "gendered". This is consistent with previous research, such as that of Pittman (1999), which shows that gender-specific social interactions between patients and providers might have an impact on quality of care and health outcomes. Other studies describe comparable concerns in racialized immigrant populations in terms of stigma. For example, one study performed by Kingori et al., (2018) examined the stigma associated with racialized women's sexual health in Somali communities in the United States. While their research focused on younger women, they also underlined the prevalence of social restrictions that are exclusive to women, which are rooted in religious and cultural norms of society (Kingori et al., 2018). Lin's (2021) multi-level eco-social framework emphasizes the significance of language as a factor to be taken into account in the patient-provider dyad interactions. Consistent with our research, the multi-level eco-social model highlights the importance of communication stressing that within the meso-system of patient-clinician dyads, difficulties arising from language and cultural barriers can result in communication issues, such as leading to the misinterpretation of symptoms, which may lead to reduced access to healthcare services (Lin, 2021).

Patient engagement is currently regarded as a key element of high-quality healthcare service provision. Over the last few decades, a patient-centered care model that aims to tailor

care to each patient's needs, values, and experiences has evolved from the paternalistic approach to healthcare, where healthcare providers make all the decisions with the patient having little or no involvement in their own care (Bauman et al., 2003; Ford, 2004; Stewart et al., 2000). The majority of patient engagement literature focuses primarily on the involvement of the patients (Bombard et al., 2018). However, our findings underline the importance of family members, particularly spouses and children, in the patient engagement process, especially pertaining to healthcare decision making. Participants explained that while they maintained that the physician is the medical expert, they closely incorporate their family's input when it comes to making a decision about their health. Our findings shed light on the collectivist nature of certain racialized immigrant communities reported in other studies (Martin et al., 2015; Oishi, 2000; Sheldon et al., 2004). According to Markus & Kitayama (1991), individuals' experiences, emotions, and motivations are influenced by the significantly varied constructs of the "self" and "others" that are frequently used across different cultures. In contrast to those in individualist societies, people in collectivist cultures, such as South Asian communities, internalise the expectations of their friends and family. As a result, in collectivist societies as opposed to individualist cultures, people's assessments of their level of life satisfaction and experiences seem to be more heavily influenced by their familial expectations (Markus & Kitayama, 1991). This was consistent with our findings where families play a prominent role in the healthcare experiences of South Asian older adults. Therefore, our findings aligned with Triandis' (1995) individualism-collectivism theory, which states that collectivists are a group of people who see themselves primarily as components of a larger whole, such as a family, and thus are influenced by the norms and obligations established by the collective unit. On the other hand, some participants who had come to Canada considerably earlier, tended to approach healthcare decision-making more

independently. Some of them also stated that, while they consider their family's thoughts, the final decision about their health was their own. Because they have spent the great bulk of their lives in Canada, one explanation for this would be that they have "assimilated" or acculturated into a more “Westernised” culture over time, adopting health behaviours that are more in line with an individualist society than a collectivist one (Triandis, 1995). As such, our findings show that patient engagement is not always a dyadic exchange, but rather a dynamic, triadic, process between the care-provider, the care-recipient, and their families. Our study's findings regarding the dynamic engagement process aligns with a perspective that somewhat differs from Lin's (2021) model. Lin's (2021) multi-level eco-social framework incorporates family through the concept of the "patient-caregiver dyad”. Contrary to the model, we found that the "patient-caregiver dyad" and "patient-provider dyad" interactions are not distinct and separate. In our research, we emphasize that this process often occurs as a "patient-caregiver-provider" triad, as is evident with South Asian participants in our study.

French philosopher Voltaire once expressed his admiration for physicians, stating “those who are occupied in the restoration of health to others, by the joint exertion of skill and humanity, are above all the great of the earth” (Voltaire, 1746). He even attributed a divine quality to their work, asserting that the ability to preserve and renew life is almost as noble as the act of creation itself (Yates, 1969). In a 1983 article, author Brian Zack compares a physician's role to that of a mechanic, emphasising that the physician's superiority is due to tasks that require "a higher intellectual capacity or greater professional skill" (p. 2), and that the key difference between the two professions is that for a physician, the "dysfunctional machine is the client" (p. 2). Putting aside the unfortunate perception of patients as "dysfunctional machines" that persists to some extent even today, these adages highlight the prominent position physicians hold in

society. Historically, several cultures revered physicians as being "second to God" and typecasting them to have Godlike attributes due to stereotypes of them being intelligent and knowledgeable (Goranson et al., 2020; Schroeder & Fishbach, 2015). Our study highlighted that this status and perceptions of doctors can influence patients by shaping their tendency of conformance. Participants in our study, particularly those with a Hindu background, made references to the notion that they felt compelled to agree with the doctor rather than express their worries because of their upbringing, which taught them to treat doctors with the same respect they would show to God. Our findings indicate that patients with such attitudes are more likely to exhibit a greater inclination to conform to the decisions made by physicians regarding their health and well-being, which may limit their engagement in their care and their desire to involve their family in the process. Similar findings have been documented in previous studies exploring cultures outside of South Asia. For instance, in their study looking at family engagement in medical decision making, Alden et al., (2018) found that South Korean patients tended to view shared decision making as acceptable only when their doctor actively encouraged it, but not when there is no encouragement from the physician. The authors hypothesize that this could be attributed to South Korean culture's strong emphasis on the social norms of conformance (Alden et al., 2018; Reimar et al., 2014). Specific to newer immigrants, Hasnain and colleagues (2013) suggest the notion that immigrants who have not fully acculturated into healthcare systems in the Global North, which prioritize patient autonomy, are more likely to show greater reverence or deference towards physicians compared to those who have. Similarly, Cervantes-Ortega et al., (2020) reports that in their study, Latina women with lower levels of acculturation exhibited increased appreciation for any form of care they receive, leading to higher ratings of quality of care, and held providers in higher regards and esteem than those who have had more

opportunities to acculturate. They also state that longer-term immigrants who have had time and opportunity to integrate into the healthcare systems of the Global North have higher expectations of care than newer immigrants (Cervantes-Ortega et al., 2020). However, these finding contrast with the findings of our study, because participants in our study who are long-term residents of Canada also report having reverence and deference towards their physicians. Although the multi-level eco-social model includes the "patient-provider" and "patient-caregiver" dyad within its concentric circles (Lin, 2021), our paper contributes to this model by specifically examining healthcare decision-making, which represents a specific form of engagement. In addition to contributing to the understanding of the "patient-provider dyad" in Lin's (2022) model, our paper centers on factors that influence this interaction, including the patient's perception of the physician's status and the influence of gender and culture, specifically.

3.8 Implications for Practice & Policy Considerations

As the value of patient-centered care becomes more widely recognised around the world, particularly in multicultural migrant-receiving countries, research studies such as ours will improve understanding of cross-cultural similarities and differences in approaches to patient engagement and shared decision making (Bell, 2014; Bokhour et al., 2018; Constand et al., 2014; Fix et al., 2018; Ortiz, 2018). Recognizing differences in cultural perspectives among racialized immigrant patients, as well as their preferences for how they want to be involved in their own care and the factors that influence provider-patient interactions, can provide healthcare providers with valuable insights (Stubbe, 2020; Zghal et al., 2021). Understanding such nuances that exist among patient populations, for instance, can assist them in avoiding reliance on cultural stereotypes when engaging with patients and their families (Vela et al., 2022). Consistent with prior research, our study reinforces the notion that involving patients in their healthcare is not a

simple matter of associating specific nationalities or cultural backgrounds with predetermined beliefs and norms (Kirby et al., 2018). Given the contextual nature of the experiences of migration experiences and given the vast societal and cultural differences that exist on top of specific lived experiences of some subgroups and not others, we must exercise caution before embracing generalizations without considering the specific circumstances (Galanti et al., 2000). Several studies have emphasized the significance of clinicians proactively examining individual cultural preferences in medical settings, especially regarding patient and family preferences for decision-making and information regarding their diagnosis and prognosis (Barclay et al., 2007; Blackhall et al., 1995; Chiu et al., 2016; Vahdat et al., 2014). Similarly, our findings also emphasize the need to tailor care delivery for racialized immigrant older adults and for effective communication between clinicians and patients, considering their specific linguistic, cultural, and spiritual needs and values. Policy and organizational mandates as well as training programs focused on culturally sensitive care must emphasize the significance of being aware of potential normative variations when considering patients as unique individuals with diverse preferences for patient and family engagement in healthcare decision-making (Saha et al., 2008; Seeleman et al., 2009).

The findings of our study have significant implications for the development of linguistically and culturally sensitive/aligned tools, resources, or recommendations to support engagement of racialized immigrant older adults and their families in managing their care. Similar to the diabetes management tools suggested by Chun et al., (2011) for the Chinese communities, we recommend creating informational resources in various South Asian languages that cater to the immigrant community, particularly newer immigrants with language barriers. An example of informational resources could be directories designed to assist older adults in

navigating the healthcare system in Canada. These directories could provide information on the locations of various healthcare settings (e.g., walk-in clinics, testing centres, hospitals) in a particular region, as well as who or which organizations to approach for additional healthcare-related information. For instance, the directories could offer guidance on finding a family doctor in the patients' region or explaining the guidelines on when it is appropriate to visit a pharmacist instead of a physician. Our study also helps identify barriers that prevent immigrants from participating in healthcare decision-making. Per our suggestions, policies can emphasise the promotion of inclusive healthcare practises that enable immigrant patients' active involvement in decision-making. Examples of these practises include shared decision-making models, instructional materials that are relevant for their culture, and family or community support networks' involvement (Anderson et al., 2003). Additionally, we suggest avoiding the assumption that cultural competence in healthcare is automatically achieved by having ethnic or language concordance between healthcare providers and patients. Therefore, as echoed by Engstrom et al., (2009), special attention is warranted for training of bilingual and ethnically-matched healthcare staff with navigating the interactions between care providers and recipients influenced by cultural and social norms. Regarding the role of family in the care journey, it is important for healthcare providers to regularly assess the shifts in patients' expectations, responsibilities, and family support as a routine part of care provisions. We also recommend creating a communication training model that is appropriate for racialized immigrant populations, such as for South Asian communities (von Fragstein et al., 2008). Instead of relying on a Eurocentric communications guideline, a culturally tailored communication skills model that aligns with the individuals in the specific culture can be more advantageous in training healthcare providers to effectively communicate with patients from diverse backgrounds (Parker

et al., 2020). Lastly, providers must be aware of and be attuned to the potential inclination within certain communities or among newly arrived immigrants towards reverence and deference. Health care providers should proactively create an environment that encourages alternative perspectives and make space for other ways of thinking. For instance, if a physician knows that a patient is likely to agree with anything they suggest, they should make an active and conscious effort to present multiple options and provide a thorough review of the advantages and disadvantages of each option.

3.9 Limitations

Our study contributes to the existing, but limited, research on patient engagement and shared decision-making, concerning not only racialized immigrant patients but also older adults. However, our qualitative study had some limitations. First, our sample of participants was geographically limited because we recruited participants from Southern Ontario, focusing primarily on urban cities. This also resulted in the possible exclusion of racialized immigrant older adults residing in rural areas who may or may not have had different healthcare experiences. Secondly, although we conducted comprehensive interviews with older adults to explore their preferences and perspectives on patient engagement, shared decision-making, and family involvement, our study would benefit from additional insights that might be gained by also interviewing family caregivers about their role in providing care. Similarly, it would have been beneficial to interview healthcare providers regarding their firsthand experiences in engaging racialized immigrant older adults and their families in care, providing insights from the perspective of care providers. Thirdly, this study focused on only on the experiences and perspectives of the South Asian immigrant communities in Canada. Subsequent research should investigate the viewpoints and experiences of other communities within the Canadian

demographic landscape, such as the Chinese community and the Arabic-speaking community. Fourthly, we had a large number of participants who were highly educated, came from higher socioeconomic backgrounds, and had high English language proficiency. Although our sample aligns with the migration patterns of South Asian older adults in Canada (i.e., many South Asian families migrated to Canada during the mid-20th century and are now older adults, as reported by the Government of Canada in 2021), it is important to understand and specifically study the experiences of recent immigrants from less privileged socioeconomic backgrounds and those for whom English is a second language. Lastly, it is important for studies of this kind to specifically address refugees who have migrated to Canada, distinguishing between immigrants and refugees due to their significantly distinct experiences of migration.

3.10 Conclusion

This paper examines South Asian-born older adults' experiences and approaches to patient engagement, collaborative healthcare decision-making, and the factors that influence patient engagement and healthcare decision-making within this population. The study's contribution includes a thorough understanding of the importance of family, gender, and culture in South Asian older adults' healthcare experiences as well as how communication extends beyond language. The findings also show that patients' perceptions of physicians and their status can influence their approach to patient engagement. This paper challenges previous research that assumes language concordance as well as ethnic matching between patients and healthcare providers are unanimously beneficial.

3.11 Acknowledgements

We sincerely thank the research participants who generously shared their experiences and perspectives with us. This work was supported by the Canadian Institutes of Health Research (grant number: 452873) and the International Doctoral Scholarship Award granted to DC.

3.12 References

Agoritsas, T., Heen, A. F., Brandt, L., Alonso-Coello, P., Kristiansen, A., Akl, E. A., Neumann, I., Tikkinen, K. A., Weijden, T. van der, Elwyn, G., Montori, V. M., Guyatt, G. H., & Vandvik, P. O. (2015). Decision aids that really promote shared decision making: The pace quickens. *BMJ*, *350*, g7624. https://doi.org/10.1136/bmj.g7624

Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of language barriers for healthcare: A systematic review. *Oman Medical Journal*, *35*(2), e122. https://doi.org/10.5001/omj.2020.40

Al-Amer, R., Ramjan, L., Glew, P., Darwish, M., & Salamonson, Y. (2015). Translation of interviews from a source language to a target language: Examining issues in cross-cultural health care research. *Journal of Clinical Nursing*, *24*(9–10), 1151–1162. https://doi.org/10.1111/jocn.12681

Alden, D. L., Friend, J., Lee, P. Y., Lee, Y. K., Trevena, L., Ng, C. J., Kiatpongsan, S., Lim Abdullah, K., Tanaka, M., & Limpongsanurak, S. (2018). Who decides: Me or we? Family involvement in medical decision making in eastern and western countries. *Medical Decision Making*, *38*(1), 14–25. https://doi.org/10.1177/0272989X17715628

Alegría, M., Carson, N., Flores, M., Li, X., Shi, P., Lessios, A. S., Polo, A., Allen, M., Fierro, M., Interian, A., Jimenez, A., La Roche, M., Lee, C., Lewis-Fernández, R., Livas-Stein, G., Safar, L., Schuman, C., Storey, J., & Shrout, P. E. (2014). Activation, self-management, engagement, and retention in behavioral health care: A randomized clinical trial of the DECIDE intervention. *JAMA Psychiatry*, *71*(5), 557–565. https://doi.org/10.1001/jamapsychiatry.2013.4519

Alvi, S., & Zaidi, A. U. (2017). Invisible Voices: An intersectional exploration of quality of life for elderly South Asian immigrant women in a Canadian sample. *Journal of Cross-Cultural Gerontology*, *32*(2), 147–170. https://doi.org/10.1007/s10823-017-9315-7

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine, 24(*3, Supplement), 68–79. https://doi.org/10.1016/S0749-3797(02)00657-8

Armstrong, M. J., Shulman, L. M., Vandigo, J., & Mullins, C. D. (2016). Patient engagement and shared decision-making. *Neurology: Clinical Practice*, *6*(2), 190–197. https://doi.org/10.1212/CPJ.0000000000000240

Barclay, J. S., Blackhall, L. J., & Tulsky, J. A. (2007). Communication strategies and cultural issues in the delivery of bad news. *Journal of Palliative Medicine*, *10*(4), 958–977. https://doi.org/10.1089/jpm.2007.9929

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making—Pinnacle of patient-centered care. *The New England Journal of Medicine*, *366*(9), 780–781. https://doi.org/10.1056/NEJMp1109283

Bauman, A. E., Fardy, H. J., & Harris, P. G. (2003). Getting it right: Why bother with patient-centred care? *The Medical Journal of Australia*, *179*(5), 253–256. https://doi.org/10.5694/j.1326-5377.2003.tb05532.x

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics*. Oxford University Press.

Bell, L. (2014). Patient-centered care. *American Journal of Critical Care: An Official Publication, American Association of Critical-Care Nurses*, 23(4), 325. https://doi.org/10.4037/ajcc2014383

Bito, S., Matsumura, S., Singer, M. K., Meredith, L. S., Fukuhara, S., & Wenger, N. S. (2007). Acculturation and end-of-life decision making: Comparison of Japanese and Japanese-American focus groups. *Bioethics*, *21*(5), 251–262. https://doi.org/10.1111/j.1467-8519.2007.00551.x

Blackhall, L. J., Murphy, S. T., Frank, G., Michel, V., & Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. *JAMA*, *274*(10), 820–825. https://doi.org/10.1001/jama.1995.03530100060035

Blair, E. (2015). A reflexive exploration of two qualitative data coding techniques. *Journal of Methods and Measurement in the Social Sciences*, *6*(1), Article 1. https://doi.org/10.2458/v6i1.18772

Bokhour, B. G., Fix, G. M., Mueller, N. M., Barker, A. M., Lavela, S. L., Hill, J. N., Solomon, J. L., & Lukas, C. V. (2018). How can healthcare organizations implement patient-centered care? Examining a large-scale cultural transformation. *BMC Health Services Research*, 18(1), 168. https://doi.org/10.1186/s12913-018-2949-5

Boland, L., Kothari, A., McCutcheon, C., Graham, I. D., & for the Integrated Knowledge Translation Research Network. (2020). Building an integrated knowledge translation (IKT) evidence base: Colloquium proceedings and research direction. *Health Research Policy and Systems, 18*(1), 8. https://doi.org/10.1186/s12961-019-0521-3

Bombard, Y., Baker, G. R., Orlando, E., Fancott, C., Bhatia, P., Casalino, S., Onate, K., Denis, J.-L., & Pomey, M.-P. (2018). Engaging patients to improve quality of care: A systematic review. *Implementation Science : IS*, *13*, 98. https://doi.org/10.1186/s13012-018-0784-z

Bournes, D. A. (2000). A commitment to honoring people's choices. *Nursing Science Quarterly*, *13*(1), 18–23. https://doi.org/10.1177/089431840001300108

Bowen, S. (2001). *Language barriers in access to health care* (p. 120). Ottawa: Health Canada.

Boyd, C. M., Darer, J., Boult, C., Fried, L. P., Boult, L., & Wu, A. W. (2005). Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: Implications for pay for performance. *JAMA*, *294*(6), 716–724. https://doi.org/10.1001/jama.294.6.716

Boyd, C., Smith, C. D., Masoudi, F. A., Blaum, C. S., Dodson, J. A., Green, A. R., Kelley, A., Matlock, D., Ouellet, J., Rich, M. W., Schoenborn, N. L., & Tinetti, M. E. (2019). Decision making for older adults with multiple chronic conditions: Executive summary for the American Geriatrics Society guiding principles on the care of older adults with multimorbidity. *Journal of the American Geriatrics Society*, *67*(4), 665–673. https://doi.org/10.1111/jgs.15809

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3(*2), 77–101. https://doi.org/10.1191/1478088706QP063OA

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press. http://www.gbv.de/dms/bowker/toc/9780674224568.pdf

Broom, A., Good, P., Kirby, E., & Lwin, Z. (2013). Negotiating palliative care in the context of culturally and linguistically diverse patients. *Internal Medicine Journal*, *43*(9), 1043–1046. https://doi.org/10.1111/imj.12244

Brown, E., Patel, R., Kaur, J., & Coad, J. (2013). The South Asian culture and palliative care for children, young people, and families—A discussion paper. *Issues in Comprehensive Pediatric Nursing*, *36*(1–2), 120–143. https://doi.org/10.3109/01460862.2013.787131

Bukamal, H. (2022). Deconstructing insider–outsider researcher positionality. *British Journal of Special Education*, *49*(3), 327–349. https://doi.org/10.1111/1467-8578.12426

Carman, K. L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2013a). Patient and family engagement: A framework for understanding the elements and developing interventions and policies. *Health Affairs*, *32*(2), 223–231. https://doi.org/10.1377/hlthaff.2012.1133

Carman, K. L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2013b). Patient and family engagement: A framework for understanding the elements and developing interventions and policies. *Health Affairs*, *32*(2), 223–231. https://doi.org/10.1377/hlthaff.2012.1133

Cervantes-Ortega, M., Du, S., Biegler, K. A., Al-Majid, S., Davis, K. C., Chen, Y., Kobsa, A., Mukamel, D. B., & Sorkin, D. H. (2020). Participatory decision-making for cancer care in a high-risk sample of low income Mexican-American breast cancer survivors: The role of acculturation. *International Journal of Healthcare*, *6*(2), 35–43. https://doi.org/10.5430/ijh.v6n2p35

Chambers, R. (2012). *Revolutions in development inquiry*. Routledge.

Charles, C., Gafni, A., Whelan, T., & O'Brien, M. A. (2006). Cultural influences on the physician-patient encounter: The case of shared treatment decision-making. *Patient Education and Counseling*, *63*(3), 262–267. https://doi.org/10.1016/j.pec.2006.06.018

Chen, H.-Y., & Boore, J. R. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing*, *19*(1–2), 234–239. https://doi.org/10.1111/j.1365-2702.2009.02896.x

Cherry, M. J. (2015). Re-thinking the role of the family in medical decision-making. *The Journal of Medicine and Philosophy*, *40*(4), 451–472. https://doi.org/10.1093/jmp/jhv011

Chiu, C., Feuz, M. A., McMahan, R. D., Miao, Y., & Sudore, R. L. (2016). "Doctor, make my decisions": Decision control preferences, advance care planning, and satisfaction with communication among diverse older adults. *Journal of Pain and Symptom Management*, *51*(1), 33–40. https://doi.org/10.1016/j.jpainsymman.2015.07.018

Chun, K. M., Chesla, C. A., & Kwan, C. M. L. (2011). "So we adapt step by step": Acculturation experiences affecting diabetes management and perceived health for Chinese American immigrants. *Social Science & Medicine (1982), 72*(2), 256–264. https://doi.org/10.1016/j.socscimed.2010.11.010

Chung, G. S., Lawrence, R. E., Curlin, F. A., Arora, V., & Meltzer, D. O. (2012). Predictors of hospitalised patients' preferences for physician-directed medical decision-making. *Journal of Medical Ethics, 38*(2), 77–82. https://doi.org/10.1136/jme.2010.040618

Claramita, M., Nugraheni, M. D. F., van Dalen, J., & van der Vleuten, C. (2013). Doctor–patient communication in Southeast Asia: A different culture? *Advances in Health Sciences Education*, *18*(1), 15–31. https://doi.org/10.1007/s10459-012-9352-5

Clayman, M. L., Roter, D., Wissow, L. S., & Bandeen-Roche, K. (2005). Autonomy-related behaviors of patient companions and their effect on decision-making activity in geriatric primary care visits. *Social Science & Medicine (1982)*, *60*(7), 1583–1591. https://doi.org/10.1016/j.socscimed.2004.08.004

Cody, W. K. (2003). Paternalism in nursing and healthcare: Central issues and their relation to theory. *Nursing Science Quarterly*, *16*(4), 288–296. https://doi.org/10.1177/0894318403257170

Constand, M. K., MacDermid, J. C., Dal Bello-Haas, V., & Law, M. (2014). Scoping review of patient-centered care approaches in healthcare. *BMC Health Services Research, 14,* 271. https://doi.org/10.1186/1472-6963-14-271

Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *JAMA, 282*(6), 583–589. https://doi.org/10.1001/jama.282.6.583

Corntassel, J., & Gaudry, A. (2018). Insurgent education and Indigenous- centred research: Opening new pathways to community resurgence. (pp. 167–185). *University of Toronto Press*. https://doi.org/10.3138/9781442699397-014

Cosgrove, D. M., Fisher, M., Gabow, P., Gottlieb, G., Halvorson, G. C., James, B. C., Kaplan, G. S., Perlin, J. B., Petzel, R., Steele, G. D., & Toussaint, J. S. (2013). Ten strategies to lower costs, improve quality, and engage patients: The view from leading health system CEOs. *Health Affairs (Project Hope), 32*(2), 321–327. https://doi.org/10.1377/hlthaff.2012.1074

Coulter, A. (2005). What do patients and the public want from primary care? *BMJ (Clinical Research Ed.), 331*(7526), 1199–1201. https://doi.org/10.1136/bmj.331.7526.1199

Coulter, A., & Ellins, J. (2007). Effectiveness of strategies for informing, educating, and involving patients. *BMJ (Clinical Research Ed.)*, *335*(7609), 24–27. https://doi.org/10.1136/bmj.39246.581169.80

Creswell, J. W., & Poth, C. N. (2013). *Qualitative inquiry and research design: Choosing among five approaches.* SAGE Publications.

de Moissac, D., & Bowen, S. (2017). Impact of language barriers on access to healthcare for official language minority Francophones in Canada. *Healthcare Management Forum*, *30*(4), 207–212. https://doi.org/10.1177/0840470417706378

Edwards, M., Davies, M., & Edwards, A. (2009). What are the external influences on information exchange and shared decision-making in healthcare consultations: A meta-synthesis of the literature. *Patient Education and Counseling*, *75*(1), 37–52. https://doi.org/10.1016/j.pec.2008.09.025

Ellis, C. S., & Bochner, A. (2000). *Autoethnography, personal narrative, reflexivity: Researcher as subject*. https://works.bepress.com/carolyn_ellis/49/

Emanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician-patient relationship. *JAMA*, *267*(16), 2221–2226.

Engstrom, D. W., Piedra, L. M., & Min, J. W. (2009). Bilingual social workers: Language and service complexities. *Administration in Social Work, 33*(2), 167–185. https://doi.org/10.1080/03643100902768832

Epstein, R. M. (2013). Whole mind and shared mind in clinical decision-making. *Patient Education and Counseling*, *90*(2), 200–206. https://doi.org/10.1016/j.pec.2012.06.035

Fang, M. L., Sixsmith, J., Sinclair, S., & Horst, G. (2016). A knowledge synthesis of culturally- and spiritually-sensitive end-of-life care: Findings from a scoping review. *BMC Geriatrics*, *16*(1), 107. https://doi.org/10.1186/s12877-016-0282-6

Fix, G. M., VanDeusen Lukas, C., Bolton, R. E., Hill, J. N., Mueller, N., LaVela, S. L., & Bokhour, B. G. (2018). Patient-centred care is a way of doing things: How healthcare employees conceptualize patient-centred care. *Health Expectations: An International*

Journal of Public Participation in Health Care and Health Policy, 21(1), 300–307. https://doi.org/10.1111/hex.12615

Ford, S. (2004). Patient-centered medicine, transforming the clinical method (2nd edition). *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *7*(2), 181–182. https://doi.org/10.1111/j.1369-7625.2004.00270.x

Franz, B., & Murphy, J. W. (2018). Reconsidering the role of language in medicine. *Philosophy, Ethics, and Humanities in Medicine*, *13*(1), 5. https://doi.org/10.1186/s13010-018-0058-z

French, J., French, P., & Acker, S. (1984). *Sociolinguistics and gender divisions*. London: Kogan Page

Galanti, G.-A. (2000). An introduction to cultural differences. *Western Journal of Medicine, 172*(5), 335–336.

Gallagher, S. M. (1998). Paternalism in healthcare decision making. *Ostomy/Wound Management*, *44*(4), 22, 24–25.

Galletta, M., Piazza, M. F., Meloni, S. L., Chessa, E., Piras, I., Arnetz, J. E., & D'Aloja, E. (2022). Patient involvement in shared decision-making: Do patients rate physicians and nurses differently? *International Journal of Environmental Research and Public Health*, *19*(21), 14229. https://doi.org/10.3390/ijerph192114229

Gauthier, N., Ellis, K., Bol, N., & Stolee, P. (2005). Beyond knowledge transfer: A model of knowledge integration in a clinical setting. *Healthcare Management Forum*, *18*(4), 33–37. https://doi.org/10.1016/S0840-4704(10)60067-1

Geertz, C. (1976). *The Religion of Java*. University of Chicago Press.

Gillon, R. (1985). Paternalism and medical ethics. *British Medical Journal (Clinical Research Ed.)*, *290*(6486), 1971–1972. https://doi.org/10.1136/bmj.290.6486.1971

Glasgow, N. J., Jeon, Y.-H., Kraus, S. G., & Pearce-Brown, C. L. (2008). Chronic disease self-management support: The way forward for Australia. *The Medical Journal of Australia, 189*(S10), S14-16. https://doi.org/10.5694/j.1326-5377.2008.tb02203.x

Goranson, A., Sheeran, P., Katz, J., & Gray, K. (2020). Doctors are seen as Godlike: Moral typecasting in medicine. *Social Science & Medicine*, *258*, 113008. https://doi.org/10.1016/j.socscimed.2020.113008

Government of Canada. (2021, April 29). *Significant events in the history of Asian communities in Canada*. https://www.canada.ca/en/canadian-heritage/campaigns/asian-heritage-month/important-events.html

Greene, J., Hibbard, J. H., Sacks, R., Overton, V., & Parrotta, C. D. (2015). When patient activation levels change, health outcomes and costs change, too. *Health Affairs, 34*(3), 431–437. https://doi.org/10.1377/hlthaff.2014.0452

Guest, G., MacQueen, K., & Namey, E. (2012). *Applied Thematic Analysis*. SAGE Publications, Inc. https://doi.org/10.4135/9781483384436

Harmsen, H., Meeuwesen, L., van Wieringen, J., Bernsen, R., & Bruijnzeels, M. (2003). When cultures meet in general practice: Intercultural differences between GPs and parents of child patients. *Patient Education and Counseling*, *51*(2), 99–106. https://doi.org/10.1016/s0738-3991(02)00195-7

Hasnain, M., Schwartz, A., Girotti, J., Bixby, A., Rivera, L., & UIC Experiences of Care Project Group. (2013). Differences in patient-reported experiences of care by race and acculturation status. *Journal of Immigrant and Minority Health*, *15*(3), 517–524. https://doi.org/10.1007/s10903-012-9728-x

Helmich, E., Cristancho, S., Diachun, L., & Lingard, L. (2017). 'How would you call this in English?' *Perspectives on Medical Education*, *6*(2), 127–132. https://doi.org/10.1007/s40037-017-0329-1

Hibbard, J. H., & Cunningham, P. J. (2008). How engaged are consumers in their health and health care, and why does it matter? *Research Brief, 8*, 1–9.

Hibbard, J. H., & Greene, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences; fewer data on costs. *Health Affairs (Project Hope), 32*(2), 207–214. https://doi.org/10.1377/hlthaff.2012.1061

Hirst, S. P., Lane, A., & Stares, R. (2013). Health promotion with older adults experiencing mental health challenges: a literature review of strength-based approaches. *Clinical Gerontologist, 36*(4), 329-355.

Hogan, C., Lunney, J., Gabel, J., & Lynn, J. (2001). Medicare beneficiaries' costs of care in the last year of life. *Health Affairs (Project Hope), 20*(4), 188–195. https://doi.org/10.1377/hlthaff.20.4.188

Holroyd-Leduc, J., Resin, J., Ashley, L., Barwich, D., Elliott, J., Huras, P., Légaré, F., Mahoney, M., Maybee, A., McNeil, H., Pullman, D., Sawatzky, R., Stolee, P., & Muscedere, J. (2016). Giving voice to older adults living with frailty and their family caregivers: Engagement of older adults living with frailty in research, health care decision making, and in health policy. *Research Involvement and Engagement, 2*, 23. https://doi.org/10.1186/s40900-016-0038-7

Hsueh, L., Hirsh, A. T., Maupomé, G., & Stewart, J. C. (2021). Patient-provider language concordance and health outcomes: A systematic review, evidence map, and research agenda. *Medical Care Research and Review: MCRR*, *78*(1), 3–23. https://doi.org/10.1177/1077558719860708

Igwe, P. A., Madichie, N. O., & Rugara, D. G. (2022). Decolonising research approaches towards non-extractive research. *Qualitative Market Research: An International Journal*, 25(4), 453–468. https://doi.org/10.1108/QMR-11-2021-0135

Inhetveen, K. 2012. Translation challenges: Qualitative interviewing in a multi-lingual field. *Qualitative Sociology Review, 8*, 2, 28-45. doi:10.1007/978-3-663-07909-5

James, J. (2013). Patient engagement. *Health Affairs Health Policy Brief*, *14*(10.1377).

Jordan, J. E., Briggs, A. M., Brand, C. A., & Osborne, R. H. (2008). Enhancing patient engagement in chronic disease self-management support initiatives in Australia: The need for an integrated approach. *The Medical Journal of Australia, 189*(S10), S9–S13. https://doi.org/10.5694/j.1326-5377.2008.tb02202.x

Kambhampati, S., Ashvetiya, T., Stone, N. J., Blumenthal, R. S., & Martin, S. S. (2016). Shared decision-making and patient empowerment in preventive cardiology. *Current Cardiology Reports*, *18*(5), 49. https://doi.org/10.1007/s11886-016-0729-6

Kiełkiewicz-Janowiak, A. (2012). Class, age, and gender-based patterns. In *The handbook of historical sociolinguistics* (pp. 307-331).

Kingori, C., Ice, G. H., Hassan, Q., Elmi, A., & Perko, E. (2018). 'If I went to my mom with that information, I'm dead': Sexual health knowledge barriers among immigrant and refugee Somali young adults in Ohio. *Ethnicity & Health*, *23*(3), 339–352. https://doi.org/10.1080/13557858.2016.1263285

Kirby, E., Lwin, Z., Kenny, K., Broom, A., Birman, H., & Good, P. (2018). "It doesn't exist…": Negotiating palliative care from a culturally and linguistically diverse patient and caregiver perspective. *BMC Palliative Care*, *17*(1), 90. https://doi.org/10.1186/s12904-018-0343-z

Kothari, A., McCutcheon, C., & Graham, I. D. (2017). Defining integrated knowledge translation and moving forward: A response to recent commentaries. *International Journal of Health Policy and Management*, *6*(5), 299–300. https://doi.org/10.15171/ijhpm.2017.15

Kouritzin, S., & Nakagawa, S. (2018). Toward a non-extractive research ethics for transcultural, translingual research: Perspectives from the coloniser and the colonised. *Journal of Multilingual and Multicultural Development*, 39(8), 675–687. https://doi.org/10.1080/01434632.2018.1427755

Krist, A. H., Tong, S. T., Aycock, R. A., & Longo, D. R. (2017). Engaging patients in decision-making and behavior change to promote prevention. *Studies in Health Technology and Informatics*, *240*, 284–302.

Laidsaar-Powell, R. C., Butow, P. N., Bu, S., Charles, C., Gafni, A., Lam, W. W. T., Jansen, J., McCaffery, K. J., Shepherd, H. L., Tattersall, M. H. N., & Juraskova, I. (2013). Physician-patient-companion communication and decision-making: A systematic review of triadic medical consultations. *Patient Education and Counseling*, *91*(1), 3–13. https://doi.org/10.1016/j.pec.2012.11.007

Larson, M. L. (1984). *Meaning-based translation: A guide to cross-language equivalence / Mildred L. Larson.* University Press of America.

Lash, S. (2003). Reflexivity as non-linearity. *Theory, Culture & Society*, *20*(2), 49–57. https://doi.org/10.1177/0263276403020002003

Laurance, J., Henderson, S., Howitt, P. J., Matar, M., Al Kuwari, H., Edgman-Levitan, S., & Darzi, A. (2014). Patient engagement: Four case studies that highlight the potential for improved health outcomes and reduced costs. *Health Affairs (Project Hope), 33*(9), 1627–1634. https://doi.org/10.1377/hlthaff.2014.0375

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Levinson, W., Kao, A., Kuby, A., & Thisted, R. A. (2005). Not all patients want to participate in decision making. A national study of public preferences. *Journal of General Internal Medicine, 20*(6), 531–535. https://doi.org/10.1111/j.1525-1497.2005.04101.x

Liamputtong, P. (2008). Doing research in a cross-cultural context: Methodological and ethical challenges. In P. Liamputtong (Ed.), *Doing cross-cultural research* (Vol. 34, pp. 3–20). Springer Netherlands. https://doi.org/10.1007/978-1-4020-8567-3_1

Lin, S. (Lamson). (2021). Access to health care among racialised immigrants to Canada in later life: A theoretical and empirical synthesis. *Ageing & Society*, *42*(8), 1735–1759. https://doi.org/10.1017/S0144686X20001841

Lofland, J., Snow, D., Anderson, L., & Lofland, L. H. (2006). Analyzing social settings: A guide to qualitative observation and analysis, Fourth Edition. Waveland Press.

Mahbub, T. (2017). Case Study 2. In H. Kidwai, R. Iyengar, M. A. Witenstein, E. J. Byker, & R. Setty (Eds.), *Participatory action research and educational development: South Asian perspectives* (pp. 235–246). Springer International Publishing. https://doi.org/10.1007/978-3-319-48905-6_11

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Markle-Reid, M., Ganann, R., Ploeg, J., Heald-Taylor, G., Kennedy, L., McAiney, C., & Valaitis, R. (2021). Engagement of older adults with multimorbidity as patient research

partners: Lessons from a patient-oriented research program. *Journal of Multimorbidity and Comorbidity, 11*, 2633556521999508. https://doi.org/10.1177/2633556521999508

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, *98*, 224–253. https://doi.org/10.1037/0033-295X.98.2.224

Marmamula, S., Barrenkala, N. R., Challa, R., Kumbham, T. R., Modepalli, S. B., Yellapragada, R., Bhakki, M., Friedman, D. S., & Khanna, R. C. (2020). Falls and visual impairment among elderly residents in "homes for the aged" in India. *Scientific Reports*, *10*(1), 13389. https://doi.org/10.1038/s41598-020-70066-2

Martin, P., Kelly, N., Kahana, B., Kahana, E., Willcox, B. J., Willcox, D. C., & Poon, L. W. (2015). Defining successful aging: A tangible or elusive concept? *The Gerontologist*, *55*(1), 14–25. https://doi.org/10.1093/geront/gnu044

McKenna, L. (2022). Translation of research interviews: Do we have a problem with qualitative rigor? *Nurse Author & Editor*, *32*(1), 1–3. https://doi.org/10.1111/nae2.31

McNeil, H., Elliott, J., Huson, K., Ashbourne, J., Heckman, G., Walker, J., & Stolee, P. (2016). Engaging older adults in healthcare research and planning: A realist synthesis. *Research Involvement and Engagement, 2*(1), 10. https://doi.org/10.1186/s40900-016-0022-2

Menichetti, J., Graffigna, G., & Steinsbekk, A. (2018). What are the contents of patient engagement interventions for older adults? A systematic review of randomized controlled trials. *Patient Education and Counseling, 101*(6), 995–1005. https://doi.org/10.1016/j.pec.2017.12.009

Moore, K. N. (1995). Compliance or collaboration? The meaning for the patient. *Nursing Ethics*, *2*(1), 71–77. https://doi.org/10.1177/096973309500200109

Morse, J. M. (2010). How different is qualitative health research from qualitative research? Do we have a subdiscipline? *Qualitative Health Research*, *20*(11), 1459–1464. https://doi.org/10.1177/1049732310379116

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, 25(9), 1212–1222. https://doi.org/10.1177/1049732315588501

Nguyen, G., Hsu, L., Kue, K. N., Nguyen, T., & Yuen, E. J. (2010). Partnering to collect health services and public health data in hard-to-reach communities: A community-based participatory research approach for collecting community health data. *Progress in Community Health Partnerships: Research, Education, and Action, 4*(2), 115–119. https://doi.org/10.1353/cpr.0.0120

Nolan, M. T., Hughes, M., Narendra, D. P., Sood, J. R., Terry, P. B., Astrow, A. B., Kub, J., Thompson, R. E., & Sulmasy, D. P. (2005). When patients lack capacity: The roles that patients with terminal diagnoses would choose for their physicians and loved ones in making medical decisions. *Journal of Pain and Symptom Management, 30*(4), 342–353. https://doi.org/10.1016/j.jpainsymman.2005.04.010

Nys, T. R. V. (2008). Paternalism in public health care. *Public Health Ethics*, *1*(1), 64–72. https://doi.org/10.1093/phe/phn002

Oishi, S. (2000). Goals as cornerstones of subjective well-being: Linking individuals and cultures. In *Culture and subjective well-being* (pp. 87–112). The MIT Press. https://doi.org/10.1007/978-90-481-2352-0_2

Ong, L. M., de Haes, J. C., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine (1982)*, *40*(7), 903–918. https://doi.org/10.1016/0277-9536(94)00155-m

Ortiz, M. R. (2018). Patient-centered care: Nursing knowledge and policy. *Nursing Science Quarterly, 31*(3), 291–295. https://doi.org/10.1177/0894318418774906

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Patton, M. Q. (2014). Qualitative research and evaluation methods. In *SAGE Publications, Inc*. (4th ed.). Sage.

Park, S., Lee, H., & Kang, M. (2018). Factors affecting health literacy among immigrants—Systematic review. *European Journal of Public Health*, *28*(suppl_4), cky214.283. https://doi.org/10.1093/eurpub/cky214.283

Parker, M., Fang, X., & Bradlyn, A. (2020). Costs and effectiveness of a culturally tailored communication training program to increase cultural competence among multi-disciplinary care management teams. *BMC Health Services Research, 20*(1), 784. https://doi.org/10.1186/s12913-020-05662-z

Pérez-Stable, E. J., Nápoles-Springer, A., & Miramontes, J. M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical Care*, *35*(12), 1212–1219. https://doi.org/10.1097/00005650-199712000-00005

Phillippi, J., & Lauderdale, J. (2018). A guide to field notes for qualitative research. *Context and Conversation. Qualitative Health Research*, 28(3), 381–388. https://doi.org/10.1177/1049732317697102

Pittman, P. M. (1999). Gendered experiences of health care. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*, *11*(5), 397–405. https://doi.org/10.1093/intqhc/11.5.397

Prasad, K., Dwivedi, S. N., Kant, S., Vibha, D., Pandit, A. K., Karthikeyan, G., . Tripathi, M., Srivastava, A.K., Nehra, A., Vivekanandhan, S., Garg, A., Chutani, A.M., Verma, V., Kumar, S., Kumar, A., Gulati, K., Gulati, A., Makharia, G., Seth, T., Dhingra, K., Mandal, P.K., Mishra, N.K., Ikram, K. and Tiemeier, H. (2021). Cohort profile: The LoCARPoN—a population-based prospective cohort study in middle-aged and older adults in India. *International Journal of Epidemiology. 51*, 1, 29-30.

Ramirez, A. G. (2003). Consumer-provider communication research with special populations. *Patient Education and Counseling*, *50*(1), 51–54. https://doi.org/10.1016/s0738-3991(03)00080-6

Rao, V., Warburton, J., & Bartlett, H. (2006). Health and social needs of older Australians from culturally and linguistically diverse backgrounds: Issues and implications. *Australasian Journal on Ageing*, *25*(4), 174–179.

Riemer, H., Shavitt, S., Koo, M., & Markus, H. R. (2014). Preferences don't have to be personal: Expanding attitude theorizing with a cross-cultural perspective. *Psychological Review*, *121*(4), 619–648. https://doi.org/10.1037/a0037666

Rodriguez, K. L., Appelt, C. J., Switzer, G. E., Sonel, A. F., & Arnold, R. M. (2008). Veterans' decision-making preferences and perceived involvement in care for chronic heart failure.

Heart & Lung: The Journal of Critical Care, 37(6), 440–448. https://doi.org/10.1016/j.hrtlng.2008.02.003

Sacks, R. M., Greene, J., Hibbard, J., Overton, V., & Parrotta, C. D. (2017). Does patient activation predict the course of type 2 diabetes? A longitudinal study. *Patient Education and Counseling, 100*(7), 1268–1275. https://doi.org/10.1016/j.pec.2017.01.014

Sadler, G. R., Lee, H.-C., Lim, R. S.-H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing & Health Sciences*, *12*(3), 369–374. https://doi.org/10.1111/j.1442-2018.2010.00541.x

Sagong, H., & Yoon, J. Y. (2021). Pathways among frailty, health literacy, acculturation, and social support of middle-aged and older korean immigrants in the USA. *International Journal of Environmental Research and Public Health*, *18*(3), 1245. https://doi.org/10.3390/ijerph18031245

Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine*, *159*(9), 997–1004. https://doi.org/10.1001/archinte.159.9.997

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275–1285.

Saldaña, J. (2021). *The coding manual for qualitative researchers*. Thousand Oaks: Sage Publications

Sallis, J. F., & Owen, N. (2015). Ecological models of health behavior. In *Health behavior: Theory, research, and practice, 5th ed* (pp. 43–64). Jossey-Bass/Wiley.

Santos, H. P. O., Black, A. M., & Sandelowski, M. (2015). Timing of translation in cross-language qualitative research. *Qualitative Health Research*, *25*(1), 134–144. https://doi.org/10.1177/1049732314549603

Savignon, S. J. (1976). *Communicative competence: Theory and classroom practice.* https://eric.ed.gov/?id=ed135245

Schirato, T., & Webb, J. (2003). *Understanding globalization* (p. 232). https://doi.org/10.4135/9781446216552

Schroeder, J., & Fishbach, A. (2015). The "empty vessel" physician: Physicians' instrumentality makes them seem personally empty. *Social Psychological and Personality Science*, 6(8), (pp. 940–949). https://doi-org.proxy.lib.uwaterloo.ca/[10.1177/1948550615597976](https://doi-org.proxy.lib.uwaterloo.ca/10.1177/1948550615597976)

Schwei, R. J., Del Pozo, S., Agger-Gupta, N., Alvarado-Little, W., Bagchi, A., Chen, A. H., Diamond, L., Gany, F., Wong, D., & Jacobs, E. A. (2016). Changes in research on language barriers in health care since 2003: A cross-sectional review study. *International Journal of Nursing Studies*, *54*, 36–44. https://doi.org/10.1016/j.ijnurstu.2015.03.001

Searight, H. R., & Gafford, J. (2005). Cultural diversity at the end of life: Issues and guidelines for family physicians. *American Family Physician*, *71*(3), 515–522.

Shah, S. L., & Siegel, C. A. (2015). Increasing patient activation could improve outcomes for patients with inflammatory bowel disease. *Inflammatory Bowel Diseases, 21*(12), 2975–2978. https://doi.org/10.1097/MIB.0000000000000575

Shay, L. A., & Lafata, J. E. (2015). Where is the evidence? A systematic review of shared decision making and patient outcomes. *Medical Decision Making, 35*(1), 114–131. https://doi.org/10.1177/0272989X14551638

Sheldon, K. M., Elliot, A. J., Ryan, R. M., Chirkov, V., Kim, Y., Wu, C., Demir, M., & Sun, Z. (2004). Self-concordance and subjective well-being in four cultures. *Journal of Cross-Cultural Psychology*, *35*(2), 209–223. https://doi.org/10.1177/0022022103262245

Siegler, M. (1985). Who should decide? Paternalism in health care, by James F. Childress. *Perspectives in Biology and Medicine*, *28*(3), 452–456. https://doi.org/10.1353/pbm.1985.0033

Søgaard, M. B., Andresen, K., & Kristiansen, M. (2021). Systematic review of patient-engagement interventions: Potentials for enhancing person-centred care for older patients with multimorbidity. *BMJ Open, 11*(12), e048558. https://doi.org/10.1136/bmjopen-2020-048558

Squires, A. (2008). Language barriers and qualitative nursing research: Methodological considerations. *International Nursing Review*, *55*(3), 265–273. https://doi.org/10.1111/j.1466-7657.2008.00652.x

Stewart, M., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Weston, W. W., & Jordan, J. (2000). The impact of patient-centered care on outcomes. *The Journal of Family Practice*, *49*(9), 796–804.

Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *Focus: Journal of Life Long Learning in Psychiatry, 18*(1), 49–51. https://doi.org/10.1176/appi.focus.20190041

Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1995). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, *59*(4), 533–540. https://doi.org/10.1037//0022-006x.59.4.533

Sulmasy, D. P., Hughes, M. T., Thompson, R. E., Astrow, A. B., Terry, P. B., Kub, J., & Nolan, M. T. (2007). How would terminally ill patients have others make decisions for them in the event of decisional incapacity? A longitudinal study. *Journal of the American Geriatrics Society, 55*(12), 1981–1988. https://doi.org/10.1111/j.1532-5415.2007.01473.x

Thind, A., Hoq, L., Diamant, A., & Maly, R. C. (2010). Satisfaction with care among low-income women with breast cancer. *Journal of Women's Health*, *19*(1), 77–86. https://doi.org/10.1089/jwh.2009.1410

Tong, C. E., McKay, H. A., Martin-Matthews, A., Mahmood, A., & Sims-Gould, J. (2020). "These few blocks, these are my village": The physical activity and mobility of foreign-born older adults. *The Gerontologist*, *60*(4), 638–650. https://doi.org/10.1093/geront/gnz005

Triandis, H. C. (1995). *Individualism & collectivism* (pp. xv, 259). Westview Press.

Vahdat, S., Hamzehgardeshi, L., Hessam, S., & Hamzehgardeshi, Z. (2014). Patient involvement in health care decision making: A review. *Iranian Red Crescent Medical Journal, 16*(1), e12454. https://doi.org/10.5812/ircmj.12454

Vela, M. B., Erondu, A. I., Smith, N. A., Peek, M. E., Woodruff, J. N., & Chin, M. H. (2022). Eliminating explicit and implicit biases in health care: Evidence and research needs. *Annual Review of Public Health, 43*, 477–501. https://doi.org/10.1146/annurev-publhealth-052620-103528

Venkatesh, B. T., Andrews, T., Mayya, S. S., Singh, M. M., & Parsekar, S. S. (2015). Perception of stigma toward mental illness in South India. *Journal of Family Medicine and Primary Care*, *4*(3), 449–453. https://doi.org/10.4103/2249-4863.161352

Verhoeven, L. (2017). Sociolinguistics and education. In *The handbook of sociolinguistics* (pp. 387–404). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781405166256.ch24

Voltaire, F. (1746). *Philosophical Dictionary*. Penguin UK.

von Fragstein, M., Silverman, J., Cushing, A., Quilligan, S., Salisbury, H., Wiskin, C., & UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education. (2008). UK consensus statement on the content of communication curricula in undergraduate medical education. *Medical Education, 42*(11), 1100–1107. https://doi.org/10.1111/j.1365-2923.2008.03137.x

Weingart, S. N., Zhu, J., Chiappetta, L., Stuver, S. O., Schneider, E. C., Epstein, A. M., David-Kasdan, J. A., Annas, C. L., Fowler, F. J., & Weissman, J. S. (2011). Hospitalized patients' participation and its impact on quality of care and patient safety. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*, *23*(3), 269–277. https://doi.org/10.1093/intqhc/mzr002

Wodak, R., & Benke, G. (2017). Gender as a sociolinguistic variable: New perspectives on variation studies. In *The Handbook of Sociolinguistics* (pp. 127–150). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781405166256.ch8

Wolff, J. L., Clayman, M. L., Rabins, P., Cook, M. A., & Roter, D. L. (2015). An exploration of patient and family engagement in routine primary care visits. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *18*(2), 188–198. https://doi.org/10.1111/hex.12019

World Health Organization. (2021). *Global report on ageism: Executive summary*. https://apps.who.int/iris/handle/10665/340205

Yates, G. (1969). Rehabilitation and the general practitioner. *The Journal of the Royal College of General Practitioners*, *17*(82), 292–298.

Zghal, A., El-Masri, M., McMurphy, S., & Pfaff, K. (2021). Exploring the impact of health care provider cultural competence on new immigrant health-related quality of life: A cross-sectional study of Canadian newcomers. *Journal of Transcultural Nursing, 32*(5), 508–517. https://doi.org/10.1177/1043659620967441

Zhang, Y., Su, H., Shang, L., Li, D., Wang, R., Zhang, R., & Xu, Y. (2011). Preferences and perceived involvement in treatment decision making among Chinese patients with chronic hepatitis. *Medical Decision Making: An International Journal of the Society for Medical Decision Making, 31*(2), 245–253. https://doi.org/10.1177/0272989X10375990

Chapter 4

"When in Rome…": Structural determinants impacting healthcare access, health outcomes, and well-being of South Asian Older Adults in Ontario

Key words: healthcare system, structural determinants, access to care, cultural competence, virtual care, white normativity

Abstract

With the increase in international migration, the need for an equitable healthcare system is increasing. The current biomedical model of healthcare is constructed largely in the Eurocentric tradition of medicine, which often disregards the diverse health perspectives of Canada's racialized immigrant older adults. As a result, current healthcare approaches (adopted in the US and Canada) fall short in addressing the health needs of a considerable segment of the population, impeding their ability to access healthcare services. This study sought to identify and understand the structural determinants and systemic factors influencing the healthcare experiences and well-being of South Asian older adults in Canada. We conducted in-depth individual and dyadic interviews (n=28) utilizing a descriptive multilingual cross-cultural qualitative approach. Through this research, participants expressed that their understanding of well-being does not align with that of their healthcare providers, resulting in unmet health needs. Our study uses an intersectional lens to demonstrate participants' perceptions of virtual accessibility and systemic factors, such as mandatory assimilation and whiteness as a taken-for-granted norm impacting the health and well-being of South Asian older adults. The findings of this research can offer valuable insights to healthcare providers and policymakers in developing culturally competent practices, guidelines, and training policies that effectively address the healthcare needs of the South Asian population in Canada.

4.1 Introduction

There has been considerable research and policy attention related to the needs of the aging population, but older adults still face significant obstacles when it comes to accessing services, which remains a prominent challenge for this subgroup (Fitzpatrick et al., 2004). The presence of ethnocultural diversity among the older adult population further complicates the situation in terms of both access and equity (Westwood, 2017). Historically, Canada and other Global North nations have been structured in a manner that primarily benefits the majority of the population (Lai & Chau, 2007). However, it is also important to acknowledge that people identifying as white receive more attentive treatment over racialized individuals, since the entire system has been constructed with a bias towards prioritizing the needs and interests of people with the greatest proximity to whiteness (Campbell & Lawford, 2021; Grenier, 2020; Pitts, 2015; Todic et al., 2022). Consequently, it is unsurprising that individuals who are less proximal to whiteness encounter additional challenges in having their healthcare needs met (Dupuis-Blanchard et al., 2014). Some communities of older adults are currently grappling with fundamental issues, such as access to care, that are essential for their overall welfare (Lai & Chau, 2007). In particular, migrants from diverse cultural backgrounds who are racialized are especially vulnerable. Being an older adult has disadvantages in a youth-oriented society, and these disadvantages may be exacerbated for older adults who are also members of a racialized ethnocultural group, putting their well-being at greater risk (Dowd & Bengston, 1978; Kang & Kim, 2022; Lai & Chau, 2007). Racialized immigrant older adults may face a higher likelihood of receiving inadequate support from health professionals within their new home nation (Dilworth-Anderson et al., 2012; Jimenez et al., 2022; Lin, 2022; Lum & Vanderaa, 2010). This lack of support appears to stem from their encounters with barriers to care, exposure to

discrimination, and unequitable treatment within the Canadian healthcare system (Lin et al., 2023; Sadavoy et al., 2004; Tuyisenge & Goldenberg, 2021).

4.2 Background

In the sections below we articulate access to care, the need for an intersectional lens, the intersection of white supremacy, capitalism, and patriarchy, the need for anti-racist perspectives, and cultural competence and humility as they relate to the health care experiences of racialized immigrant older adults in Canada.

4.2.1 Defining access to care

The effectiveness of healthcare systems around the world depends largely, but not solely, on access to care (Penchansky & Thomas, 1981; Shengalia et al., 2005). In the last century, there have been significant variations in the definitions and interpretations of healthcare access (Frenk, 1985; Gulliford et al., 2002; Mooney, 1983; Penchansky & Thomas, 1981; Romanelli & Hudson, 2017). Different authors' interpretations of *access to care* demonstrate the complexity of the concept (Daniels, 1982; Haddad & Mohindra, 2002; Richard et al., 2016), though, access in the context of health care is generally characterised by the ability or simplicity with which consumers or communities are able to use relevant services in proportion to their needs (Daniels, 1982; Levesque et al., 2013; Whitehead, 1992). Opinions regarding the components of care access vary and it is generally undecided whether the emphasis should be on describing provider characteristics or the actual process of care, despite that the term "access" is frequently used to describe factors or characteristics influencing the first point of contact with services or the use of services (Andersen, 1995; Frenk, 1992; Jackson et al., 2002). Salkever (1976) considers access to be more of a characteristic of health services, pointing out that individuals in need of medical

attention may use or access them. Others place more emphasis on health care resource characteristics that affect the use of services, acting as a facilitator between the capacity to produce services and their consumption (Donabedian & Fund, 1973; Levesque et al., 2011).

Penchansky & Thomas (1981) were among those who defined care access in terms of the compatibility of client expectations and client attributes with provider characteristics and health services. In this context, access may be perceived as the point of contact between potential patients and healthcare resources, and it would be impacted by both the qualities of people who provide the services and those who utilize them (Penchansky & Thomas, 1981). According to Mooney (1983), access depends on both supply and demand. Based on this perspective, the location, cost, appropriateness, and availability of services and burden of disease are products of supply variables. On the other hand, Frenk (1992) provides a theoretically appealing way to view access which is to think of it as the degree of adaptation between the population's characteristics and those of the healthcare resources. This perspective sees access as a functional relationship between the public, healthcare facilities, and resources that reflects the existence of either barriers or facilitators for the recipients of healthcare (Frenk, 1992). Following a thorough analysis of the terms used to describe health care access, Levesque et al., (2013) proposed defining access as a set of opportunities to "identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use health care services, and to actually be offered services appropriate to the needs for care" (p. 4). This is the definition adopted for the study at hand.

4.2.2 Intersectionality

The intersectionality movement emphasises the significance of looking at the various, interconnected systems of dominance that influence and shape people's lives through the interaction of differentiating categories, such as race, sex, and age, within larger systems of oppression (Brotman et al., 2015; Collins, 1990; Crenshaw, 1989; Crenshaw, 1991; Sokoloff & Dupont, 2005). Intersectionality, coined by Crenshaw (1989), was borne of a statement by a Black feminist lesbian organization that criticized the widespread exclusion of Black women from the anti-racist, white feminist movements of the time (Combahee River Collective, 1983; Crenshaw 1989; Mehrotra, 2010). The idea that social categories are organised through systems of dominance, which are the historically rooted structures of racism, patriarchy, and capitalism, which all stem from colonization, is at the heart of this literature (Ferrer et al., 2017). Thus, intersectionality scholars assert that every process of differentiation and system of dominance is interconnected; where oppressive and dominating structures could not exist or function without racial and gender inequality, economic exploitation, sexism, heterosexism, and other forms of discrimination (Collins, 1990). Intersectional analyses facilitate the comprehension of the ways individuals become subject to processes of differentiation in diverse ways, and how systems of dominance both reflect and depend on these processes (Ferrer et al., 2017). The intersections of identities are present at the micro, meso, and macro-levels, both in the context of how people engage with others interpersonally in various socio-cultural contexts and at the societal-level where rules and regulations are established and reproduced by social structures and institutions (Koehn et al., 2013).

Since numerous controversies continue to be discussed by scholars about intersectionality and its various uses, it would be difficult to engage and respond to an in-depth discussion of the multiple critiques of intersectionality within this paper. It is not obvious whether intersectionality

should be kept to the study of individual experiences and identity theory, or whether it should be viewed as a characteristic of social structures and cultural discourses (Alvi & Zaidi, 2017; Davis, 2008). Despite ongoing debates about the intent of intersectional analysis as a theoretical and empirical tool, the experiences of marginalised and vulnerable people can be more broadly theorized and considered with more nuance through an intersectional lens, which takes into account an individual's many identities, as well as the various social structures of power, control, and inequity in their social environment (Alvi & Zaidi, 2017; Dill & Zambrana, 2009). Multiple oppressions are not assumed to add up (i.e., be additive) in intersectional analysis (Alvi & Zaidi, 2017). Because they interact with one another, they are multiplicative rather than merely adding to the total number of oppressive factors (Alvi & Zaidi, 2017; Severs et al., 2016). McCall (2005) further adds to this notion by stating that intersectionality is not an additive-linear model, but rather reflects multiple/triple jeopardy. Therefore, what may at first appear to be a series of inconsequential microaggressions that make race more salient, in reality, may involve an accumulation of interrelated multiple jeopardies (Hancock, 2007).

A scoping review informed by an intersectional approach report that the impacts of social inequities are felt by people as simultaneous interactions between many identity markers that are embedded within larger systems of power, dominance, and oppression (Hankivsky 2011; Koehn et al., 2013; Schulz & Mullings, 2006). Each individual's intersecting identities, social positions, and the larger social and political contexts in which they exist are specifically relevant to the experience of discrimination and access to power and resources/privileges such as positive health-care experiences (Dhamoon & Hankivsky, 2011; Guruge & Khanlou, 2004). Moreover, the essential premise of intersectionality is the recognition that individual's experiences differ noticeably from others because of the multiplicity and variety of social location, identity, and

many forms of inequality they encounter (Alvi & Zaidi, 2017). It highlights the fact that there are political and social repercussions to the categories of differences of age, gender, and race and that they are mutable (Alvi & Zaidi, 2017). For instance, given the variety of experiences and identities that go under the umbrella term "South Asian," it is incorrect to assume that just because women are members of a homogeneous racialized group such as South Asians, their experiences will be the same (Alvi & Zaidi, 2017; Davis, 2008). In light of this, intersectional theory highlights what is overlooked when a certain identity is essentialized as the defining quality of a group (by highlighting, for instance, race), and the other internal identities, such as gender, age, or citizenship/legal status, are excluded (Davis, 2008; Hankivsky et al., 2014).

4.2.3 The intersectional oppression of the big three: white supremacy, patriarchy, and capitalism

Sociologist Mary Romero highlighted a significant divide between immigration research and the sociology of race in her article published in Contemporary Justice Review in 2008, expressing that there exists a substantial ideological and theoretical gap between these two fields (Romero, 2017). Since then, numerous publications have worked towards bridging this divide by integrating race analysis and shifting away from assimilationist frameworks. For instance, Sanchez and Romero (2010) emphasize the significance of race in shedding light on issues of illegality and racialized citizenship. Sáenz and Douglas (2015) demonstrate how assimilationist frameworks may mask the impact of racial antagonism towards immigrants. Treitler (2015) further elucidates how assimilationist viewpoints reinforce that white supremacy places the burden of “integration”/adopting dominant culture on racialized immigrants while needing to overcome or disregarding racial barriers. Recognizing the interconnectedness of various systems of inequality such as patriarchy, capitalism, and white supremacy is crucial (Delgado & Stefancic, 2023; Yosso & Solorzano, 2005). Patriarchy, white supremacy, and global capitalism

are interconnected systems of oppression that significantly influence migration patterns and the process of immigrant integration. Patriarchy refers to a social structure where men occupy positions of power and authority in various realms such as the family, community, government, and society at large (Akgul, 2017; Hunnicutt, 2009). White supremacy entails the dominance and control exerted by white individuals or groups (Mills, 2014). Global capitalism aims to maximize profits for capitalists by exploiting workers, which is an inherent aspect of the capitalist system (DiCristina, 2015). By employing an intersectionality framework, we emphasize the simultaneous influence of these oppressive systems on the lives of racialized immigrants (Crenshaw, 1991; Golash-Boza et al., 2019; Hooks, 2000; McCall, 2005; Romero, 2017; Weber, 1998).

4.2.4 The need for anti-colonial and anti-racist perspectives in examining and reframing healthcare

Although the history of the start of colonization dates farther back, the early 19th century's newly conceived theories of evolution gave way to the white supremacy that exists today (Grenier, 2020). European biomedical systems operated under the believe that white populations were the "evolutionarily-selected beings" while non-white races were the "non-evolved, lack of the human" (Wynter, 1994, p. 47). One of the ways in which oppression and mistreatment of the "other, lesser/non-human" was rationalized by this belief and white superiority was assumed and reinforced by legal, healthcare, and education systems (Grenier, 2020). Despite modern science rejecting the idea of a single classification system for assigning race, the social and political significance of race and racialisation remains an important consideration (Brah, 1992; Fenton, 1999; Miles, 1989). In other words, "race may not be real, but racism is" (Culley, 2006, p. 3). For instance, after the Railway construction in Canada,

Chinese immigrants were categorised as one of the lesser "non-white" races compared to white individuals (Grenier, 2020; Wynter, 1994). Furthermore, in Canada, the genocide of Indigenous peoples and exploitation of people of African descent are rooted in structural racism from its colonial past (Cooper, 2007; Dei, 2012; Hamed et al., 2022).

Since contemporary inequities of racial discrimination are related to historic global colonization, an anti-colonial perspective can aid in challenging the racism rooted in colonialism (Benn-John, 2019; Dei, 2000; Pon et al., 2011). An anti-colonial perspective is concerned with resistance against imperial and colonial ideologies/practices, while upholding equality and justice to re-establish Indigenous forms of knowledge and culture that reflects and centres around the global majority (Carlson, 2017; Pon et al., 2011). Complementary to this, an anti-oppressive perspective works to address systems of domination that "denies individuals dignity, human rights, social resources and power'' (Dominelli, 2008, p. 10). Similarly, an anti-racist perspective involves examining the power imbalances between racialized and non-racialized persons and addressing racism within other "interlocking systems of oppression" (Corneau & Stergiopoulos, 2012; Dei & Calliste, 2000, p. 11). While frameworks of anti-racism and anti-oppression share overlapping conceptual and theoretical features, the difference lies in the fact that the latter does not predetermine a particular category of oppression, whereas the former analyzes privilege, power, and oppression through the lens of race (Dei, 2000; Dei, 2012; Dei & Asgharzadeh, 2001; Larson, 2008). Employing anti-racism and anti-colonial frameworks on hegemonic approaches to healthcare can provide strategies to challenge institutional power dynamics, interrupt production of social inequities within medicine of the Global North and enable a deeper understanding on how racism and colonialism, even still, shapes and structures the Canadian healthcare system (Benn-John, 2019; Gahayr, 2011).

4.2.5 Cultural competence & cultural humility

Cultural competence is increasingly recognized as a framework to improve health outcomes and satisfaction with care for racialized and ethnoculturally diverse populations produced by migration (Blunt, 2007; Brottman et al., 2020; Mullings & Gien, 2013; Taylor & Lurie, 2004; Kirmayer, 2012). Cross and colleagues (1989) provide a commonly used definition of cultural competence that entails allowing systems/individuals to operate effectively and respond respectfully in cross-cultural contexts (Lum, 2011). While cultural competence is widely incorporated into organizational guidelines and policy mandates, it has faced sharp criticisms (Fisher-Borne et al., 2015; Furlong & Wight, 2011; Gopalkrishnan, 2018). It is criticized for being tokenistic, for the assumption that healthcare providers come from a dominant culture, for discounting power analysis, for regarding culture as static, and finally, for approaching culture from a value-neutral position, disregarding the oppression experienced by cultural groups (Bin-Sallik, 2003; Chen, 2015; Furlong & Wight, 2011; Garran & Rozas, 2013; Gopalkrishnan, 2018; Herring et al., 2013; Pon, 2009; Sakamoto, 2007). Another key critique of this concept is the "competence" approach, which relies on the capabilities of the care-provider to have a priori knowledge on ethnocultural differences, neglecting participation of the care-recipients (Danso, 2018; Gopalkrishnan, 2018; Johnson & Munch, 2009). This approach is criticized because achieving competence at another's culture is virtually impossible owing to the fluidity and multidimensionality of cultures (Johnson & Munch, 2009; Saunders et al., 2015).

Given the critiques of cultural competency, scholars have suggested replacing cultural competence with cultural humility (Abell et al., 2015; Duntley-Matos, 2014; Kools et al., 2015; Yeager & Bauer-Wu, 2013). Cultural humility entails addressing power imbalances between physician and patient, by committing to self-reflection and critiquing internal biases to develop

mutually constructive, non-paternalistic relationships (Chavez, 2018; Danso, 2018). Cultural humility expands the traditional considerations of ethnicity and race to include the multidimensionality of cultures of individuals from diverse backgrounds (Chavez, 2018). By taking cultural fluidity into account, cultural humility is attentive to the mutability of other social-identity indicators, such as sexual orientation and gender (Tervalon & Murray-Garcia, 1998). While a key strength of cultural humility is that it does not necessitate providers to be experts on cultural knowledge of care-recipients, several scholars argue that cultural humility lacks conceptual clarity and a concrete definition (Danso, 2018; Fisher-Borne et al., 2015; Foronda et al., 2016; Hook et al., 2013). Another fundamental critique of cultural humility is the assumption that being culturally humble equates to having respect for diversity (Hester, 2012; Johnson & Munch, 2009; Kools et al., 2015; Tervalon & Murray-Garcia, 1998). Because the term "humility" lacks definitional unanimity, it would be difficult for a provider to know if they were culturally humble (Danso, 2018).

While most of the literature dichotomizes cultural competence and cultural humility, it can be argued that both constructs can be used complementarily by offsetting mutual deficits and enhancing mutual strengths. Both cultural competence and humility emerged as a response to the ethnocultural diversity in nations of the global majority and the need for implementing an anti-colonial and anti-racism framework in healthcare contexts (Furness, 2005; Kirmayer, 2012). Therefore, instead of directing attention to the differences between the two, a better approach proposed in the literature is finding mutuality, recognizing why the constructs emerged in the first place, and focusing on attaining outcomes (i.e., addressing inequities and issues of diversity) that one cannot achieve without the other (Mullings & Gien, 2013; Saunders et al., 2015). In alignment with cultural humility practices, providers need to embrace culture as fluid and

complex, avoid essentializing care-recipients, and approach patients from a “not-knowing” position to equalize the power dynamics at play (Danso, 2018; Saunders et al., 2015). Additionally, in accordance with cultural competence, providers must recognise and overcome cultural prejudices and forge relationships that transcend cultural barriers (Danso, 2015; Furlong & Wight, 2011; Ridley et al., 2001).

Patient perspectives on the quality of healthcare delivery, which historically were led by healthcare professionals and policy officials, are increasingly acknowledged as being important (Epner, 2012). As a result, in the past few decades, person-centered care, which emphasises seeing older adults as participants in receiving, planning, and monitoring care, has garnered much attention (Howard et al., 2018). Patients' involvement and centrality in their care are increasingly understood to be essential for promoting high-quality healthcare (Kaehne, 2018). Person-centered care deserves significant consideration in the treatment of foreign-born older adults since older adults from ethnoculturally diverse origins are often erroneously classed as a homogenous group despite the stark sociocultural distinctions that exist among them (George & Selimos, 2019). A person-centered care approach mandates care providers adapt care delivery to the participants' unique sociocultural backgrounds, moving away from a "one-size-fits-all" paradigm (Chowdhury et al., 2022; Kaehne, 2018). Therefore, providing person-centered care is crucial for ensuring cultural competence in healthcare settings (Chowdhury et al., 2022).

4.2.6 The present study

Despite being one of the largest and most rapidly growing racialized communities in Canada, the health needs and experiences of South Asians have not received extensive research focus (Veenstra & Patterson, 2016). Various studies have indicated that South Asian individuals born in Canada tend to encounter worse health outcomes when compared to their Canadian-born

counterparts (Anand et al., 2000; Chiu et al., 2010; De Maio, 2010; Gupta et al., 2002; Kim et al., 2013; Liu et al., 2010; Omariba, 2015; Veenstra, 2009; Vissandjee et al., 2004). The data on South Asian older adults in Canada is limited, with a focus on areas such as mental health, specific chronic diseases, and some socioeconomic factors (e.g., Guruge et al., 2015; Koehn et al., 2013; Wang et al., 2021). Consequently, there is a noticeable gap in both empirical and theoretical knowledge concerning the health and well-being of South Asian older adults in the Canadian context, particularly regarding the structural determinants that influence their health and well-being at the individual level. The purpose of our study was to identify and understand the structural determinants and systemic factors influencing the healthcare experiences and well-being of South Asian older adults in Canada. While the study initially set out to understand individual-level experiences, participants largely pointed towards structural and systemic issues which, both directly and indirectly, impacted their healthcare experiences and overall well-being. The study also provides recommendations in alignment with a solutions-oriented perspective to facilitate culturally competent care delivery, aiming to foster positive health outcomes.

4.3 Methods

The present study and analysis form a component of a broader qualitative inquiry which sought to understand the involvement or lack thereof of racialized immigrant older adults in their own healthcare (Tong et al., 2022). To understand the perspectives of and experiences with the healthcare system among South Asian older adults residing in Canada, who were born in foreign countries, we conducted 28 in-depth qualitative interviews. These interviews were conducted in six different South Asian languages, utilizing a descriptive qualitative approach that was both multilingual and cross-cultural (Liamputtong, 2010). The chosen methodology for this study is qualitative description (Kim et al., 2017). This study was carried out in the Southern region of

Ontario, Canada, which is a significant hub for immigration and home to diverse communities. We acknowledge that the term "South Asian" may oversimplify and overlook the lived experiences and individual identities of people within this group. Therefore, instead of relying solely on country of origin, we recruited participants based on the languages they spoke. By adopting this approach, we aimed to identify cultural groups connected through language, rather than being limited by arbitrarily defined borders imposed during colonization. It is important to note that while the selected languages represented the most commonly spoken languages in South Asia, this methodology allowed us to better reflect shared cultural experiences.

4.3.1 Study, setting, and context

South Asians constitute 25% of the racialized population in Canada and make up 5.6% of the overall population (Statistics Canada, 2021). Toronto, the capital of Ontario, and its surrounding region, known as the Greater Toronto Area, is home to significant concentrations of South Asian immigrants, with a substantial number coming from countries such as India, Pakistan, Bangladesh, and Sri Lanka (Islam et al., 2017). The majority of individuals of South Asian origin in these areas are foreign-born (68%), while the remaining 32% were born in Canada (Statistics Canada, 2021).

4.3.2 Sample, eligibility, and recruitment

Participants in the study were older adults (aged 60 years and above) of South Asian descent, presently living in Southern Ontario. They were required to be capable of giving informed consent and conducting the interviews in one of the following languages: Hindi, Punjabi, Tamil, Urdu, Bangla, or English. Since we focused on an immigrant population, we utilized the World Health Organization's age cut-off of 60 for defining older adults, which aligns

with how the term "older adult" has been utilized in previous studies involving individuals from South Asia (Prasad et al., 2021; World Health Organization, 2021). Participants were recruited from various South Asian community organizations using a combination of methods such as email and community referrals. Initially, some of the participants who had already joined the study voluntarily helped with snowball sampling, following the approach outlined by Sadler et al., (2010). They shared our recruitment materials with their friends and family who also met the criteria for participation. In preparation for the interviews, consent forms were distributed in advance through email. Further information can be found in the protocol paper by Tong et al., (2022) that outlines the methods the larger study in detail.

4.4 Data collection and Analysis

This study received ethics clearance from the University of Waterloo Office of Research Ethics (ORE#43297). Data collection took place September 2020 to December 2021.

4.4.1 Qualitative interviews

Data for this study were collected during the on-going COVID-19 pandemic in Canada. Due to the prevailing circumstances and restrictions imposed on in-person interactions, all interviews were conducted remotely via video calls, providing flexibility for participants to choose a convenient time. A total of 28 South Asian older adults participated in the study; information regarding participants' demographics can be found in Table 4-1. The determination of the sample size was guided by the concept of information power proposed by Malterud and colleagues (2016), considering the richness of the obtained data and the availability of relevant theories within the existing literature. Among the participants, twelve requested dyad interviews, and sixteen completed individual one-on-one interviews. Although the same interview guide was

used for both interview types, the wording of the questions was adjusted accordingly. The dyad interviews were intentionally extended to ensure the inclusion of all the questions asked to each participant. To protect participant anonymity, pseudonyms were assigned during the analysis, and Table 4-2 provides links between the pseudonyms and demographic information, interview language, and interview type.

A semi-structured interview guide was utilized to explore participants' experiences with and perspectives of the healthcare system. Sample interview questions can be found in Table 4-3. The interviews had an average duration of 84 minutes, ranging from 32 minutes to 120 minutes. All interviews were recorded digitally and transcribed professionally. As a token of appreciation for their time, interview participants received an honorarium in the form of a $20 CAD gift card.

The challenges associated with interpreting and translating qualitative data have been acknowledged by qualitative researchers (Inhetveen, 2012). It is important to note that translating qualitative data goes beyond linguistic conversion and involves incorporating the cultural context in which the data were collected (Chen & Boore, 2010). Given the anticipated complexity and multilingual nature of our data collection, we employed the written translation approach outlined by Inhetveen (2012) to translate the interviews into English and generate English-language transcripts for analysis. This approach, performed shortly after the interviews, ensured a comprehensive translation that captured all details and aimed to achieve a lexical equivalence with the original phrasing (Inhetveen, 2012). Following the guidelines proposed by McKenna (2022), we also adopted a forward translation method, whereby the original source language was translated into the language used for analysis and reporting. Consequently, all transcripts were translated into English, allowing for comprehensive analysis of the dataset (McKenna, 2022).

4.4.2 Theoretical framework: Multilevel Eco-social Framework

The "socio-ecological model" was developed in the late 1970s to acknowledge the extensive array of social influences and nested environmental interactions affecting individuals (Bronfenbrenner, 1979). This model is built upon various levels of environmental impacts, with the individual and their unique characteristics at its core (Bronfenbrenner, 1979, 1994). The first level of influence, known as microsystems, includes factors such as family, spiritual systems, and healthcare systems (Bronfenbrenner, 1979). The interactions and dynamics between two or more microsystems constitute the second level of influence, referred to as mesosystems (e.g., family and health clinic interactions) (Bronfenbrenner, 1994). Moving up, the next level of influence is exo-systems, encompassing larger social systems comprising two or more settings and both direct and indirect influences (e.g., caregiver leave eligibility) (Bronfenbrenner, 1994). Finally, the topmost level, called macrosystems, involves broad cultural and subcultural characteristics that exert an impact on all the other layers (e.g., attitudes and belief systems of the larger culture) (Bronfenbrenner, 1979, 1994).

The multilevel eco-social framework (see Lin, 2021, p. 10) builds upon the socio-ecological model and delves into the intricate relationship between racialized older immigrants and their access to healthcare. This framework views healthcare access as a complex social process, influenced by a combination of individual and contextual factors that interplay between the health needs of older immigrants and healthcare providers (Lin, 2022). Bronfenbrenner's ecological theory also contributes to this understanding by proposing that seeking healthcare among racialized immigrants involves a person-environment interaction across various overlapping systems, leading to an ecological transition in healthcare (Bronfenbrenner, 1979).

4.4.3 Qualitative analysis and strategies for rigor

The transcripts underwent a series of preparatory steps, including cleaning, anonymization, and uploading into NVivo 12 along with field notes and meeting notes, for analysis. Braun and Clarke's (2006) thematic analysis approach was selected as the analytical method for examining the data in this research. In addition to the theoretical flexibility that Braun and Clarke's (2006) thematic analysis offers, while preserving data complexity, this approach also emphasizes the active involvement of the researcher in knowledge production. Our coding process followed an iterative approach, involving the proposal of initial codes and the subsequent addition of new codes as required. Concepts from Lin's (2022) multilevel eco-social framework guided the initial coding structure. This iterative process was carried out through a line-by-line analysis of the data, led by the first author DC. A detailed account of the iterative coding strategy can be found in Table 4-4. To ensure rigor in our analysis, we engaged in reflexive memoing during the coding process (Birks et al., 2008), holding regular team meetings throughout the data collection and analysis phases (Guest et al., 2012), and conducting team-based analysis involving members from different disciplines and ethnocultural backgrounds.

Table 4 - 1

Participant Demographics

Interview Sample (n=28)	
Age	Mean: 74 (min: 60, max: 88)
Gender	
Men	13
Women	15

Country of Origin	
India	11
Bangladesh	6
Sri Lanka	7
Pakistan	4
Years in Canada	Mean: 34 (min: 10, max: 62)
Education	
Secondary	3
Undergraduate	14
Graduate	11
Marital Status	
Married	25
Widowed	1
Divorced	2
Lives with	
Spouse	8
Spouse & children	14
Spouse, children, & grandchildren	3
Alone	3
Has family doctor	
Yes	26
No	2
English Proficiency (self-reported)	
Reading	
Poor	1
Well	2
Very well	25
Writing	
Poor	0
Well	2
Very well	26
Speaking	
Poor	2
Well	0
Very well	26

Table 4 - 2

Interview Participant Pseudonyms and Demographic Information

Pseudonym	Age	Gender	Country of Origin	Religion/Faith System	Length of time in Canada (Years)	Type of Interview Conducted	Language interview conducted in
Ashish	88	Male	Bangladesh	Hinduism	29	Individual	English
Rajib	74	Male	Bangladesh	Hinduism	12	Dyad	Bengali
Aarini	62	Female	Bangladesh	Hinduism	15	Dyad	Bengali
Prisha	63	Female	India	Hinduism	51	Individual	Hindi
Shivanya	76	Female	India	Hinduism	51	Individual	Tamil
Shankar	86	Male	India	Hinduism	52	Individual	English
Zarina	60	Female	Pakistan	Islam	17	Individual	Urdu
Irfaan	68	Male	Pakistan	Islam	21	Dyad	Urdu
Aaron	75	Male	India	Christian	57	Dyad	English
Aileen	68	Female	India	Christian	52	Dyad	English
Prithvish	71	Male	India	Hinduism	45	Individual	Tamil
Shastik	77	Male	Sri Lanka	Hinduism	26	Dyad	Tamil
Gayatri	78	Female	Sri Lanka	Hinduism	31	Dyad	Tamil
Sharvaa	73	Female	Sri Lanka	Hinduism	25	Dyad	Tamil
Abhijeet	75	Male	Sri Lanka	Hinduism	45	Dyad	Hindi
Tarala	78	Female	Sri Lanka	Hinduism	28	Individual	English
Sarath	82	Male	Sri Lanka	Hinduism	28	Dyad	English
Srijit	75	Male	Bangladesh	Hinduism	48	Individual	Bengali
Amit	86	Male	India	Hinduism	53	Individual	English
Shalini	67	Female	Sri Lanka	Hinduism	42	Dyad	Hindi
Jamal	60	Male	Pakistan	Islam	16	Dyad	Urdu
Beena	73	Female	India	Hinduism	34	Individual	English
Ananya	61	Female	India	Hinduism	32	Individual	Hindi
Janaia	64	Female	India	Hinduism	10	Individual	English
Sharad	87	Male	India	Hinduism	62	Individual	English
Shujata	77	Female	Bangladesh	Hinduism	34	Individual	Bengali
Malini	83	Female	India	Hinduism	10	Individual	Punjabi
Ravi	72	Male	India	Hinduism	45	Individual	Hindi

Table 4 - 3

Sample Interview Questions

Primary Questions	Probe
Have you ever disagreed with your healthcare provider and/or their decisions regarding your health?	If so, could you tell me how you dealt with that?
When you want to know more about your health, where do you go for information?	Family, internet, news, social media, talking with friends, relatives overseas, etc.
What role do family members play in your health care?	Do they join you for appointments? Drive you to appointments? Do they help with translation? Do they get medications for you? Prepare special meals? What does this support mean to you?
What would you like health care providers to know/understand about your culture?	How does that impact your health?

Table 4 - 4

A priori & Emergent, Evolving Coding Structure

Initial Codes from the Multi-level Eco-social Framework	Codes added during further reading of transcripts	Codes less salient, either removed or collapsed; not highlighted in the results	Final, high-level clustering of themes and sub-themes, as presented in the results
			
Exo-system: Labour & capital adequacy Language services Sensitivity	Virtual care Healthcare equity	Appointment system Navigation Impacts of covid-19	**Access to Care** • The importance of language services

Professional values			• Virtual care and its role in enabling or hindering access
Macro-system: Healthcare policy Immigration policy Societal values and ideology Oppression and discrimination Stigma	Cultural Humility and competence Holistic vs biomedical model of healthcare White supremacy	Long term care services	**Cultural Humility and Competence** • Culture competence for mental health needs • Holistic versus the biomedical model of care • Making space for "other" ways of being, healing, and care
	Need to fit into the system		**Negotiating Candidacy** • The need to be a "good" citizen • Eurocentrism and "whiteness" as a standard

4.5 Results

Through the analysis we identified three themes and respective sub-themes pertaining to structural determinants and systemic factors influencing the healthcare experiences and well-being of South Asian older adults in Canada, summarized in Table 4-5. The first theme of access to care highlighted the need for language services to be embedded within the healthcare system to cater to racialized immigrant older adults that have language barriers. The results also demonstrate how virtual care both enable and hindered access to care. The second theme underscored the importance of culturally competent and humble care delivery, while also highlighting the challenges that arise with a lack of cultural competence and humility in healthcare provision. Within this theme, the findings highlighted the importance of incorporating alternative methods of understanding and healing into the existing biomedical-focused healthcare

model. The results demonstrate that this adaptation is necessary to effectively address the needs of patients and to ensure healthcare providers have a comprehensive understanding of their patients' broader care context beyond the formal healthcare system. Lastly, the final theme of our analysis, negotiating candidacy, indicates that participants have felt a pressure to conform to societal norms that have historically been set by white individuals and upheld by white individuals, racialized individuals, and systemic organizations.

Table 4 - 5

Summary of Themes and Sub-themes

Theme	Sub-theme(s)
Access to care	The importance of language services
	The skills and resources needed to access virtual care
Cultural competence and humility	The need for cultural competence and humility in healthcare provision
	Holistic versus biomedical model of care
Negotiating candidacy	The need to "fit in" and whiteness as the standard

4.5.1 Access to care

To reiterate, in our study, we adopted Levesque et al.'s (2013) definition of access, which encompasses a comprehensive set of opportunities: "to identify healthcare needs, to seek

healthcare services, to reach the healthcare resources, to obtain or use health care services, and to actually be offered services appropriate to the needs for care" (p. 4).

4.5.1.1 The importance of language services

Participants highlighted the difficulties they faced as a result of language barriers, as well as those faced by their relatives and social connections, such as recent immigrants. The problems associated with language underscored how language barriers impeded access to healthcare. As an example, one participant, Irfaan, discussed the significance of having a physician who shares the same language as them,

> *Initially we got a Chinese doctor who was good but couldn't understand us well. So, we had to find an Urdu speaking doctor. It's very hard for us Pakistanis without someone who can speak Urdu. I can't speak in English very well at all. My children can understand English very well, but they can't come with me every time.*
>
> - Irfaan, male, 68 years old

Other participants have also expressed a similar sentiment regarding the significance of involving family members instead of relying on formal language services. As an illustration, Jamal highlighted the challenges they encounter when trying to buy medications because of the obstacles posed by language differences,

> *It would be impossible for me to go get medications if my son or daughter didn't go with me. Everything is in English, and I am not a fluent speaker. Even with my doctor, who speaks Urdu with me, gives me the prescriptions in English, right? Thankfully, the kids know English and go with us. I don't know what we would do without them.*
>
> - Jamal, male, 60 years old

This quote highlights the heavy dependence that many participants have on their children and family members to access and utilize the healthcare system. Additionally, this emphasizes that even if patients and their healthcare providers share the same language, there may still be a lack

of language concordance with other members of the healthcare team who may not speak the patient's language. Consequently, the significance of language concordance extends beyond the patient's primary point of contact, typically their family physician, as there are other crucial healthcare professionals within the system, including pharmacists, who play important roles in patient care. A few participants specifically brought up the need for translation services and how that would render helpful for those with language barriers and a lack of familial support. On this point, Ravi noted,

> *It's hard for people who don't know English that well. They don't come from an educated background, so how would they know English? My children can go with me if I need them to, but some of our relatives here from India, who would they go to the doctor with? Their kids don't live close because their workplace is far from here. If they have some, some kind of translator at the hospital or the walk-in clinics, that would help, right? You know, there's lot of Indians here, they can at least provide the basic languages for the immigrants here.*
>
> - Ravi, male, 72 years old

Ravi's statement also highlights education as a potential determinant impacting a patient's healthcare experience, indicating that individuals with lower education might encounter greater challenges in accessing the healthcare system. Participants also extensively discussed the scarcity of available doctors and the limited access to specialized care, underscoring the prolonged wait times within the existing healthcare system.

4.5.1.2 Access to virtual care

The COVID-19 pandemic led to the more rapid adoption of technology, as provinces sought virtual care as a means of ensuring safe access to healthcare services. Participants in the study shared varied opinions regarding the usefulness and user-friendliness of virtual care. Some

participants acknowledged its utility, highlighting its conveniences. Shankar, talks about his perspectives on virtual care and the benefits of technology,

> *No. I didn't face any challenges with virtual services. It is all accessible. And, you know, we are equipped for it, so amazing. I mean, technically, the computers are after our time, right, we have not well advanced as far as, you know, use of the computer, but we can still make use of it. We are not like, like my sister. She's in India. She's only four years older than I am. But she won't touch the computer.*
>
> - Shankar, male, 86 years old

Shankar's quote underscores the notion that for certain individuals, in order to participate in virtual care and consequently gain access to healthcare services through virtual care, there is a need for them to adjust and familiarize themselves with using technology. However, other participants expressed concerns about the challenges faced by their family members who are recent immigrants or those who are less proficient in English, suggesting that virtual care may not be as accessible or beneficial for them. One such quote is provided by Prisha,

> *Covid-19 was actually quite helpful for us. My doctor is far, so talking to them online means I don't have to travel that far to speak with him. And I don't feel it's necessary to speak with my doctor face to face. But I can see it being a challenge for people like my sister who just came to Canada not long ago. Her English isn't very strong so I can imagine it being much harder for her.*
>
> - Prisha, female, 63 years old

Other participants pointed out that virtual care was especially beneficial for individuals disabled individuals. Tarala describes her situation with her father-in-law, who has limited mobility, and how virtual care had an impact on their experience,

> *This [virtual care] is a godsend because it's very difficult to take my father-in-law in the clinic with the catheter, and all that we have to change into a leg bag and some amount of preparation is required before we take him. So, I would say in his case, I would say*

that I prefer the telephone conversations and the virtual one, because he has a mobility issue.

- Tarala, female, 78 years old

Contrarily, reflecting on their own experiences of struggling with virtual care, Irfaan notes,

I can't express myself in English. You can maybe say one or two things but can't do a proper conversation in English. English is harder over call without body language too. In person is better. Immigrants like us have the most trouble with this. They can't say things properly.

- Irfaan, male, 68 years old

Similar to Irfaan, other participants shared the perspective that virtual care could be advantageous for older adults who have a strong command of the English language. However, they also noted that it could present difficulties for certain groups such as recent immigrants, emphasizing the importance of body language in facilitating communication when language barriers exist. Zarina also offers insights based on similar experiences with virtual care.

Doctor samne nahi hota hai toh baat hi nahi hota. Adhi bimari doctor seh baat karne se hi khatam ho jata hai" [translation: if the doctor is not in front of me then engaging with them does not feel the same. Half my sickness goes away when I speak to the doctor face-to-face]. Disease goes away. Covid ruined everything. Virtual care was not satisfying. You forget what you needed to say in the middle of it and can't reach them again after. In person conversations with my doctor has more feeling, more interaction.

- Zarina, female, 60 years old

In contrast to the quotes mentioned earlier, Zarina discusses the disadvantages of the COVID-19 situation and the reliance on technology instead of in-person appointments, strongly indicating that face-to-face interactions with healthcare providers were preferable. Other participants emphasized different issues connected to virtual care, specifically regarding privacy concerns. Rajib explains his perspective on it,

I live with my son and daughter-in-law, so when I have to speak to a doctor over a computer or over the phone, I can't do it alone. There isn't any privacy in a household like this, we are all together and around each other all the time. It can be uncomfortable to talk about certain things in that environment. But in-person is just me and the doctor – I can just tell my son to wait outside the doctor's office.

- Rajib, male, 74 years old

Other participants living in multigenerational households with their children and grandchildren in the study also echoed similar concerns regarding privacy in virtual care settings. Some participants also explained that discussing certain sensitive topics in front of family members of the opposite gender is deemed inappropriate or discouraged in their cultural and familial context.

4.5.2 Culture competence and humility

In discussing the health care experiences and needs of South Asian older adults, most participants highlighted cultural competence and humility as necessary components of healthcare delivery to meet the needs of patients effectively and to ensure healthcare providers possess vital information about the patients' health.

4.5.2.1 The need for cultural competence in health care provision or services

Participants in the study expressed varying opinions regarding the importance of culturally competent care, with some emphasizing its importance, while others expressing that it was not essential. Most participants predominantly linked the need for medical care to physical health issues and ailments and believed healthcare professionals did not necessarily need to be aware of their ethnocultural background. For example, Shankar provides his viewpoint on the significance of culturally competent care,

> *They need to give me proper care and that's about it. My culture may impact my personal health, like food or practices, but I need doctors to just provide good care and solve my ailments. That's really it.*
>
> - Shankar, male, 86 years old

Shankar's statement emphasizes the potential disparity in how individuals perceive health and healthcare. It suggests that patients prioritize the role of culture when it comes to their own well-being, but this aspect may not hold the same significance when considering the Canadian healthcare system as a whole. Participants largely emphasized the importance of cultural competence when it comes to addressing mental health needs. For instance, Janaia discussed her experience with her psychiatrist.

> *My appointments with my psychiatrist were not helpful at all because she did not understand that I come from a different culture, and background. So, the discussions were based on a very, on a very sort of vague, you know, a vague understanding of how Indian people conducts oneself within a family setup. And I found she didn't understand my background and what it meant to be a 60 something year old person who comes from an Indian culture and race. At the end of the sessions, I'd feel frustrated. In the sense that I sit here, and we talk, but I don't even feel that you understand the basics of where I have come from. My psychiatrist was totally disconnected with my background.*
>
> - Janaia, female, 64

The quote demonstrates the significance of a healthcare provider adopting a culturally competent approach in this scenario. It highlights the importance of understanding the patient's familial structure and dynamics, as without this understanding, any medical guidance provided to the patient may lack relevance. Other participants in the study described how cultural competence could be a relevant factor even in addressing physical health requirements. When asked about why it might be important for her doctor to have or inquire about cultural understanding in relation to her physical health, Aileen said responded by stating,

I think it's important for doctors to understand our family structure, and how we operate within that family structure. My doctors says we have to have a structure in our lives where we can have two to three hours of physical exercise a week for ourselves to get out to go for a walk, listen to some music, meditation, things like that. Giving yourself time going out, you know, perhaps for a coffee with your friends. That's all very well, it's all very good - in theory, we'd all like to do that. But I today live in this house, this home with just my husband and myself. You know, our children, two from his previous marriage and one from mine. And it is a struggle for me to get out and dedicate three to four hours a week for myself. Simply because of the structure, you know, our cultural structure, you know, who runs the home? Who does this? Who does that, you know, all that domestic chores. And this is not only unique to our culture, even within the Western culture is the woman who takes on more than the man does, right? The expectations are different. I have to be the one to cook and put dinner on the table every day, not my husband or my children or my in laws. It's just how it works in our culture. So now if my family doctor says go exercise or go take time for yourself without understanding what responsibilities I have, do you think I can follow through?

- Aileen, female, 68

Aileen's quote emphasizes the importance of adopting a culturally tailored approach even when addressing aspects related to physical health, such as exercise prescription. The quote also brings attention to the intersectional experiences of the participants in our study, specifically those who identify as racialized individuals and women.

4.5.2.2 Holistic vs biomedical model of care

Participants emphasized that there existed a lack of acceptance towards any form of medication or healing practices that fell outside the boundaries of allopathic medicine. As an example, Beena shares her experience of her primary physician disregarding her suggestions regarding ayurvedic medications.

I had severe pain due to some nerve problems and they completely disregarded the pain I was feeling after I tried the medications he prescribed. So, I suggested ayurveda to help with this, and he was so dismissive of that. And then when the man wasn't taking me seriously, I was seriously upset, you know, and I'm not fussy like, he knows me well enough to know, I'm not a hypochondriac. But he wasn't supportive. And it came to a stage where I didn't even bother telling him certain things. You know, I just did my own thing. I basically felt I had to advocate for myself.

- *Beena, female, 73 years old*

Beena explains how she addressed her doctor's resistance towards Ayurvedic medicine through self-advocacy. This example also highlights the reluctance of healthcare providers to be receptive and knowledgeable about alternative healing practices that deviate from allopathic medicine.

One of the participants in our study, Sharad, who is a retired healthcare professional, provided an explanation for the necessity of a culturally competent approach when engaging with ethnocultural communities.

As a provider, I would like to know what their perspective is on health and taking care of their body. I'd like to know, what is their indigenous method of treatment, home treatment that they use? And what do they do? Because people have traditional methods that they bring with them. And unless you understand that, well, maybe your Medicare treatment may be interfering with that, and you know, you may have problem without realizing what is happening, you know, so it's important to not only understand it, but explore it, educate yourself in that method, whatever it is, you know, it may be traditional Chinese medicine, it may be Unani, it may be Ayurveda. It may be homeopathy that comes from Europe, or Germany. It may be Native American treatment, depending upon who you're treating. You got to know what it means, and you have to be open to it. You can't ask somebody to do this or that, you know, without understanding what they are, they're limited to, or what they will do, there may be something richer, under the skin, you know? Very important that you don't just dismiss it.

- Sharad, male, 87 years old

Sharad's perspective emphasizes an additional aspect of the significance of cultural competence, which lies in healthcare providers' awareness of the potential treatments and medications employed by their patients, which is essential to prevent contraindications and ensure optimal healthcare outcomes. This viewpoint underscores that the significance of cultural competence extends beyond showing respect for others and their cultures as it also holds medical utility and practical value. It also highlights that healthcare providers need to be open to approaches to health and healthcare that are not white-centric.

4.5.3 Negotiating Candidacy: the need to "fit in"

Koehn (2009) argues that older immigrants negotiate their "candidacy", which refers to how people assess their eligibility to access healthcare services and how they justify their relationship with and use of services. The process of effectively presenting oneself, in order to establish the legitimacy of a claim to candidacy is challenging for both immigrants and older people in general (Koehn, 2009). Moreover, the ability of older immigrants to make a legitimate claim is often constrained by language inconsistency between care provider and recipient (Dixon-Woods et al., 2005, 2006; Koehn, 2009). According to Koehn (2009), the practise of othering becomes apparent when healthcare practitioners categorise patients and subsequently refer them to screening and expert services based on the patient's presentation (or candidacy) and their own presumptions, professional or otherwise. The candidacy framework highlights the difficulty in gaining access to healthcare, as well as the need for a variety of measures to overcome obstacles faced by racialized immigrant older adults. The findings of our research suggest that the participants in our study have experienced a desire to conform to societal norms that have traditionally been established and maintained by white individuals.

4.5.3.1 The need to "fit in" and whiteness as a health provision/care standard

The participants in this research have recognized the need to modify their behavior and conform to the dominant Canadian system, including the healthcare system, in order to feel accepted and integrated. For instance, Shujata provided her viewpoint on why she was able to avoid experiencing discrimination as a patient within the Canadian healthcare system.

> *I didn't face that [discrimination] since I came here. Luckily. And that's probably because of my personality and because I can speak the language very well. And that's why the healthcare providers would not do these things with me. But if some other woman was there who doesn't speak the language properly or wear the right clothes, that don't fit the culture here, then those people will be underestimated and then treated like that, I think.*
>
> - Shujata, female, 77 years old

The quoted statement implies that the responsibility of being a responsible citizen and consequently being able to access the healthcare system – a fundamental human right – rests on the patient. Shujata emphasizes that fluency in English, wearing appropriate attire, and feeling the need to assimilate into Canadian culture are requirements for accessing the healthcare system without encountering racial discrimination. Similarly, when questioned about the importance of healthcare providers taking into account a patient's ethnocultural background and its potential influence on their health, Aarini provided the following response:

> *Religion is not even an issue that's considered. Same for ethnicity and other things. When we all came 40 years ago, we had to be Romans in Rome. That means where we didn't have a lot of ethnic doctors available and things like that. So, we learn to live together with what we have. Immigrants, you know, when in Rome, act like Romans!*
>
> - Aarini, female, 62 years old

Aarini further reinforces the notion of “assimilating” into Canadian society as a prerequisite for effectively using the healthcare system. Participants similarly also highlighted that the significance of religion and ethnicity is often overlooked since it is not as prominent of a factor in the considerations of Canadian society. Jamal offers an alternative viewpoint on how being an immigrant has not affected him and suggests measures that should be taken to prevent such impacts,

> *No, we haven’t been impacted for being an immigrant because we don't cross our limits. We know there’s this border and we can't cross this border, because past that is danger. We stay within our bounds, and we stay with our own. We Pakistanis here think that way. One other example of this is that we are terrified of the police. They are strict on us. So, we don’t act in any way that will get us into trouble. We have to remember to stay within our bounds because we are immigrants, we are not like the Canadians here.*
>
> - Jamal, male, 60 years old

Jamal's description of an implicit "border" that should not be crossed highlights the expectation for immigrants to assimilate and conform to a predetermined set of norms. According to him, there seems to be an unspoken rule for immigrants to adhere to specific behaviors and conform to certain societal expectations, both their own and that of their new society. Jamal further explained that this need to adhere to specific expectations extends to the healthcare context; for instance, one such rule that people must adhere to is speaking English or arranging for someone (e.g., children) who speaks English, in order to navigate and access the healthcare system.

A prominent and recurring theme in the interviews with the participants revolved around the concept of "whiteness" and white individuals being regarded as the norm or standard. Although the participants acknowledged that whiteness should not be regarded as the standard, they explained that this internalized belief is held by both white individuals and those from racialized backgrounds. One of the participants, Srijit, explains this phenomenon succinctly,

New immigrants from India and Bangladesh could be intimidated by a white doctor, white Caucasian doctor. And we seem to have this thing that you know, we always respect to the highest degree to the Caucasian people. I see that it's basically a reverse discrimination that we do, in fact. Our mind is wired for white supremacism - we are dark, and they are white so let us elevate this class up there. But this should not be so.

- Srijit, male 75 years old

Additionally, participants emphasize that the feeling of being considered "lesser than" sometimes leads to a lack of belongingness in their current communities compared to their countries of origin. On the issue of assimilating into a Canadian society that puts whiteness and white individuals at its center, Janaia discusses the influence it has on her sense of identity and consequently, her health and overall well-being.

I moved to Canada in the 80s. Very early 80s. When it was not what it is today. It was still very much a white country, more so than now. You know, to fit in, to fit in, was hard. I was one person at home and another person outside of the home, you know. And it created that dual identity for myself. And, you know, I feel that at this stage now, I feel that is so detrimental to an individual. Because you, you're not one or the other. Right? And who are you as a whole? You know, and I have brought the best from the Western culture to my own, but at the same time, it has impacted my own ethnic culture. Where do I fit in with the ethnic culture? Do I one hundred percent fit into my ethnic culture? No, I don't. Do I do I fit in with the Western culture one hundred percent? No, I don't. So here I am. I'm a whole of two different cultures. Right? And you can say that, you know, it's, enhanced me, but I would say, perhaps, it has been detrimental to me.

- Janaia, female, 64 years old

Janaia's statement emphasises the complex nature of identity experienced by racialized immigrants living in a predominantly white country such as Canada. It brings attention to the dualities they face, which can have adverse effects on their well-being and sense of belonging. It is important to note that viewpoints such as the one above was provided by participants,

spontaneously, during a discussion where they were prompted to reflect on their heath as an immigrant and their healthcare experiences in Canada. The participants' quotes, therefore, reflect not only their specific healthcare experiences but also their perspectives on the sociopolitical system at large that they believe impacted their health and healthcare experiences at the individual, interpersonal, level.

4.6 Discussion and Recommendations for Policy and Practice

4.6.1 Applying Lin's (2021) multilevel eco-social framework to the current study

The multilevel eco-social framework acknowledges the structural determinants specific to racialized and marginalized communities, which significantly shape the healthcare experiences of older immigrants (Lin, 2021). At the micro-level, Lin (2021) highlights social and economic challenges in a post-migration environment, as well as socio-cultural variations within clinical settings (Lin, 2021). In the meso- and exo-system, Lin (2021) points out the importance of capital and labor, as well as the significance of healthcare organizations being accessible and sensitive to the needs of these populations. Lastly, the macro-level factors, such as immigration and social policies, along with societal values and ideologies, are recognized as overarching structural elements influencing all other levels in the framework.

In discussing accessibility, it is important to recognize that this fluctuates across various levels. Lin's (2021) model, represented by an elliptical diagram, describes the impact of large and smaller factors related to accessing care. The framework aligns with this idea of larger structural factors impacting individual-level experiences, as it explores how interactions with physicians and potential discrimination are influenced not only by individual interactions but also by the broader socio-political system that may impose certain expectations on racialized immigrant

older adults, putting the onus on older adults themselves, to avoid discrimination. However, this study introduces several fundamental ideas that supplement Lin's (2021) model. Particularly, this paper contributes the concept of candidacy and the perceived necessity to conform to the system (to both feel included and avoid discrimination), the incorporation of virtual care, and the comparison between the holistic and biomedical models of care in the context of South Asian older adults.

4.6.2 The need to look at broader society to understand individuals' experiences

Sociologist Emile Durkheim once stated that, "one can understand people, not by looking at individuals, but only by examining their society" (Pope, 1975, p. 6). In the context of our research, this idea implies that one must consider the society to which racialized immigrants belong, including the factors that shaped its current state and the individuals or groups responsible for its formation. By doing so, we can gain a deeper understanding of racialized immigrants' experiences and the broader social dynamics at play that impact those experiences (Levesque et al., 2013). The issue of accessibility is such that it necessitates a comprehensive understanding at both the systems level and the interpersonal level for an adequate understanding of its complexities (Horrill et al., 2018). Although considerable efforts have been made to offer adequate healthcare services to all Canadians, disparities persist in the utilization and accessibility of primary healthcare and preventative services between foreign-born and Canadian-born residents (Bacal et al., 2019; Lebrun & Dubay, 2010; Vahabi et al., 2016). Various factors, such as geographical accessibility, economic constraints, limited operating hours, wait times, language barriers, challenges in navigating the healthcare system, and cultural differences, present significant obstacles to accessing healthcare services (Ahmed et al., 2016; 2016; Chiarenza et al., 2019; Higginbottom & Safipour, 2015; Kalich et al., 2016). Additionally,

studies have found factors such as relying on others to take time off for appointments (Ahmad et al., 2012), transportation issues (Ahmed et al., 2016; Donnelly et al., 2009), the need to prioritize household responsibilities over health concerns (Donnelly et al., 2009), and delaying seeking healthcare until it becomes urgent (Ahmed et al., 2016; Higginbottom & Safipour, 2015), can hinder new immigrants' access to healthcare. These results of our study corroborate these findings. For example, participants emphasized factors such as depending on family members for appointments and not having enough personal time for self-care and health-related pursuits (such as exercise) due to their familial responsibilities. Consistent with our findings, Attum et al., (2023) whose study focused specifically on Muslim patients, affirm that the aim of understanding how to provide care for patients is to empower all healthcare professionals with the capacity, knowledge, and skills to meet the distinct needs of each patient and, just as importantly, their family. The findings of this study, therefore, indicate the necessity for healthcare providers, and the larger healthcare system, to refrain from making assumptions about familial dynamics (Attum et al., 2023; Swihart et al., 2023). It is crucial to abandon the notion that all families operate in the same manner (Butler et al., 2016). Instead, a personalized approach is needed to offer culturally and individually suitable medical and healthcare advice to patients (Abrishami, 2018; Butler et al., 2016; Epner & Baile, 2012). As highlighted by our participant, Aileen, failure to consider such nuances of familial structure and individual contexts could lead to overlooking underlying factors that may significantly impact patient care (Lor et al., 2016). It is, therefore, important to implement policies that focus on cultivating cultural competence and humility, at the systems level, for those entering or currently in the healthcare and medical field (Truong et al., 2014). To achieve this, it is vital to avoid merely tokenistic or performative gestures of cultural awareness, but rather adopt actionable, result-oriented, steps to

ensure cultural safety at the organizational and systemic level (Radich, 2021; Wulf, 2011). Effective approaches may involve making cultural safety an essential criterion for accreditation and continuous certification of healthcare institutions and practitioners (Curtis et al., 2019; Dawson et al., 2022). Additionally, mandating cultural safety training and performance evaluation for all staff, supervisors, and assessors could also prove helpful in achieving this goal (Curtis et al., 2019)

4.6.3 The need for translators and interpreters

The literature reports that language services is a critical aspect of access to care for racialized immigrants (Ku, 2007; Pandey et al., 2021; Rasi, 2020). de Moissac and Bowen (2019) report that immigrants facing language barriers were at a higher risk of encountering medication errors, delays in diagnosis, and suboptimal care. Additionally, immigrants were more prone to having a strained relationship with their healthcare providers, facing challenges in effectively communicating their health needs, developing mistrust, and experiencing racism and discrimination (Ali & Watson, 2018; Bajgain et al., 2020; de Moissac & Bowen, 2019; Pollock et al., 2012). These findings were consistent with the current study, as participants emphasized that language barriers and the absence of language or translation services hindered healthcare access. This study underscores the importance of offering language assistance during medical consultations to address language barriers faced by immigrants. To ensure high-quality, equitable, and patient-centered care, this study supports the establishment of guidelines for recruiting, training, and effectively engaging language interpreters during medical consultations (Hsieh, 2006; Hudelson, 2005; Joshi et al., 2013; Pandey et al., 2015; Papic et al., 2012; Tonkin, 2017). Participants in this study, similar to findings in other research (Floyd & Sakellariou, 2017; George et al., 2014; Joshi et al., 2013; Pandey et al., 2015) emphasized the necessity of having

bilingual healthcare providers. Molina and Kasper (2019) advocate for language-concordant care, as it has been shown to offer safe and high-quality healthcare. However, the findings of our study suggest caution against assuming that care will automatically be of good quality solely based on language concordance. Additionally, echoing Shommu et al., (2016) community health navigators can play a vital role in improving access to primary and preventative healthcare services and can act as cultural brokers and language interpreters for racialized immigrant older adults. Lastly, recognizing that implementing cultural competence/humility and having medical interpreters available in every healthcare sector in Canada might be an ambitious idea, the study's findings propose that these aspects could hold greater significance in certain sectors than others. Cultural competence/humility and medical interpreters may play a more crucial role in mental healthcare services compared to acute care settings (Gopalkrishnan, 2018). As an example, the presence of a medical interpreter and cultural competence/humility may hold greater significance when a patient seeks mental health support, necessitating the explanation of intricate family dynamics, as opposed to the role of these services during routine blood work at a clinic.

4.6.4 Considerations related to virtual care

Our results showed that virtual care could both facilitate and impede access to healthcare services for South Asian participants. Much like Ahmed et al., (2012) pointing out transportation challenges as a hindrance to accessibility, some of our participants noted that virtual care was advantageous because it provided convenience, especially for individuals with disabilities, eliminating the need to travel to see a healthcare provider. However, other participants expressed concerns that virtual care created a greater divide from their already distant (i.e., hard to reach) healthcare providers. Additionally, virtual care brought forth other challenges, such as a lack of privacy, which hindered patients' ability to access healthcare providers in a confidential and

sensitive environment. Hardcastle and Ogbogu (2020) also highlight privacy issues in virtual care, emphasizing that irrespective of the delivery method, adherence to privacy laws is imperative for virtual healthcare services. In our study, participants primarily emphasized privacy concerns at the interpersonal level, mentioning their reluctance to discuss sensitive health matters in front of their children or grandchildren, who, in multi-generational households, often help with the set-up of virtual appointments. In contrast, Hardcastle and Ogbogu (2020) addressed privacy from a broader perspective, examining aspects such as the ownership and custodianship of virtual care health information, broad authorization for unspecified use and sharing of patient health information, as well as data security. Regarding privacy concerns at the interpersonal level, Cohen and Casper (2002) offer valuable insights related to racialized communities, particularly Black and Latino individuals. Their research relates the arrangement of multigenerational households and its implications to privacy issues as well as individual independence (Cohen & Casper, 2002). However, while our study addresses the privacy of older adults living within their children's homes, Cohen and Casper (2002) examine the privacy concerns of younger adults who depend on the support of their older relatives. Even though virtual care saw rapid adoption in response to COVID-19, there is now an opportunity for policy-makers to reassess its integration before it becomes a permanent fixture in the healthcare system (Bond, 2023; Hardcastle & Ogbogu, 2020; Jones et al., 2023). Beyond regulatory considerations, policymakers and healthcare providers should also address the specific privacy concerns of racialized immigrant older adult populations living in multigenerational households. Taking all these factors into account will contribute to a more thoughtful, effective, and culturally competent approach to virtual care implementation (Hilty et al., 2020).

4.6.5 Whiteness as the standard, and making space for deviations from the standard through cultural competence and humility

The fundamental concept of white normativity is succinctly described by Morris (2016) in the following manner: white individuals are considered fully human, while individuals from other racial groups are deemed fully human only to the extent that they resemble white individuals. Although it can be intertwined with explicit discrimination or racial animosity, white normativity operates in a more nuanced manner (Haney, 2006; Morris, 2016). Whiteness establishes the standard or accepted spectrum of behaviors and traits, and all other racial groups are compared against whiteness as deviations from this norm (Harlap & Riese, 2021; Resane, 2021; Ward, 2008). Consequently, whiteness occupies a central position in the classification of races and the process of racialization (Bejan, 2022; Morris, 2016).

As the recognition to dismantle white normativity grows, both in Canada and globally, there is an increasing emphasis on the significance of establishing an equitable healthcare system (Miller & Xie, 2020). However, Canada's models of care operate with the assumption that biomedical model of health rooted in Eurocentric traditions medicine is the all-encompassing gold standard (Boersma, 2020; McGibbon, 2019). The healthcare system in Canada, therefore, is structured around Eurocentric approaches to health and well-being (Eni et al., 2021; McGibbon, 2018). However, such an approach ignores a significant portion Canada's population that are racialized. Participants of our study expressed that their approach to well-being and understanding of it did not align with their healthcare providers, resulting in unmet health needs. In relation to seeking medical advice for her mental health, one of our participants highlighted that the recommendations provided by her psychiatrist were not suitable for her circumstances as a female Indian immigrant residing in a multi-generational household. A culturally competent

approach would require the provider to understand the context of a patient's life and the cultural underpinnings that affect it (Garran & Werkmeister Rozas, 2013). Additionally, a culturally humble approach requires that a healthcare provider does not take a standardized prescriptive approach, but rather one that tailors care to their unique context. This means that healthcare providers need to move away from the Eurocentric approach that places white folks in the centre and make space for other ways of knowing and being that go beyond Eurocentric traditions of medicine. Medical discourse in the Global North should be more accepting of traditional medicinal knowledge and health practices that generations of racialized and immigrant communities have transmitted and reproduced (Redvers & Blondin, 2020). Analogous to how whiteness is the standard, and non-whiteness a deviation, "Western" medicine is seen as the convention, and any "alternative" form of knowledge is unconventional and a departure from the norm (Ben-John, 2019). Medicine in the Global North is largely based on biomedical foundations of health and well-being, while several definitions of health in the Global South take a more holistic approach (Baskin, 2011; Dei, 2012; Wane, 2001). For instance, while the Global North medicine primarily emphasises clinical care, participants in this study highlighted approaches such as Ayurvedic medicine, which revolves around the idea of fostering well-being instead of merely combatting illnesses and upholding a harmonious balance between the individual and nature (Chopra & Doiphode, 2002; Mishra et al., 2010; Rastogi, 2010). Forms of healing that originate in the Global South often diverge away from aspects of medicine in the Global North rooted in technological, biomedical, and pharmaceutical hegemony (Ben-John, 2019). Therefore, it is important for the healthcare system to recognize the legitimacy of other ways of "knowing", and therefore, healing.

4.6.6 Negotiating candidacy: fitting the mould of whiteness or shedding difference?

The Healthy Immigrant Effect posits that immigrants have a health advantage over Canadian-born citizens that diminishes with length of residency (Gee et al., 2004; Newbold, 2006). These variations underscore the need to identify if and how older immigrants encounter barriers related to healthcare access (DesMeules et al., 2004). Although the older population in Canada is growing and its ethnic makeup is rapidly diversifying, racialized immigrant older adults are underrepresented in research and in social and health policies because it is assumed that they are cared for by their families and that their numbers are too small to be considered a "problem" (Morrissey et al., 2022). According to Brotman (2003), the strength of filial piety is often referenced by healthcare providers as a way to shift the responsibility of care onto family members, which can have detrimental effects on both caregivers and older adults. Furthermore, othering is a pattern of differentiation and marginalisation based on identities that apart from the norm, impacting on how individuals perceive and treat those who are viewed as belonging to the in-group as opposed to those who are viewed as belonging to the out-group (Brotman, 2003; Forbat, 2004; Johnson et al., 2004). In our study, participants specifically detailed the occurrences of othering they experienced, which involved the dismissal of healing practices from their cultural heritage, such as Ayurveda. Participants also expressed the impact of othering that stemmed from internalized white supremacy. In the context of healthcare, othering acts as discrimination and a barrier to care access, rooted in institutional structures and policies that were intended to be equitable but created using white-centric ideologies and frameworks (Curtis et al., 2019).

As a consequence of employing approaches and health care practices deeply entrenched in the Eurocentric paradigm, both at the interpersonal and systemic levels, individuals who are

non-white are expected to conform to these pre-established principles (Sanchez, 2018; Treitler, 2015). Consistent with existing literature, our research findings indicate that the individuals we examined expressed an inclination to conform to societal norms that have historically been set by white individuals, but are upheld by both white individuals and racialized persons who have internalized white supremacy and those who are so deeply colonized that they discipline themselves, and each other, for stepping outside of the standard template. Koehn's (2009) candidacy framework aligns well with the findings of this study since it highlights the challenges faced by racialized immigrant older adults in accessing healthcare and emphasizes the requirement for ethnoculturally diverse individuals to overcome these obstacles. As an example, participants in this study discussed the necessity of dressing in a manner that resembles white individuals to receive suitable healthcare services from healthcare providers. These findings are consistent with other research in the literature that has shown that clothing choices and adopting speech patterns similar to those of white individuals decreases racial stereotyping and act as a protective measure against discrimination (Archer et al., 2007; Aruguete et al., 2017; Gurung et al., 2023; Kahn & Davies, 2017; Lévy & Jobard, 2011; Livingston & Gurung, 2019; MacLin & Herrera, 2006; Mason, 2018). Thus, our research, consistent with existing literature, reinforces the notion that racialized immigrant communities are subjected to certain expectations and constraints to meet the standards of whiteness, in order to attain the rights and privileges granted to white individuals, as a condition of being considered "good" citizens (Hackl, 2022).

4.6.7 The complexities of immigrant identity through the lens of Du Boisian theory of double consciousness

According to Pierce and colleagues (2003), individuals are driven to define and express their self-identity. This self-identity acts as a boundary between the person and society, and it

develops as individuals perceive themselves through the lens of society (Clarke & James, 2003; Pierce et al., 2003). This notion of ownership as a symbol of the self is a core concept in sociology (Clarke & James, 2003), characterized by a dynamic and fluid process of identification, with its significance rooted in an individual's self-identity. Identity is not an isolated concept but rather shaped and constructed through social norms, symbols, values, and beliefs that are reflected in an individual's actions and thought processes (Karnilowicz, 2011). The active experience of psychological ownership plays a vital role in mediating these symbols, values, and beliefs (Pierce et al., 2003). Karnilowicz (2011) reports that this process forms a unified reality where cultural, social, and individual aspects intertwine to create a singular and cohesive whole. Contrary to this, some participants of this study had a different perception regarding their own identity.

Published in 1903, "The Souls of Black Folk" is a widely studied collection of essays in which Du Bois eloquently depicts the psychosocial impact of racism, drawing from his personal experiences of growing up as a Black individual in a predominantly white society (Burawoy, 2021; Henderson, 2017; Shuford, 2010; Zuckerman, 2004). In Chapter 1, Du Bois introduces two fundamental concepts that have become integral to sociology and race theory: "double-consciousness" and "the veil" (Clair, 2021; Zuckerman, 2004). Du Bois utilizes the metaphor of the veil to illustrate how Black individuals perceive the world differently from their white counterparts, given how their experiences and interactions are influenced by race and racism (Joseph & Golash-Boza, 2021; Mayrl, 2023). On a physical level, the veil can be likened to dark skin, which serves as a societal marker distinguishing Black people from white people (Yancy, 2005). Joseph and Golash-Boza (2021) argues that Du Boisian theory, particularly the concept of double consciousness, continues to hold relevance in comprehending social and political

divisions related to racialized immigrants in contemporary times of the 21st century. The authors propose that this theory can be expanded to encompass the notion of "racialized legal status," which involves the intersection of race, ethnicity, and an individual's legal status. It can be argued that Du Bois' concept of double consciousness, which illustrated the psychological impact on racialized individuals living in a racist society during the 20th century, holds relevance for the South Asian immigrant populations involved in this study. Specifically, Du Bois' characterization of double consciousness as the dilemma African Americans encounters while trying to uphold their black cultural identity while simultaneously adhering to the norms of the prevailing white society (Du Bois, 1945) is comparable to experiences shared by participants of this study. For example, Janaia discusses the duality of her identities, stemming from her membership within her ethnocultural community and the simultaneous necessity to assimilate into white society. This situation which gives rise to a dual identity, where Janaia doesn't entirely belong to either group, closely resembles the idea of "two-ness", i.e., being both Canadian and something else, that Du Bois (1903) held true for African Americans. Du Bois' (1903) explanation of the presence of "warring ideals" and "two unreconciled strivings" (p. 3) has significantly influenced and continues to shape people's encounters with racialized status in countries such as Canada that have large migrant populations. While the intersection of race, ethnicity, and immigrant status varies for each individual, according to Du Bois (1903), "warring ideals" and "two unreconciled strivings" (p. 3) have a profound impact on individuals and communities' experiences of having racialized status in countries such as Canada. Similar experiences have been documented in other empirical studies with other racialized communities. Negrón-Gonzales (2011), for example, found that the combination of being racialized as Latinx and holding illegal immigrant status generated a "hybridized sense of self" (p. 9). This state of

being both an “insider” and an “outsider” significantly influences the personal-political trajectories of Latinx youth (Negrón-Gonzales, 2011).

4.6.8 Intersectionality

Despite the increasing usage of the term "intersectionality" in academic discourse, researchers often oversimplify and overlook the interconnectedness of people's multiple identities (Lesch et al., 2019). The findings of this study highlight that the category of "older adults" is significant, considering the biological changes that occur during this phase of life, necessitating modified medical interventions (Sims et al., 2022). However, it is important to understand the “older adult” category in relation to those who also encompass diverse identities and cultural connections that they have cultivated throughout their lives (Warner & Brown, 2011). It is simultaneously also important to recognize that these identities, along with personalities, habits, and preferences, persist and evolve throughout one’s lifespan, including into older adulthood (Dilworth-Anderson et al., 2020; Lesch et al., 2018).

The current study also supports the notion that micro-level factors, such as an individual’s racial or ethnocultural identity, and macro-level factors, such as colonial history, are interconnected and present in every social interaction (Veenstra, 2011). An individual’s race might be relevant to or even dominate how they experience a given social interaction or circumstance, but there may also be other identities at play that are less obvious (Ammar et al., 2013). Therefore, we must be aware of and open to the possibility that other axes of inequality, interwoven inseparably with race, are at work in addition to race as the governing explanatory factor for a given experience (Ammar et al., 2013; Veenstra, 2011). Race, racialization, or racism cannot be considered the sole explanatory factor for any given experience (Ammar et al., 2013). Therefore, intersectionality affirms that race, class, gender, religion, and other social constructs

are mutually constitutive, dynamic, and flexible categories that operate with one another dynamically and in varying degrees of tension (i.e., individual, systematic, structural, institutional, global) within broader social environments and in the context of healthcare (Alvi & Zaidi, 2017; Veenstra, 2011).

Lastly, it is important to acknowledge that at the forefront of this study concerning racialized immigrants lies the intersection of white supremacy, patriarchy, and capitalism as the underlying factors influencing global migration patterns (Golash-Boza et al., 2019). These forces significantly mold the encounters of people of the global majority in both migrant-sending and receiving communities (Golash-Boza et al., 2019; Nee & Victor, 2002; Yu, 2022). Therefore, it is essential to bring about significant and lasting improvements in the health and well-being of racialized individuals on a global scale (Paradies et al., 2015). This requires a thorough and critical examination of the social position of white folks regarding their role in the historical scientific enterprise, as well as their influence on power dynamics (Mazzochhi, 2006). Understanding the reasons behind the current state of affairs also requires recognition of contemporary colonial practices, and the implementation of top-down global health governance and programming initiatives (Williams & Cooper, 2019).

4.7 Limitations

Our qualitative study has some limitations. First, our sample of participants was geographically limited because we recruited participants from Southern Ontario, focusing primarily on urban cities. This also resulted in the possible exclusion of racialized immigrant older adults residing in rural areas who may have a lower socio-economic status. Secondly, although we conducted in-depth interviews with older adults to explore their perspectives on systemic barriers and how it impacts healthcare experiences, our study would benefit from

additional insights by also interviewing family caregivers about their role in providing care. Similarly, it would have been beneficial to interview healthcare providers regarding their firsthand experiences in engaging racialized immigrant older adults and their families in care, providing insights from the perspective of care providers. Thirdly, this study focused on only on the experiences and perspectives of the South Asian immigrant communities in Canada. Subsequent research should investigate the viewpoints and experiences of other communities within the Canadian demographic landscape, such as the Chinese community and the Arabic-speaking community. Fourthly, we had a large number of participants who were highly educated, came from higher socioeconomic backgrounds, and had high English language proficiency. Although our sample aligns with the migration patterns of South Asian older adults in Canada (i.e., many South Asian families migrated to Canada during the mid-20th century and are now older adults, as reported by the Government of Canada in 2021), it is important to understand and specifically study the experiences of recent immigrants from less privileged socioeconomic backgrounds and those for whom English is a second language. Lastly, it is important for studies of this kind to specifically address refugees who have migrated to Canada, distinguishing between immigrants and refugees due to their significantly distinct experiences of migration.

4.8 Conclusion

The objective of this study was to evaluate the structural determinants and systemic factors influencing the healthcare experiences and overall health and well-being of South Asian older adults in Canada. Consistent with previous literature, the study found that challenges with accessibility remains a critical issue for racialized immigrant older adult populations (Bacal et al., 2019; Lebrun & Dubay, 2010; Vahabi et al., 2016), while the rapid adoption of technology presents novel challenges that demand attention in both healthcare research and practice

(Hardcastle & Ogbogu, 2020). To tackle these issues related to accessibility and address the need for reform healthcare at a systems level, person-centered care and cultural competence and humility are proposed as potential solutions (Gopalkrishnan, 2018). Additional research is necessary to devise innovative solutions for addressing the current challenges encountered by the racialized immigrant older adult population. For instance, exploring the potential of virtual care platforms and artificial intelligence to facilitate language and translation services could prove beneficial. Implementing such solutions at a provincial and federal level becomes especially important and relevant given the increasing number of immigrants in Canada and the growing integration of technology in healthcare practices.

The findings of the study support the notion that intersectionality can be utilized to explore the unique interactions between experiences such as education, immigration status, age, and gender and how they are positioned within larger oppressive systems (Ferrer et al., 2017). The impact of a colonial and oppressive history continues today with perpetuating racism that is ubiquitous in our societies, deeply entrenched at the institutional and interpersonal level (Datta et al., 2021; Grenier, 2020). It is, therefore, essential to start considering racism as a determinant of health (Paradies et al., 2015). Health researchers, practitioners, and decision-makers in Canada should not shy away from addressing the complexities of racism in combination with other "isms" (Cho et al., 2013; Datta, 2018). To cater to the needs of racialized immigrant older adults, it is crucial to offer a diverse array of healthcare options, including "non-Western" systems that have been and continue being "othered" (Ben et al., 2017; Johnson et al., 2004). Embracing diversity and finding innovative solutions to longstanding healthcare challenges requires challenging the prevailing dominance of the biomedical model of health and research (Engel, 2012; Pearson et al., 2020). It is also important to move beyond an exclusive emphasis on

assimilation theories, since they center around whiteness and focus on how immigrants of color become more similar or distant from the dominant group, middle-class Whites, over time (Alba & Nee, 2003; Jimenez, 2010; Lee & Bean, 2010; Portes & Rumbaut, 2001; Waters, 2001; Zhou, 1997). Anti-oppression and anti-racism frameworks can aid in identifying, analyzing, and transforming the attitudes, structures, and behaviors that perpetuate systemic racism, white normativity, and other forms of societal oppression (Smith, 2012). It is equally important to establish best practices, incorporating both cultural competence and humility frameworks, to effectively serve a culturally, ethnically, and racially diverse population (Stubbe, 2020). If historical structures in Canada have contributed to biased systems, it becomes imperative to create new paradigms that receive adequate funding and support, at the systems level, to address the significant challenge of rectifying historical injustices and recognizing ongoing ones.

4.9 Acknowledgments

We sincerely thank the research participants who generously shared their experiences and perspectives with us. This work was supported by the Canadian Institutes of Health Research (grant number: 452873) and the International Doctoral Scholarship Award granted to DC.

4.10 References

Abell, M. L., Manuel, J., & Schoeneman, A. (2015). Student attitudes toward religious diversity and implications for multicultural competence. *Journal of Religion & Spirituality in Social Work: Social Thought*, *34*(1), 91–104. https://doi.org/10.1080/15426432.2014.943920

Abrishami, D. (2018). The need for cultural competency in health care. *Radiologic Technology*, *89*(5), 441–448.

Ahmad, F., Mahmood, S., Pietkiewicz, I., McDonald, L., & Ginsburg, O. (2012). Concept mapping with South Asian immigrant women: Barriers to mammography and solutions. *Journal of Immigrant and Minority Health*, *14*(2), 242–250. https://doi.org/10.1007/s10903-011-9472-7

Ahmed, S., Shommu, N. S., Rumana, N., Barron, G. R. S., Wicklum, S., & Turin, T. C. (2016). Barriers to access of primary healthcare by immigrant populations in Canada: A literature review. *Journal of Immigrant and Minority Health*, *18*(6), 1522–1540. https://doi.org/10.1007/s10903-015-0276-z

Akgul, F. (2017). Understanding Patriarchy. In F. Akgul (Ed.), *Patriarchal Theory Reconsidered: Torture and Gender-Based Violence in Turkey* (pp. 29–65). Springer International Publishing. https://doi.org/10.1007/978-3-319-49766-2_3

Alba, R., & Nee, V. (2003). Remaking the american mainstream: Assimilation and contemporary immigration. In *Remaking the American Mainstream*. Harvard University Press. https://doi.org/10.4159/9780674020115

Ali, P. A., & Watson, R. (2018). Language barriers and their impact on provision of care to patients with limited English proficiency: Nurses' perspectives. *Journal of Clinical Nursing*, *27*(5–6), e1152–e1160. https://doi.org/10.1111/jocn.14204

Alvi, S., & Zaidi, A. U. (2017). Invisible voices: An intersectional exploration of quality of life for elderly South Asian immigrant women in a Canadian sample. *Journal of Cross-Cultural Gerontology*, *32*(2), 147–170. https://doi.org/10.1007/s10823-017-9315-7

Ammar, N., Couture-Carron, A., Alvi, S., & San Antonio, J. (2013). Experiences of Muslim and non-Muslim battered immigrant women with the police in the United States: a closer understanding of commonalities and differences. Violence Against Women, 19(12), 1449–1471. https://doi.org/10.1177/1077801213517565

Anand, S. S., Yusuf, S., Vuksan, V., Devanesen, S., Teo, K. K., Montague, P. A., Kelemen, L., Yi, C., Lonn, E., Gerstein, H., Hegele, R. A., & McQueen, M. (2000). Differences in risk factors, atherosclerosis, and cardiovascular disease between ethnic groups in Canada: The study of health assessment and risk in ethnic groups (SHARE. *Lancet (London, England)*, *356*(9226), 279–284. https://doi.org/10.1016/s0140-6736(00)02502-2

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? Journal of Health and Social Behavior, 36(1), 1–10.

Archer, L., Hollingworth, S., & Halsall, A. (2007). "University's not for me--I'm a Nike person": Urban, working-class young people's negotiations of "style", identity and educational engagement. *Sociology*, *41*(2), 219–237. https://doi.org/10.1177/0038038507074798

Aruguete, M., Slater, J., & Mwaikinda, S. (2017). The effects of professors' race and clothing style on student evaluations. *The Journal of Negro Education*, *86*, 494. https://doi.org/10.7709/jnegroeducation.86.4.0494

Attum, B., Hafiz, S., Malik, A., & Shamoon, Z. (2023). Cultural competence in the care of muslim patients and their families. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK499933/

Bacal, V., Blinder, H., Momoli, F., Wu, K. Y., & McFaul, S. (2019). Is immigrant status associated with cervical cancer screening among women in Canada? Results from a cross-sectional study. *Journal of Obstetrics and Gynaecology Canada: JOGC = Journal d'obstetrique et Gynecologie Du Canada: JOGC*, *41*(6), 824-831.e1. https://doi.org/10.1016/j.jogc.2018.07.010

Bajgain, B. B., Bajgain, K. T., Badal, S., Aghajafari, F., Jackson, J., & Santana, M.-J. (2020). Patient-reported experiences in accessing primary healthcare among immigrant population in Canada: A rapid literature review. *International Journal of Environmental Research and Public Health*, *17*(23), 8724. https://doi.org/10.3390/ijerph17238724

Baskin, C. (2011). Strong helpers' teachings: The value of Indigenous knowledges in the helping professions. Toronto, ON: Canadian Scholars' Press.

Bejan, R. (2022). Whiteness in Question: The Anatomy of a Taxonomy Across Transnational Contexts. *Dialectical Anthropology*, *46*(3), 347–372. https://doi.org/10.1007/s10624-022-09665-6

Ben, J., Cormack, D., Harris, R., & Paradies, Y. (2017). Racism and health service utilisation: A systematic review and meta-analysis. *PloS One*, *12*(12), e0189900. https://doi.org/10.1371/journal.pone.0189900

Benn-John, J. (2019). *Decolonizing Western Medicine and Systems of Care: Implications for Education* (pp. 81–93). https://doi.org/10.1007/978-3-030-25320-2_6

Bin-Sallik, M. (2003). Cultural Safety: Let's name it! *The Australian Journal of Indigenous Education*, *32*, 21–28. https://doi.org/10.1017/S1326011100003793

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing*, *13*(1), 68–75. https://doi.org/10.1177/1744987107081254

Blunt, K. (2007). Social work education. *Journal of Teaching in Social Work*, *27*(3–4), 93–114. https://doi.org/10.1300/J067v27n03_07

Boersma, K. A. (2020, July 16). *RE: Is it Time for a Change in Western medicine?* https://www.cmaj.ca/content/re-it-time-change-western-medicine

Bond, A. (2023). Margin notes from the COVID-19 pandemic for the future of healthcare innovation. *Healthcare Management Forum*, 08404704231185487. https://doi.org/10.1177/08404704231185487

Brah, A. (1992). Difference, diversity, differentiation. *Theories of Race and Racism*. https://doi.org/10.1080/03906701.1991.9971087

Braun, V., & Clarke, V. (2013). Successful qualitative research: A practical guide for beginners. *Successful qualitative research*, 1-400

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press. http://www.gbv.de/dms/bowker/toc/9780674224568.pdf

Bronfenbrenner, U. (1994). Ecological models of human development (Vol. 3). *International Encyclopedia of Education*.

Brotman, S., Ferrer, I., Sussman, T., Ryan, B., & Richard, B. (2015). Access and equity in the design and delivery of health and social care to LGBTQ older adults: A Canadian

perspective. In *The lives of LGBT older adults: Understanding challenges and resilience* (pp. 111–140). American Psychological Association. https://doi.org/10.1037/14436-006

Brottman, M. R., Char, D. M., Hattori, R. A., Heeb, R., & Taff, S. D. (2020). Toward cultural competency in health care: A scoping review of the diversity and inclusion education literature. *Academic Medicine: Journal of the Association of American Medical Colleges*, *95*(5), 803–813. https://doi.org/10.1097/ACM.0000000000002995

Burawoy, M. (2021). Why is classical theory classical? Theorizing the canon and canonizing Du Bois. *Journal of Classical Sociology*, *21*(3–4), 245–259. https://doi.org/10.1177/1468795X211036955

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J., Rosser, S., Larson, S., Allen, M., Fu, S., & Kane, R. L. (2016). *Improving Cultural Competence to Reduce Health Disparities*. Agency for healthcare research and quality (US). http://www.ncbi.nlm.nih.gov/books/NBK361126/

Campbell, E., & Lawford, K. (2021). Combating physician-assisted genocide and white supremacy in healthcare through anti-oppressive pedagogies in Canadian medical schools to prevent the coercive and forced sterilization of Indigenous women. *INYI Journal*, *11*(1), Article 1. https://doi.org/10.25071/1929-8471.86

Carlson, E. (2017). Anti-colonial methodologies and practices for settler colonial studies. *Settler Colonial Studies*, *7*(4), 496–517. https://doi.org/10.1080/2201473X.2016.1241213

Chavez, V. (2018). Cultural humility: Reflections and relevance for CBPR. In Wallerstein, N., Duran, B., Oetzel, J., Minkler, M. (Eds.), Community-based participatory research for health: Advancing social and health equity (3rd ed., pp. 357-362). San Francisco, CA: Jossey-Bass.

Chen, G.-M. (2015). Theorizing global community as cultural home in the new century. *International Journal of Intercultural Relations*, *46*. https://doi.org/10.1016/j.ijintrel.2015.03.024

Chen, H.-Y., & Boore, J. R. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing*, *19*(1–2), 234–239. https://doi.org/10.1111/j.1365-2702.2009.02896.x

Chiarenza, A., Dauvrin, M., Chiesa, V., Baatout, S., & Verrept, H. (2019). Supporting access to healthcare for refugees and migrants in European countries under particular migratory pressure. *BMC Health Services Research*, *19*, 513. https://doi.org/10.1186/s12913-019-4353-1

Chiu, M., Austin, P. C., Manuel, D. G., & Tu, J. V. (2010). Comparison of cardiovascular risk profiles among ethnic groups using population health surveys between 1996 and 2007. *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *182*(8), E301-310. https://doi.org/10.1503/cmaj.091676

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: theory, applications, and praxis. *Signs: Journal of Women in Culture and Society*, *38*(4), 785–810. https://doi.org/10.1086/669608

Chopra, A., & Doiphode, V. V. (2002). Ayurvedic medicine: Core concept, therapeutic principles, and current relevance. *Medical Clinics*, *86*(1), 75–89. https://doi.org/10.1016/S0025-7125(03)00073-7

Chowdhury, D., Baiocco-Romano, L., Sacco, V., El Hajj, K., & Stolee, P. (2022). Cultural competence interventions for health care providers working with racialized foreign-born

older adults: Protocol for a systematic review. *JMIR Research Protocols*, *11*(7), e31691. https://doi.org/10.2196/31691

Clair, M. (2021). Criminalized subjectivity: Du Boisian sociology and visions for legal change. *Du Bois Review: Social Science Research on Race*, *18*(2), 289–319. https://doi.org/10.1017/S1742058X21000217

Clarke, J. N., & James, S. (2003). The radicalized self: the impact on the self of the contested nature of the diagnosis of chronic fatigue syndrome. Social Science & Medicine (1982), 57(8), 1387–1395. https://doi.org/10.1016/s0277-9536(02)00515-4

Cohen, P. N., & Casper, L. M. (2002). In whose home? Multigenerational families in the United States, 1998–2000. *Sociological Perspectives*, *45*(1), 1–20. https://doi.org/10.1525/sop.2002.45.1.1

Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). Routledge. https://doi.org/10.4324/9780203900055

Combahee River Collective. (1983). The Combahee river collective statement. *Home girls: A Black feminist anthology*, *1*, 264-274.

Cooper, A. (2007). The hanging of Angélique. *Georgia Press*. https://ugapress.org/book/9780820329406/the-hanging-of-angelique

Corneau, S., & Stergiopoulos, V. (2012). More than being against it: Anti-racism and anti-oppression in mental health services. *Transcultural Psychiatry*, *49*(2), 261–282. https://doi.org/10.1177/1363461512441594

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(1). https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241–1299. https://doi.org/10.2307/1229039

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed (Vol. 1). Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center. Retrieved from https://archive.org/details/towardscultural

Culley, L. (2006). Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry*, *13*(2), 144–153. https://doi.org/10.1111/j.1440-1800.2006.00311.x

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Daniels, N. (1982). Equity of access to health care: Some conceptual and ethical issues. *The Milbank Memorial Fund Quarterly. Health and Society*, *60*(1), 51–81.

Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work*, *18*(4), 410–430. https://doi.org/10.1177/1468017316654341

Datta, G., Siddiqi, A., & Lofters, A. (2021). Transforming race-based health research in Canada. *Canadian Medical Association Journal*, *193*(3), E99–E100. https://doi.org/10.1503/cmaj.201742

Davis, K. (2008). Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. *Feminist Theory*, *9*(1), 67–85. https://doi.org/10.1177/1464700108086364

Dawson, J., Laccos-Barrett, K., Hammond, C., & Rumbold, A. (2022). Reflexive practice as an approach to improve healthcare delivery for Indigenous peoples: A systematic critical synthesis and exploration of the cultural safety education literature. *International Journal of Environmental Research and Public Health, 19*(11), 6691. https://doi.org/10.3390/ijerph19116691

De Maio, F. G. (2010). Immigration as pathogenic: A systematic review of the health of immigrants to Canada. *International Journal for Equity in Health*, *9*(1), 27. https://doi.org/10.1186/1475-9276-9-27

de Moissac, D., & Bowen, S. (2019). Impact of language barriers on quality of care and patient safety for official language minority francophones in Canada. *Journal of Patient Experience*, *6*(1), 24–32. https://doi.org/10.1177/2374373518769008

Dei, G., & Asgharzadeh, A. (2001). The power of social theory: The anti-colonial discursive framework. *The Journal of Educational Thought (JET) / Revue de La Pensée Éducative*, *35*(3), 297–323.

Dei, G. J. S. (2000). Rethinking the role of Indigenous knowledges in the academy. *International Journal of Inclusive Education*, *4*(2), 111–132. https://doi.org/10.1080/136031100284849

Dei, G. S. (2012). Indigenous anti-colonial knowledge as 'heritage knowledge' for promoting Black/African education in diasporic contexts. *Decolonization: Indigeneity, Education & Society*, *1*(1), Article 1. https://jps.library.utoronto.ca/index.php/des/article/view/18631

Dei, G. J. S., & Calliste, A. (2000). Mapping the terrain: Power knowledge and anti-racism education.

Delgado, R., & Stefancic, J. (2023). *Critical Race Theory, Fourth Edition: An Introduction*. NYU Press.

DesMeules, M., Gold, J., Kazanjian, A., Manuel, D., Payne, J., Vissandée, B., McDermott, S., & Mao, Y. (2004). New approaches to immigrant health assessment. Canadian Journal of Public Health = Revue Canadienne De Sante Publique, 95(3), I22-26.

Dhamoon, R. K., & Hankivsky, O. (2011). Why the theory and practice of intersectionality matter to health research and policy. *Health Inequities in Canada: Intersectional Frameworks and Practices*, 16–50.

DiCristina, B. (2015). *The Birth of Criminology: Readings from the Eighteenth and Nineteenth Centuries*. Aspen Publishing.

Dill, B. T., & Zambrana, R. E. (2009). Critical thinking about inequality: An emerging lens. In *Feminist Theory Reader* (5th ed.). Routledge.

Dilworth-Anderson, P., Moon, H., & Aranda, M. P. (2020). Dementia caregiving research: Expanding and reframing the lens of diversity, inclusivity, and intersectionality. *The Gerontologist*, *60*(5), 797–805. https://doi.org/10.1093/geront/gnaa050

Dilworth-Anderson, P., Pierre, G., & Hilliard, T. S. (2012). Social justice, health disparities, and culture in the care of the elderly. *Journal of Law, Medicine & Ethics*, *40*(1), 26–32. https://doi.org/10.1111/j.1748-720X.2012.00642.x

Dixon-Woods, M., Kirk, D., Agarwal, S., Annandale, E., Arthur, T., Harvey, J., ... & Sutton, A. (2005). Vulnerable groups and access to health care: a critical interpretive review. Report

for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). Leicester: University of Leicester, 4-10.

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R., & Sutton, A. J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology*, 6, 35. https://doi.org/10.1186/1471-2288-6-35

Dominelli, L. (2008). Anti-racist social work (3rd edn.). Houndmills, UK: Palgrave Macmillan.

Donabedian, A., & Fund, C. (1973). Aspects of medical care administration: Specifying requirements for health care.

Donnelly, T. T., McKellin, W., Hislop, G., & Long, B. (2009). Socioeconomic influences on Vietnamese-Canadian women's breast and cervical cancer prevention practices: A social determinant's perspective. *Social Work in Public Health*, *24*(5), 454–476. https://doi.org/10.1080/19371910802678772

Dowd, J. J., & Bengtson, V. L. (1978). Aging in minority populations: An examination of the double jeopardy hypothesis. *Journal of Gerontology*, *33*(3), 427–436. https://doi.org/10.1093/geronj/33.3.427

Duntley-Matos, R. (2014). Transformative complicity and cultural humility: De- and reconstructing higher education mentorship for under-represented groups. *Qualitative Sociology, 37*, 443–466. doi:10.1007/s11133-014-9289-5

Du Bois, W. E. B. (1903). *The souls of black folk*. Oxford University Press.

Du Bois, W. E. B. (1945). Color and democracy: Colonies and peace.

Dupuis-Blanchard, S., Villalon, L., & Alimezelli, H. T. (2014). [Healthy ageing in a linguistic minority situation in Canada: Issues, challenges and collective mobilization]. *Global Health Promotion*, *21*(1 Suppl), 70–75. https://doi.org/10.1177/1757975913512161

Engel, G. L. (2012). The need for a new medical model: A challenge for biomedicine. *Psychodynamic Psychiatry*, *40*(3), 377–396. https://doi.org/10.1521/pdps.2012.40.3.377

Eni, R., Phillips-Beck, W., Achan, G. K., Lavoie, J. G., Kinew, K. A., & Katz, A. (2021). Decolonizing health in Canada: A Manitoba first nation perspective. *International Journal for Equity in Health, 20*(1), 206. https://doi.org/10.1186/s12939-021-01539-7

Epner, D. E. (2012). Patient-centered care: The key to cultural competence. *Annals of Oncology*, *23*, 33–42.

Epner, D. E., & Baile, W. F. (2012). Patient-centered care: The key to cultural competence. *Annals of Oncology: Official Journal of the European Society for Medical Oncology*, *23 Suppl 3*, 33–42. https://doi.org/10.1093/annonc/mds086

Fenton, S. (1999). Ethnicity and racism. In S. Fenton, *Ethnicity* (pp. 61–87). Macmillan Education UK. https://doi.org/10.1007/978-1-349-27560-1_3

Ferrer, I., Grenier, A., Brotman, S., & Koehn, S. (2017). Understanding the experiences of racialized older people through an intersectional life course perspective. *Journal of Aging Studies*, *41*, 10–17. https://doi.org/10.1016/j.jaging.2017.02.001

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, *34*(2), 165–181. https://doi.org/10.1080/02615479.2014.977244

Fitzpatrick, A. L., Powe, N. R., Cooper, L. S., Ives, D. G., & Robbins, J. A. (2004). Barriers to Health Care Access Among the Elderly and Who Perceives Them. *American Journal of*

Public Health, *94*(10), 1788–1794. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448535/

Floyd, A., & Sakellariou, D. (2017). Healthcare access for refugee women with limited literacy: Layers of disadvantage. *International Journal for Equity in Health*, *16*(1), 195. https://doi.org/10.1186/s12939-017-0694-8

Forbat, L. (2004). The Care and Abuse of Minoritized Ethnic Groups: The Role of Statutory Services. *Critical Social Policy*, *24*(3), 312–331. https://doi.org/10.1177/0261018304044362

Foronda, C., Baptiste, D.-L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society*, *27*(3), 210–217. https://doi.org/10.1177/1043659615592677

Frenk, J. (1985). [Concept and measurement of accessibility]. *Salud Publica De Mexico*, *27*(5), 438–453.

Furlong, M., & Wight, J. (2011). Promoting "critical awareness" and critiquing "cultural competence": Towards disrupting received professional knowledges. *Australian Social Work*, *64*(1), 38–54. https://doi.org/10.1080/0312407X.2010.537352

Furness, S. (2005). Shifting sands: Developing cultural competence. *Practice*, *17*(4), 247–256. https://doi.org/10.1080/09503150500425638

Gahayr, S. (2011). *Invisibility, disappearance and reclamation: A sociological investigation into the locations(s) of Aboriginal and African women in Canada*. 133.

Garran, A. M., & Rozas, L. (2013). Cultural Competence Revisited. *Journal of Ethnic & Cultural Diversity in Social Work*, *22*(2), 97–111. https://doi.org/10.1080/15313204.2013.785337

Gee, E. M., Kobayashi, K. M., & Prus, S. G. (2004). Examining the healthy immigrant effect in mid- to later life: Findings from the Canadian community health survey. *Canadian Journal on Aging = La Revue Canadienne Du Vieillissement*, *23 Suppl 1*, S61-69.

George, P., Lennox Terrion, J., & Ahmed, R. (2014). Reproductive health behaviour of Muslim immigrant women in Canada. *International Journal of Migration, Health and Social Care*, *10*(2), 88–101. https://doi.org/10.1108/IJMHSC-09-2013-0032

George, G., & Selimos, E. D. (2019). Searching for belonging and confronting exclusion: A person-centred approach to immigrant settlement experiences in Canada. *Social Identities, 25*(2), 125–140. https://doi.org/10.1080/13504630.2017.1381834

Golash-Boza, T., Duenas, M. D., & Xiong, C. (2019). White supremacy, patriarchy, and global capitalism in migration studies. *American Behavioral Scientist*, *63*(13), 1741–1759. https://doi.org/10.1177/0002764219842624

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, *6*, 179. https://doi.org/10.3389/fpubh.2018.00179

Grenier, M.-L. (2020). Cultural competency and the reproduction of White supremacy in occupational therapy education. *Health Education Journal*, *79*(6), 633–644. https://doi.org/10.1177/0017896920902515

Guest, G., MacQueen, K., & Namey, E. (2012). *Applied Thematic Analysis*. SAGE Publications, Inc. https://doi.org/10.4135/9781483384436

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does "access to health care" mean? *Journal of Health Services Research & Policy*, *7*(3), 186–188. https://doi.org/10.1258/135581902760082517

Gupta, M., Doobay, A. V., Singh, N., Anand, S. S., Raja, F., Mawji, F., Kho, J., Karavetian, A., Yi, Q., & Yusuf, S. (2002). Risk factors, hospital management and outcomes after acute myocardial infarction in South Asian Canadians and matched control subjects. *CMAJ: Canadian Medical Association Journal*, *166*(6), 717–722.

Guruge, S., & Khanlou, N. (2004). Intersectionalities of influence: Researching the health of immigrant and refugee women. *The Canadian Journal of Nursing Research = Revue Canadienne De Recherche En Sciences Infirmieres*, *36*(3), 32–47.

Guruge, S., Thomson, M. S., George, U., & Chaze, F. (2015). Social support, social conflict, and immigrant women's mental health in a Canadian context: A scoping review. *Journal of Psychiatric and Mental Health Nursing*, *22*(9), 655–667. https://doi.org/10.1111/jpm.12216

Gurung, R. A. R., Stoa, R., Livingston, N., & Mather, H. (2021). Can success deflect racism? Clothing and perceptions of African American men. *Journal of Social Psychology*, *161*(1), 119–128. https://doi.org/10.1080/00224545.2020.1787938

Hackl, A. (2022). Good immigrants, permitted outsiders: Conditional inclusion and citizenship in comparison. *Ethnic and Racial Studies*, *45*(6), 989–1010. https://doi.org/10.1080/01419870.2021.2011938

Haddad, S., & Mohindra, K. (2002). Access, opportunities and communities: ingredients for health equity in the South. Paper presented at the Public Health and International Justice Workshop.

Hancock, A.-M. (2007). When multiplication doesn't equal quick addition: Examining intersectionality as a research paradigm. *Perspectives on Politics*, *5*(1), 63–79. https://doi.org/10.1017/S1537592707070065

Haney, I. (2006). *White by law: The legal construction of race*. New York University Press.

Hankivsky, O. (Ed.). (2011). *Health Inequities in Canada: Intersectional Frameworks and Practices* (1st edition). UBC Press.

Hardcastle, L., & Ogbogu, U. (2020). Virtual care: Enhancing access or harming care? *Healthcare Management Forum*, *33*(6), 288–292. https://doi.org/10.1177/0840470420938818

Harlap, Y., & Riese, H. (2021). Race talk and white normativity: Classroom discourse and narratives in Norwegian higher education. *Teaching in Higher Education*, *0*(0), 1–17. https://doi.org/10.1080/13562517.2021.1940925

Henderson, E. A. (2017). The revolution will not be theorised: Du Bois, Locke, and the Howard School's challenge to white supremacist IR theory. *Millennium*, *45*(3), 492–510. https://doi.org/10.1177/0305829817694246

Herring, S., Spangaro, J., Lauw, M., & McNamara, L. (2013). The intersection of trauma, racism, and cultural competence in effective work with Aboriginal people: Waiting for trust. *Australian Social Work*, *66*(1), 104–117. https://doi.org/10.1080/0312407X.2012.697566

Hester, R. J. (2012). The promise and paradox of cultural competence. *HEC Forum: An Interdisciplinary Journal on Hospitals' Ethical and Legal Issues*, *24*(4), 279–291. https://doi.org/10.1007/s10730-012-9200-2

Higginbottom, G., & Safipour, J. (2015). Access to primary health care by new and established immigrants in Canada. *Journal of Family Medicine & Community Health*, *2*, 1046.

Hilty, D. M., Gentry, M. T., McKean, A. J., Cowan, K. E., Lim, R. F., & Lu, F. G. (2020). Telehealth for rural diverse populations: Telebehavioral and cultural competencies, clinical outcomes and administrative approaches. *MHealth*, *6*, 20. https://doi.org/10.21037/mhealth.2019.10.04

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr., E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366. https://doi.org/10.1037/a0032595

Hooks, B. (2000). *Feminist theory: From margin to center*. Pluto Press.

Horrill, T., McMillan, D. E., Schultz, A. S. H., & Thompson, G. (2018). Understanding access to healthcare among Indigenous peoples: A comparative analysis of biomedical and postcolonial perspectives. *Nursing Inquiry*, *25*(3), e12237. https://doi.org/10.1111/nin.12237

Howard, M. C., & Hoffman, M. E. (2018). Variable-centered, person-centered, and person-specific approaches: Where theory meets the method. *Organizational Research Methods, 21(4),* 846–876. https://doi.org/10.1177/1094428117744021

Hsieh, E. (2006). Understanding medical interpreters: Reconceptualizing bilingual health communication. *Health Communication*, *20*(2), 177–186. https://doi.org/10.1207/s15327027hc2002_9

Hudelson, P. (2005). Improving patient–provider communication: Insights from interpreters. *Family Practice*, *22*(3), 311–316. https://doi.org/10.1093/fampra/cmi015

Hunnicutt, G. (2009). Varieties of patriarchy and violence against women: Resurrecting "patriarchy" as a theoretical tool. *Violence Against Women*, *15*(5), 553–573. https://doi.org/10.1177/1077801208331246

Inhetveen, K. (2012). Translation challenges: Qualitative interviewing in a multi-lingual field. *Qualitative Sociology Review*, *8*(2), 28–45. https://doi.org/10.18778/1733-8077.8.2.03

Islam, F., Multani, A., Hynie, M., Shakya, Y., & McKenzie, K. (2017). Mental health of South Asian youth in Peel Region, Toronto, Canada: A qualitative study of determinants, coping

strategies and service access. *BMJ Open*, *7*(11), e018265. https://doi.org/10.1136/bmjopen-2017-018265

Jackson, S. A., Shiferaw, B., Anderson, R. T., Heuser, M. D., Hutchinson, K. M., & Mittelmark, M. B. (2002). Racial differences in service utilization: The Forsyth County Aging Study. *Journal of Health Care for the Poor and Underserved, 13*(3), 320–333. https://doi.org/10.1353/hpu.2010.0721

Jimenez, D. E., Park, M., Rosen, D., Joo, J. hui, Garza, D. M., Weinstein, E. R., Conner, K., Silva, C., & Okereke, O. (2022). Centering culture in mental health: Differences in diagnosis, treatment, and access to care among older people of color. *The American Journal of Geriatric Psychiatry*, *30*(11), 1234–1251. https://doi.org/10.1016/j.jagp.2022.07.001

Jiménez, T. R. (2010). *Replenished ethnicity: Mexican Americans, immigration, and identity*. University of California Press.

Johnson, J. L., Bottorff, J. L., Browne, A. J., Grewal, S., Hilton, B. A., & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Communication*, *16*(2), 255–271. https://doi.org/10.1207/S15327027HC1602_7

Johnson, Y. M., & Munch, S. (2009). Fundamental contradictions in cultural competence. *Social Work*, *54*(3), 220–231. https://doi.org/10.1093/sw/54.3.220

Jones, A. M., Fan, J., Thomas-Olson, L., Zhang, W., & McLeod, C. B. (2023). Continuation of telework in the post-pandemic era: Healthcare employees' preference and determinants. *Healthcare Management Forum*, *36*(4), 256–262. https://doi.org/10.1177/08404704231170733

Joseph, T., & Golash-Boza, T. (2021). Double Consciousness in the 21st century: Du Boisian theory and the problem of racialized legal status. *Social Sciences*, *10*(9), Article 9. https://doi.org/10.3390/socsci10090345

Joshi, C., Russell, G., Cheng, I.-H., Kay, M., Pottie, K., Alston, M., Smith, M., Chan, B., Vasi, S., Lo, W., Wahidi, S. S., & Harris, M. F. (2013). A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. *International Journal for Equity in Health*, *12*(1), 88. https://doi.org/10.1186/1475-9276-12-88

Kaehne, A. (2018). Care integration - from "one size fits all" to person centred care comment on "achieving integrated care for older people: Shuffling the deckchairs or making the system watertight for the future?" *International Journal of Health Policy and Management*, *7*(10), 955–957. https://doi.org/10.15171/ijhpm.2018.51

Kahn, K., & Davies, P. (2017). What influences shooter bias? The effects of suspect race, neighborhood, and clothing on decisions to shoot: Suspect race, neighborhood, and clothing on decisions to shoot. *Journal of Social Issues*, *73*, 723–743. https://doi.org/10.1111/josi.12245

Kalich, A., Heinemann, L., & Ghahari, S. (2016). A scoping review of immigrant experience of health care access barriers in Canada. *Journal of Immigrant and Minority Health*, *18*(3), 697–709. https://doi.org/10.1007/s10903-015-0237-6

Kang, H., & Kim, H. (2022). Ageism and psychological well-being among older adults: A systematic review. *Gerontology and Geriatric Medicine, 8*, 23337214221087024. https://doi.org/10.1177/23337214221087023

Karnilowicz, W. (2011). Identity and psychological ownership in chronic illness and disease state. *European Journal of Cancer Care*, *20*(2), 276–282. https://doi.org/10.1111/j.1365-2354.2010.01220.x

Kim, I.-H., Carrasco, C., Muntaner, C., McKenzie, K., & Noh, S. (2013). Ethnicity and postmigration health trajectory in new immigrants to Canada. *American Journal of Public Health*, *103*(4), e96–e104. https://doi.org/10.2105/AJPH.2012.301185

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Koehn, S., Neysmith, S., Kobayashi, K., & Khamisa, H. (2013). Revealing the shape of knowledge using an intersectionality lens: Results of a scoping review on the health and health care of ethnocultural minority older adults. *Ageing & Society*, *33*(3), 437–464. https://doi.org/10.1017/S0144686X12000013

Kools, S., Chimwaza, A., & Macha, S. (2015). Cultural humility and working with marginalized populations in developing countries. *Global Health Promotion*, *22*(1), 52–59. https://doi.org/10.1177/1757975914528728

Ku, L. (2007). Improving health insurance and access to care for children in immigrant families. *Ambulatory Pediatrics*, *7*(6), 412–420. https://doi.org/10.1016/j.ambp.2007.08.002

Lai, D. W. L., & Chau, S. B. Y. (2007). Predictors of health service barriers for older Chinese immigrants in Canada. *Health and Social Work*, *32*(1), 57–66.

Larson, G. (2008). Anti-oppressive practice in mental health. *Journal of Progressive Human Services*, *19*(1), 39–54. https://doi.org/10.1080/10428230802070223

Lebrun, L. A., & Dubay, L. C. (2010). Access to primary and preventive care among foreign-born adults in Canada and the United States. *Health Services Research*, *45*(6 Pt 1), 1693–1719. https://doi.org/10.1111/j.1475-6773.2010.01163.x

Lee, J., & Bean, F. D. (2010). Reinventing the color line immigration and America's new racial/ethnic divide. *Social Forces*, *86*(2), 561–586. https://doi.org/10.1093/sf/86.2.561

Lesch, H., Burcher, K., Wharton, T., Chapple, R., & Chapple, K. (2019). Barriers to healthcare services and supports for signing deaf older adults. *Rehabilitation Psychology*, *64*(2), 237–244. https://doi.org/10.1037/rep0000252

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Lévy, R., & Jobard, F. (2011). Racial profiling: The Parisian police experience. *Canadian Journal of Criminology and Criminal Justice - CAN J CRIMINOL CRIM JUSTICE*, *53*, 87–93. https://doi.org/10.3138/cjccj.53.1.87

Liamputtong, P. (2010). Cross-cultural research and qualitative inquiry. *Turkish Online Journal of Qualitative Inquiry*.

Lin, S. (Lamson). (2022). Access to health care among racialised immigrants to Canada in later life: A theoretical and empirical synthesis. *Ageing & Society*, *42*(8), 1735–1759. https://doi.org/10.1017/S0144686X20001841

Lin, S. (Lamson). (2023). Inequities in mental health care facing racialized immigrant older adults with mental disorders despite universal coverage: A population-based study in Canada. *The Journals of Gerontology: Series B*, gbad036. https://doi.org/10.1093/geronb/gbad036

Liu, R., So, L., Mohan, S., Khan, N., King, K., & Quan, H. (2010). Cardiovascular risk factors in ethnic populations within Canada: Results from national cross-sectional surveys. *Open Medicine*, *4*(3), e143–e153.

Livingston, N., & Gurung, R. (2019). Trumping racism: The interactions of stereotype incongruent clothing, political racial rhetoric, and prejudice toward African Americans. *PSI CHI Journal, 24*, 52–60. https://doi.org/10.24839/2325-7342.JN24.1.52

Lor, M., Crooks, N., & Tluczek, A. (2016). A proposed model of person-, family-, and culture-centered nursing care. *Nursing Outlook*, *64*(4), 352–366. https://doi.org/10.1016/j.outlook.2016.02.006

Lum, T. Y., & Vanderaa, J. P. (2010). Health disparities among immigrant and non-immigrant elders: The association of acculturation and education. *Journal of Immigrant and Minority Health*, *12*(5), 743–753. https://doi.org/10.1007/s10903-008-9225-4

Lum, D. (2011). *Culturally competent practice: A framework for understanding diverse groups and justice issues* (4th ed.). Belmont, CA: Brooks/Cole.

MacLin, M. K., & Herrera, V. (2006). The criminal stereotype. *North American Journal of Psychology*, *8*(2), 197–207.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Marczak, B., & Scott-Railton, J. (2020). *Move fast and roll your own crypto: A quick look at the confidentiality of zoom meetings* (Citizen Lab Research Report No. 126). University of Toronto. https://citizenlab.ca/2020/04/move-fast-roll-your-own-crypto-a-quick-look-at-the-confidentiality-of-zoom-meetings/

Mason, W. (2018). 'Swagger': Urban youth culture, consumption and social positioning. *Sociology*, *52*(6), 1117–1133. https://doi.org/10.1177/0038038517698638

Mayrl, D. (2023). The funk of white souls: Toward a Du Boisian theory of the white church. *Sociology of Religion*, *84*(1), 16–41. https://doi.org/10.1093/socrel/srac009

Mazzocchi, F. (2006). Western science and traditional knowledge: Despite their variations, different forms of knowledge can learn from each other. *EMBO Reports*, *7*(5), 463–466. https://doi.org/10.1038/sj.embor.7400693

McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society*, *30*(3), 1771–1800. https://doi.org/10.1086/426800

McGibbon, E. (2018). Decolonizing health care: Reconciliation roles and responsibilities for white settlers. *Critical Studies: An International and Interdisciplinary Journal, 13*(2), Article 2. https://doi.org/10.51357/cs.v13i2.127

McGibbon, E. (2019). Truth and reconciliation: Healthcare organizational leadership. *Healthcare Management Forum, 32*(1), 20–24. https://doi.org/10.1177/0840470418803379

McKenna, L. (2022). Translation of research interviews: Do we have a problem with qualitative rigor? *Nurse Author & Editor*, *32*(1), 1–3. https://doi.org/10.1111/nae2.31

Mehrotra, G. (2010). Toward a continuum of intersectionality theorizing for feminist social work scholarship. *Affilia: Journal of Women & Social Work*, *25*(4), 417–430. https://doi.org/10.1177/0886109910384190

Miles, R. (1989). *Racism*. Routledge. https://doi.org/10.4324/9780203633663

Miller, F. A., & Xie, E. (2020). Toward a Sustainable Health System: A Call to Action. HealthcarePapers, 19(3), 9–25. https://doi.org/10.12927/hcpap.2020.26377

Mills, C. W. (2014). The racial contract. In *The racial contract*. Cornell University Press. https://doi.org/10.7591/9780801471353

Mishra, A., Gupta, A., Gupta, V., Sannd, R., & Bansal, P. (2010). Asava and Aristha: An ayurvedic medicine – An overview. *Int J Pharm Biol Arch*, *1*.

Molina, R. L., & Kasper, J. (2019). The power of language-concordant care: A call to action for medical schools. *BMC Medical Education*, *19*(1), 378. https://doi.org/10.1186/s12909-019-1807-4

Mooney, G. H. (1983). Equity in health care: Confronting the confusion. *Effective Health Care*, *1*(4), 179–185.

Morris, M. (2016). Standard white: Dismantling white normativity. *California Law Review*, *104*(4), 949–978.

Morrissey, M. B. Q., Brownell, P., & Caprio, T. (2022). Intersectionality of race, ethnicity, and culture in neglect, abuse, and violence against older persons: Human rights, global health, and systems approaches in pandemics. In R. Geffner, J. W. White, L. K. Hamberger, A. Rosenbaum, V. Vaughan-Eden, & V. I. Vieth (Eds.), Handbook of Interpersonal Violence and Abuse Across the Lifespan: A project of the National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV) (pp. 4699–4719). Springer International Publishing. https://doi.org/10.1007/978-3-319-89999-2_337

Mullings, D. V., & Gien, L. (2013). *Culturally competent i (appropriate) health and long-term care services for older immigrants in a small urban center of Newfoundland*. 81–89. https://www.researchgate.net/publication/264416428

Nee, R. A., Victor. (2002). Rethinking assimilation theory for a new era of immigration. In *The new immigrant in American society*. Routledge.

Negrón-Gonzales, G. M. (2011). *The making and unmaking of common sense: Undocumented Latino youth; political consciousness* [UC Berkeley]. https://escholarship.org/uc/item/1jx9x582

Newbold, K. B. (2006). Self-rated health within the Canadian immigrant population: Risk and the healthy immigrant effect. Social Science & Medicine (1982), 60(6), 1359–1370. https://doi.org/10.1016/j.socscimed.2004.06.048

Omariba, D. W. R. (2015). Immigration, ethnicity, and avoidable mortality in Canada, 1991-2006. *Ethnicity & Health*, *20*(4), 409–436. https://doi.org/10.1080/13557858.2014.995155

Pandey, M., Maina, R. G., Amoyaw, J., Li, Y., Kamrul, R., Michaels, C. R., & Maroof, R. (2021). Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: A qualitative study. *BMC Health Services Research*, *21*(1), 741. https://doi.org/10.1186/s12913-021-06750-4

Papic, O., Malak, Z., & Rosenberg, E. (2012). Survey of family physicians' perspectives on management of immigrant patients: Attitudes, barriers, strategies, and training needs. *Patient Education and Counseling*, *86*(2), 205–209. https://doi.org/10.1016/j.pec.2011.05.015

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLoS ONE*, *10*(9), e0138511. https://doi.org/10.1371/journal.pone.0138511

Pearson, O., Schwartzkopff, K., Dawson, A., Hagger, C., Karagi, A., Davy, C., Brown, A., Braunack-Mayer, A., & on behalf of the Leadership Group guiding the Centre for Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE). (2020). Aboriginal community controlled health organisations address health

equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia. *BMC Public Health*, *20*(1), 1859. https://doi.org/10.1186/s12889-020-09943-4

Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care*, *19*(2), 127–140. https://doi.org/10.1097/00005650-198102000-00001

Pierce, J. L., Kostova, T., & Dirks, K. T. (2003). The State of Psychological Ownership: Integrating and Extending a Century of Research. Review of General Psychology, 7(1), 84–107. https://doi.org/10.1037/1089-2680.7.1.84

Pitts, A. (2015). White supremacy, mass incarceration, and clinical medicine: A critical analysis of U.S. correctional healthcare. *Radical Philosophy Review*, *18*(2), 267–285. https://doi.org/10.5840/radphilrev201412827

Pollock, G., Newbold, K. B., Lafrenière, G., & Edge, S. (2012). Discrimination in the doctor's office: Immigrants and refugee experiences. *Critical Social Work*, *13*(2). https://doi.org/10.22329/csw.v13i2.5866

Pon, G. (2009). Cultural competency as new racism: An ontology of forgetting. *Journal of Progressive Human Services*, *20*(1), 59–71. https://doi.org/10.1080/10428230902871173

Pon, G., Gosine, K., & Phillips, D. (2011). Immediate response: Addressing anti-native and anti-black racism in child welfare. *International Journal of Child, Youth and Family Studies*, *2*(3/4), Article 3/4. https://doi.org/10.18357/ijcyfs23/420117763

Pope, W. (1975). Durkheim as a functionalist. *The Sociological Quarterly*, *16*(3), 361–379.

Portes, P. A., & Rumbaut, P. R. G. (2001). *Legacies: The Story of the Immigrant Second Generation*. University of California Press.

Prasad, K., Dwivedi, S. N., Kant, S., Vibha, D., Pandit, A. K., Karthikeyan, G., Tripathi, M., Srivastava, A. K., Nehra, A., Vivekanandhan, S., Garg, A., Chutani, A. M., Verma, V., Kumar, S., Kumar, A., Gulati, K., Gulati, A., Makharia, G., Seth, T., … Tiemeier, H. (2022). Cohort profile: The LoCARPoN-a population-based prospective cohort study in middle-aged and older adults in India. *International Journal of Epidemiology*, *51*(1), 29–30m. https://doi.org/10.1093/ije/dyab078

Radich, J. (2021). Cultural competence: Working towards Reconciliation. Every Child, 18(2), 22–24. https://doi.org/10.3316/aeipt.193560

Rasi, S. (2020). Impact of language barriers on access to healthcare services by immigrant patients: A systematic review. *Asia Pacific Journal of Health Management*, *15*(1), 35–48. https://doi.org/10.3316/ielapa.057892660325679

Rastogi, S. (2010). Building bridges between Ayurveda and modern science. *International Journal of Ayurveda Research*, *1*(1), 41–46. https://doi.org/10.4103/0974-7788.59943

Redvers, N., & Blondin, B. (2020). Traditional Indigenous medicine in North America: A scoping review. PLoS ONE, 15(8), e0237531. https://doi.org/10.1371/journal.pone.0237531

Resane, K. T. (2021). White fragility, white supremacy and white normativity make theological dialogue on race difficult. *In Die Skriflig*, *55*(1), 2661. https://doi.org/10.4102/ids.v55i1.2661

Richard, L., Furler, J., Densley, K., Haggerty, J., Russell, G., Levesque, J.-F., & Gunn, J. (2016). Equity of access to primary healthcare for vulnerable populations: The IMPACT international online survey of innovations. *International Journal for Equity in Health*, *15*, 64. https://doi.org/10.1186/s12939-016-0351-7

Ridley, C. R., Baker, D. M., & Hill, C. L. (2001). Critical issues concerning cultural competence. *The Counseling Psychologist*, *29*(6), 822–832. https://doi.org/10.1177/0011000001296003

Romanelli, M., & Hudson, K. D. (2017). Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults. *The American Journal of Orthopsychiatry*, *87*(6), 714–728. https://doi.org/10.1037/ort0000306

Romero, M. (2017). *Introducing Intersectionality*. John Wiley & Sons.

Sadavoy, J., Meier, R., & Ong, A. Y. M. (2004). Barriers to access to mental health services for ethnic seniors: The Toronto study. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, *49*(3), 192–199. https://doi.org/10.1177/070674370404900307

Sadler, G. R., Lee, H.-C., Lim, R. S.-H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing & Health Sciences*, *12*(3), 369–374. https://doi.org/10.1111/j.1442-2018.2010.00541.x

Sáenz, R., & Douglas, K. (2015). A call for the racialization of immigration studies: On the transition of ethnic immigrants to racialized immigrants. *Sociology of Race and Ethnicity*, *1*(1), 166–180. https://doi.org/10.1177/2332649214559287

Sakamoto, I. (2007). An anti-oppressive approach to cultural competence. *Canadian Social Work Review / Revue Canadienne de Service Social*, *24*(1), 105–114.

Salkever, D. S. (1976). Accessibility and the demand for preventive care. *Social Science & Medicine*, *10*(9–10), 469–475. https://doi.org/10.1016/0037-7856(76)90114-1

Sanchez, J. C. (2018). Trump, the KKK, and the versatility of white supremacy rhetoric. *Journal of Contemporary Rhetoric*, *8*

Sanchez, G., & Romero, M. (2010). Critical race theory in the US sociology of immigration. *Sociology Compass, 4(*9), 779-788.

Saunders, J. A., Haskins, M., & Vasquez, M. (2015). Cultural competence: A journey to an elusive goal. *Journal of Social Work Education*, *51*(1), 19–34. https://doi.org/10.1080/10437797.2015.977124

Schulz, A. J. and Mullings, L. (2006) *Gender, race, class, and health: Intersectional approaches*. Jossey-Bass, San Francisco.

Severs, E., Celis, K., & Erzeel, S. (2016). Power, privilege and disadvantage: Intersectionality theory and political representation. *Politics*, *36*(4), 346-354.

Shengelia, B., Tandon, A., Adams, O. B., & Murray, C. J. L. (2005). Access, utilization, quality, and effective coverage: An integrated conceptual framework and measurement strategy. *Social Science & Medicine (1982)*, *61*(1), 97–109. https://doi.org/10.1016/j.socscimed.2004.11.055

Shommu, N. S., Ahmed, S., Rumana, N., Barron, G. R. S., McBrien, K. A., & Turin, T. C. (2016). What is the scope of improving immigrant and ethnic minority healthcare using community navigators: A systematic scoping review. *International Journal for Equity in Health*, *15*(1), 6. https://doi.org/10.1186/s12939-016-0298-8

Shuford, J. (2010). *Four Du Boisian contributions to critical race theory*. In *W.E.B. Du Bois*. Routledge.

Sims, K. D., Smit, E., Batty, G. D., Hystad, P. W., & Odden, M. C. (2022). Intersectional discrimination and change in blood pressure control among older adults: The health and retirement study. *The Journals of Gerontology: Series A*, *77*(2), 375–382. https://doi.org/10.1093/gerona/glab234

Smith, L. T. (2012). Decolonizing methodologies: Research and indigenous peoples. Zed Books.

Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women*, *11*(1), 38–64. https://doi.org/10.1177/1077801204271476

Statistics Canada. (2021, October 25). *Census in Brief: Ethnic and cultural origins of Canadians: Portrait of a rich heritage*. https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016016/98-200-x2016016-eng.cfm

Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *Focus: Journal of Life Long Learning in Psychiatry*, *18*(1), 49–51. https://doi.org/10.1176/appi.focus.20190041

Swihart, D. L., Yarrarapu, S. N. S., & Martin, R. L. (2023). Cultural religious competence in clinical practice. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK493216/

Taylor, L. S., & Lurie, N. (2004). The role of culturally competent communication in reducing ethnic and racial healthcare disparities. *The American Journal of Managed Care*, *10*(1 SP). https://www.ajmc.com/view/sep04-1875psp001-sp00

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125. https://doi.org/10.1353/hpu.2010.0233

Todic, J., Cook, S. C., Spitzer-Shohat, S., Williams, J. S., Battle, B. A., Jackson, J., & Chin, M. H. (2022). Critical theory, culture change, and achieving health equity in health care

settings. *Academic Medicine*, *97*(7), 977–988. https://doi.org/10.1097/ACM.0000000000004680

Tong, C. E., Lopez, K. J., Chowdhury, D., Arya, N., Elliott, J., Sims-Gould, J., Grindrod, K., & Stolee, P. (2022). Understanding racialised older adults' experiences of the Canadian healthcare system, and codesigning solutions: Protocol for a qualitative study in nine languages. *BMJ Open*, *12*(10), e068013. https://doi.org/10.1136/bmjopen-2022-068013

Tonkin, E. (2017). The Importance of Medical Interpreters. *American Journal of Psychiatry Residents' Journal*, *12*(8), 13–13. https://doi.org/10.1176/appi.ajp-rj.2017.120806

Treitler, V. B. (2015). Social Agency and White Supremacy in Immigration Studies. *Sociology of Race and Ethnicity*, *1*(1), 153–165. https://doi.org/10.1177/2332649214560796

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research, 14*, 99. https://doi.org/10.1186/1472-6963-14-99

Tuyisenge, G., & Goldenberg, S. M. (2021). COVID-19, structural racism, and migrant health in Canada. *The Lancet*, *397*(10275), 650–652. https://doi.org/10.1016/S0140-6736(21)00215-4

Vahabi, M., Lofters, A., Kumar, M., & Glazier, R. H. (2016). Breast cancer screening disparities among immigrant women by world region of origin: A population-based study in Ontario, Canada. *Cancer Medicine*, *5*(7), 1670–1686. https://doi.org/10.1002/cam4.700

Veenstra, G. (2009). Racialized identity and health in Canada: Results from a nationally representative survey. *Social Science & Medicine (1982)*, *69*(4), 538–542. https://doi.org/10.1016/j.socscimed.2009.06.009

Veenstra, G., & Patterson, A. C. (2016). South Asian-White health inequalities in Canada: Intersections with gender and immigrant status. *Ethnicity & Health*, *21*(6), 639–648. https://doi.org/10.1080/13557858.2016.1179725

Vissandjee, B., Desmeules, M., Cao, Z., Abdool, S., & Kazanjian, A. (2004). Integrating ethnicity and migration as determinants of Canadian women's health. *BMC Women's Health*, *4 Suppl 1*, S32. https://doi.org/10.1186/1472-6874-4-S1-S32

Wane, N. (2001). Narratives of Embu Rural Women: Gender Roles and Indigenous Knowledges. Gender, Technology and Development, 5(3), 383–408. https://doi.org/10.1080/09718524.2001.11910015

Wang, Q., Davis, P. B., Gurney, M. E., & Xu, R. (2021). COVID-19 and dementia: Analyses of risk, disparity, and outcomes from electronic health records in the US. *Alzheimer's & Dementia*, *17*(8), 1297–1306. https://doi.org/10.1002/alz.12296

Ward, J. (2008). White normativity: The cultural dimensions of whiteness in a racially diverse LGBT organization. *Sociological Perspectives*, *51*(3), 563–586. https://doi.org/10.1525/sop.2008.51.3.563

Warner, D. F., & Brown, T. H. (2011). Understanding how race/ethnicity and gender define age-trajectories of disability: An intersectionality approach. *Social Science & Medicine*, *72*(8), 1236–1248. https://doi.org/10.1016/j.socscimed.2011.02.034

Waters, M. C. (2001). Black identities: West Indian immigrant dreams and American realities. In *Social Stratification, Class, Race, and Gender in Sociological Perspective, Second Edition*. Routledge.

Weber, L. (1998). A conceptual framework for understanding race, class, gender, and sexuality. *Psychology of Women Quarterly*, *22*(1), 13–32. https://doi.org/10.1111/j.1471-6402.1998.tb00139.x

Westwood, S. (Ed.). (2017). *Ageing, diversity and equality: Social justice perspectives*. Taylor & Francis. https://library.oapen.org/handle/20.500.12657/27534

Whitehead, M. (1992). The concepts and principles of equity and health. *International Journal of Health Services: Planning, Administration, Evaluation*, *22*(3), 429–445. https://doi.org/10.2190/986L-LHQ6-2VTE-YRRN

Williams, D. R., & Cooper, L. A. (2019). Reducing racial inequities in health: Using what we already know to take action. *International Journal of Environmental Research and Public Health*, *16*(4), 606. https://doi.org/10.3390/ijerph16040606

World health Organization (2021) Ageing and health. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

Wulf, C. (2011). Performativity and dynamics of intangible cultural heritage. In *Ritual, Heritage and Identity*. Routledge, India.

Wynter, S. (1994), No humans involved: A letter to my colleagues. *Knowledge on Trial, 1*(1), 42–73.

Yancy, G. (2005). Whiteness and the return of the black body. *The Journal of Speculative Philosophy*, *19*(4), 215–241.

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research: ANR*, *26*(4), 251–256. https://doi.org/10.1016/j.apnr.2013.06.008

Yosso, T. J., & Solórzano, D. G. (2005). Conceptualizing a critical race theory in sociology. In *The Blackwell Companion to Social Inequalities* (pp. 117–146). John Wiley & Sons, Ltd. https://doi.org/10.1002/9780470996973.ch7

Yu, H. (2022). Cantonese migrant networks, white supremacy, and the political utility of apologies in Canada. *Journal of Ethnic and Migration Studies*, *48*(4), 969–988. https://doi.org/10.1080/1369183X.2021.1983957

Zhou, M. (1997). Segmented assimilation: Issues, controversies, and recent research on the new second generation. *International Migration Review*, *31*(4), 975–1008. https://doi.org/10.1177/019791839703100408

Zuckerman, P. (2004). *The social theory of W.E.B. Du Bois*. SAGE Publications.

Chapter 5

5.1 Conclusion

In recent years, evidence from public health reports and research findings indicated that racialized immigrants are underserved and have a higher likelihood of receiving negative health outcomes than their non-immigrant, non-racialized counterparts (Abbas et al., 2018; de Maio, 2010; Markides & Rote, 2019). Although racialized foreign-born older adults account for a large portion of the overall population in the Global North, published research for understanding the needs of this subpopulation, particularly its older adults, is limited (Butler, 2016). My dissertation sought to understand the healthcare experiences of South Asian older adults to understand how their healthcare needs can be adequately met. My research also adds to the limited body of literature on immigrant older adults, that even still, has a Euro-centric lens (Fung, 2013).

Employing a multilingual and cross-cultural qualitative approach, 47 South-Asian older adults (60+) were interviewed in a semi-structured format, in Hindi, Tamil, Punjabi, Urdu, Bangla, and English over Zoom. Interviews lasted an average of 84 minutes (min: 32, max: 120). I participated in 167 hours of online community events (e.g., community yoga and deep-breathing sessions), in place of the in-person community engagement that we had planned prior to the pandemic. Prior to conducting the interviews, this active engagement with participants allowed the research team to establish rapport and trust with the participants. The research team intentionally adopted this collaborative approach to enhance the rigor and quality of the data collection process and to enable reciprocity between participants and researchers to avoid extractive research practices.

5.2 Multilevel Eco-social Framework: Connections and Critiques

Our conducted studies aligned very well with Lin's (2021) multi-level eco-social framework. The multilevel eco-social framework expands on the socio-ecological model by emphasising the relationship between racialized older immigrants and healthcare access as a complex social process involving individual and contextual factors that exist between older immigrants' health needs and healthcare providers (Lin, 2021).

The first manuscript (Chapter 2) of this dissertation centered on the conceptualization of healthy aging, aligning with the innermost circle of the multi-level eco-social framework proposed by Lin (2021) called the "person/patient" level. According to Lin's model, this level examines a person/patient's identity markers and their influence on both psychological and physiological health needs. Building upon this concept, the second chapter of the dissertation delved deeper by posing the question, "What does healthy aging mean to the person/patient?" The underlying assumption was that understanding individuals' perceptions of healthy aging is crucial to address their health needs effectively. The paper argued that this understanding is especially important for a specific subgroup facing the impact of not just one, but two marginalizing identity markers: being an older adult and a racialized immigrant.

In the context of the multi-level eco-social framework's second level, referred to as "enabling resources," our study and its findings confirm several concepts. These concepts are centered around patient-provider dyads and patient-caregiver dyads, as well as labor and capital adequacy. The second manuscript (Chapter 3) of our research focused on patient engagement and healthcare decision-making, shedding light on how the mentioned interactions of the "dyads" in Lin's framework manifest for South Asian older adults. While the framework uses the term "patient-caregiver dyad" interaction, our study adopted a term more closely aligned with our

findings: "patient-family" engagement. We acknowledge that family members do not necessarily need to be caregivers to be involved in the care journey of their family members. Addressing the level of "enabling resources," the framework emphasizes understanding language and cultural barriers in patient-provider dyads. Our study provided empirical data supporting these barriers for the South Asian cohort. However, our research delved deeper into the patient-provider dyad, exploring additional factors such as gender and patient perceptions of physicians, which also impact this interaction.

Finally, according to the multi-level eco-social framework proposed by Lin (2021), structural determinants specific to racialized and marginalized communities significantly influence the healthcare experiences of older immigrants. The third manuscript of this dissertation (Chapter 4) aligns with this framework, focusing on various systemic factors that impact patient experiences at the individual level. These factors include access to care, the importance of language services, experiences of oppression and discrimination, and the influence of white supremacy, all in line with the multi-level eco-social framework. While the framework emphasizes access to care concerning the need for language services, our paper expands on this model by introducing the concept of access to virtual care and how it can either facilitate or hinder healthcare access. Additionally, we integrate the idea of "negotiating candidacy" (Koehn, 2009) in this chapter, which adds a layer in our understanding of racialized immigrant older adults' healthcare experience that is missing from the Lin's (2021) model. Under the "health care system" level of the framework, there is a mention of the "ratio of ethnically matched care providers." However, our study raises a cautionary note against assuming that cultural competence is automatically achieved simply by having ethnic representation. While Lin (2021) acknowledges this concern in the literature review of the paper, the model itself lacks the nuance

that increasing representation without meaningful and action-oriented training can often be tokenistic and merely performative.

In summary, the studies in this manuscript have put the multi-level eco-social model, derived from existing literature, to the test using empirical qualitative data in multiple languages and with participants from various countries of origin. Although our findings do not contradict the model, they contribute new insights, specifically regarding the South Asian population, such as their conceptualization of healthy aging and the factors that impact their approach to patient engagement. In line with Lin's (2021) model, our study confirms that access to care is relevant at all three levels: micro, meso, and macro. Moreover, our findings show that the impact of structural determinants and the larger system extends to influence the individual-level experiences of racialized older adults. Regarding the use of the wording of "this versus that" in the multi-level eco-social framework, our study argues that in our transnational world, post versus pre migration cannot be as easily dichotomized. Instead, it is more complex and interconnected. Lastly, an important analytical lens missing from Lin's (2021) model, which our studies bring to the forefront, is intersectionality. We show that race, class, gender, religion, and other social constructs are interrelated, dynamic, and flexible categories that operate in various degrees of tension (e.g., individual, systematic, structural, institutional, global) within broader social environments and the healthcare context (Alvi & Zaidi, 2017; Veenstra, 2011).

5.3 Future Directions for Research and Practice

Our research can assist health practitioners, government organizations, and policy makers in understanding aspects of health that are important to older adults from South Asian backgrounds. For instance, government programs that are designed to support the health of older adults tend to focus on the physical aspects of health (Clarke & James, 2003); our research

points to the importance of considering health beyond the physical and initiating programs that consider not only mental health but the mind in tandem with the body. The findings of this study can be used to advance scholarship in work related to promoting healthy aging for older adults from diverse ethnic and linguistic backgrounds by informing policy and practice change at local and possibly national levels (Lin, 2021).

Recognizing differences in cultural perspectives among racialized immigrant patients, as well as their preferences for how they want to be involved in their own care and the factors that influence provider-patient interactions, can provide healthcare providers with valuable insights (Stubbe, 2020; Zghal et al., 2021). Consistent with prior research, our study reinforces the notion that involving patients in their healthcare is not a simple matter of equating specific nationalities or cultural backgrounds with predetermined beliefs and norms (Kirby et al., 2018). Understanding such nuances that exist among patient populations, for instance, can assist providers in avoiding reliance on cultural stereotypes when engaging with patients and their families (Vela et al., 2021). Regarding the role of family in the care journey, it is important for healthcare providers to regularly assess the shifts in patients' expectations, responsibilities, and family support as a routine part of care provisions. Providers must be aware of and be attuned to the potential inclination within certain communities or among newly arrived immigrants towards reverence and deference. Health care providers should proactively create an environment that encourages alternative perspectives and make space for other ways of thinking.

Our study highlights the necessity for healthcare providers, and the larger healthcare system, to refrain from making assumptions about familial dynamics (Attum et al., 2023; Swihart et al., 2023). It is crucial to abandon the notion that all families operate in the same way (Butler et al., 2016), and the assumption that immigrant families from “collectivist cultures” are all

proponents of filial piety. Instead, a personalized approach is needed to offer culturally and individually suitable medical and healthcare advice to patients (Abrishami, 2018; Epner & Baile, 2012). Regarding virtual care, policy-makers and healthcare providers should also be mindful of the specific privacy concerns of racialized immigrant older adult populations living in multigenerational households.

To tackle challenges related to accessibility and address the need to reform healthcare at a systems level, person-centered care and cultural competence and humility are proposed as potential solutions (Gopalkrishnan, 2018). Additional research is necessary to devise innovative solutions for addressing the current challenges encountered by the racialized immigrant older adult population. Implementing such solutions at a provincial and federal level becomes especially important and relevant given the increasing number of immigrants in Canada and the growing integration of technology in healthcare practices. The findings of the study support the notion that intersectionality can be utilized to explore the unique interactions between experiences such as education, immigration status, age, and gender and how they are positioned within larger oppressive systems (Ferrer et al., 2017). It is important to acknowledge that oppressive forces such as of white supremacy, patriarchy, and capitalism, rooted in colonialism, significantly mold the experiences, in healthcare and beyond, of people of the global majority (Golash-Boza et al., 2019; Nee, 2000; Yu, 2022). The impact of Canada's colonial history continues today with perpetuating racism that is ubiquitous in our societies, and deeply entrenched at the institutional and interpersonal level (Datta et al., 2021; Grenier, 2020). Implicit in this, is the Canadian healthcare system which contributes to the perpetuation of racism and white supremacy (Phillips-Beck et al., 2020). It is, therefore, essential to start considering racism as a determinant of health (Paradies et al., 2015). Health researchers, practitioners, and decision-

makers in Canada should also not shy away from addressing the complexities of racism in combination with other “isms” (Cho et al., 2013; Datta, 2018). It is also important to move beyond an exclusive emphasis on assimilation theories, since they center around whiteness and focus on how immigrants of color become more similar or distant from the dominant group, middle-class whites, over time (Alba & Nee, 2003; Jimenez, 2010; Lee & Bean, 2010; Portes & Rumbaut, 2001; Waters, 2001; Zhou, 1997). In Canada, both the healthcare system and the scientific institutions associated with healthcare research must not remain perpetrators or passive bystanders when it comes to racism and other interlocking systems of oppression. As Angela Davis's well-known quote emphasizes, “in a racist society, it is not enough to be non-racist, we must be anti-racist" (Ali et al., 2021).

5.4 References

Abbas, M., Aloudat, T., Bartolomei, J., Carballo, M., Durieux-Paillard, S., Gabus, L., Jablonka, A., Jackson, Y., Kaojaroen, K., Koch, D., Martinez, E., Mendelson, M., Petrova-Benedict, R., Tsiodras, S., Christie, D., Saam, M., Hargreaves, S., & Pittet, D. (2018). Migrant and refugee populations: A public health and policy perspective on a continuing global crisis. *Antimicrobial Resistance and Infection Control*, *7*, 113. https://doi.org/10.1186/s13756-018-0403-4

Abrishami, D. (2018). The need for cultural competency in health care. *Radiologic Technology*, *89*(5), 441–448.

Alba, R., & Nee, V. (2005). Remaking the American mainstream: Assimilation and contemporary immigration. In *Remaking the American Mainstream*. Harvard University Press. https://doi.org/10.4159/9780674020115

Ali, H. N., Sheffield, S. L., Bauer, J. E., Caballero-Gill, R. P., Gasparini, N. M., Libarkin, J., Gonzales, K. K., Willenbring, J., Amir-Lin, E., Cisneros, J., Desai, D., Erwin, M., Gallant, E., Gomez, K. J., Keisling, B. A., Mahon, R., Marín-Spiotta, E., Welcome, L., & Schneider, B. (2021). An actionable anti-racism plan for geoscience organizations. *Nature Communications*, *12*(1), Article 1. https://doi.org/10.1038/s41467-021-23936-w

Alvi, S., & Zaidi, A. U. (2017). Invisible voices: An intersectional exploration of quality of life for elderly South Asian immigrant women in a Canadian sample. *Journal of Cross-Cultural Gerontology*, *32*(2), 147–170. https://doi.org/10.1007/s10823-017-9315-7

Attum, B., Hafiz, S., Malik, A., & Shamoon, Z. (2023). Cultural Competence in the care of Muslim patients and their families. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK499933/

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J., Rosser, S., Larson, S., Allen, M., Fu, S., & Kane, R. L. (2016). *Improving cultural competence to reduce health disparities*. Agency for Healthcare Research and Quality (US). http://www.ncbi.nlm.nih.gov/books/NBK361126/

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society*, *38*(4), 785–810. https://doi.org/10.1086/669608

Datta, G., Siddiqi, A., & Lofters, A. (2021). Transforming race-based health research in Canada. *Canadian Medical Association Journal*, *193*(3), E99–E100. https://doi.org/10.1503/cmaj.201742

De Maio, F. G. (2010). Immigration as pathogenic: A systematic review of the health of immigrants to Canada. *International Journal for Equity in Health*, *9*(1), 27. https://doi.org/10.1186/1475-9276-9-27

Epner, D. E., & Baile, W. F. (2012). Patient-centered care: The key to cultural competence. *Annals of Oncology*, *23*, 33–42. https://doi.org/10.1093/annonc/mds086

Ferrer, I., Grenier, A., Brotman, S., & Koehn, S. (2017). Understanding the experiences of racialized older people through an intersectional life course perspective. *Journal of Aging Studies*, *41*, 10–17. https://doi.org/10.1016/j.jaging.2017.02.001

Fung, H. H. (2013). Aging in culture. *The Gerontologist*, *53*(3), 369–377. https://doi.org/10.1093/geront/gnt024

Golash-Boza, T., Duenas, M. D., & Xiong, C. (2019). White supremacy, patriarchy, and global capitalism in migration studies. *American Behavioral Scientist*, *63*(13), 1741–1759. https://doi.org/10.1177/0002764219842624

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, *6*, 179. https://doi.org/10.3389/fpubh.2018.00179

Grenier, M.-L. (2020). Cultural competency and the reproduction of White supremacy in occupational therapy education. *Health Education Journal*, *79*(6), 633–644. https://doi.org/10.1177/0017896920902515

Jiménez, T. R. (2010). *Replenished ethnicity: Mexican Americans, immigration, and identity*. University of California Press.

Kirby, E., Lwin, Z., Kenny, K., Broom, A., Birman, H., & Good, P. (2018). "It doesn't exist…": Negotiating palliative care from a culturally and linguistically diverse patient and caregiver perspective. *BMC Palliative Care*, *17*(1), 90. https://doi.org/10.1186/s12904-018-0343-z

Koehn, S. (2009). Negotiating candidacy: Ethnic minority seniors' access to care. *Ageing and Society*, *29*(4), 585–608. https://doi.org/10.1017/S0144686X08007952

Lee, J., & Bean, F. D. (2007). Reinventing the color line immigration and America's new racial/ethnic divide. *Social Forces*, *86*(2), 561–586. https://doi.org/10.1093/sf/86.2.561

Lin, S. (Lamson). (2021). Access to health care among racialised immigrants to Canada in later life: A theoretical and empirical synthesis. *Ageing & Society*, *42*(8), 1735–1759. https://doi.org/10.1017/S0144686X20001841

Markides, K. S., & Rote, S. (2019). The healthy immigrant effect and aging in the United States and other Western countries. *The Gerontologist*, *59*(2), 205–214. https://doi.org/10.1093/geront/gny136

Nee, R. A., Victor. (2002). Rethinking assimilation theory for a new era of immigration. *The New Immigrant in American Society*. Routledge.

Paradies, Y., Truong, M., & Priest, N. (2014). A systematic review of the extent and measurement of healthcare provider racism. *Journal of General Internal Medicine*, *29*(2), 364–387. https://doi.org/10.1007/s11606-013-2583-1

Phillips-Beck, W., Eni, R., Lavoie, J. G., Avery Kinew, K., Kyoon Achan, G., & Katz, A. (2020). Confronting Racism within the Canadian Healthcare System: Systemic exclusion of first nations from quality and consistent care. *International Journal of Environmental Research and Public Health*, *17*(22), 8343. https://doi.org/10.3390/ijerph17228343

Portes, P. A., & Rumbaut, P. R. G. (2001). *Legacies: The story of the immigrant second generation*. University of California Press.

Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *Focus: Journal of Life Long Learning in Psychiatry*, *18*(1), 49–51. https://doi.org/10.1176/appi.focus.20190041

Swihart, D. L., Yarrarapu, S. N. S., & Martin, R. L. (2023). Cultural religious competence in clinical practice. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK493216/

Veenstra, G. (2011). Race, gender, class, and sexual orientation: Intersecting axes of inequality and self-rated health in Canada. *International Journal for Equity in Health*, *10*(1), 3. https://doi.org/10.1186/1475-9276-10-3

Vela, M. B., Erondu, A. I., Smith, N. A., Peek, M. E., Woodruff, J. N., & Chin, M. H. (2022). Eliminating explicit and implicit biases in health care: Evidence and research needs. *Annual Review of Public Health*, *43*, 477–501. https://doi.org/10.1146/annurev-publhealth-052620-103528

Waters, M. C. (2001). Black identities: West Indian immigrant dreams and American realities. In *Social stratification, class, race, and gender in sociological perspective, second edition*. Routledge.

Yu, H. (2022). Cantonese migrant networks, white supremacy, and the political utility of apologies in Canada. *Journal of Ethnic and Migration Studies*, *48*(4), 969–988. https://doi.org/10.1080/1369183X.2021.1983957

Zghal, A., El-Masri, M., McMurphy, S., & Pfaff, K. (2021). Exploring the impact of health care provider cultural competence on new immigrant health-related quality of life: A cross-sectional study of Canadian newcomers. *Journal of Transcultural Nursing*, *32*(5), 508–517. https://doi.org/10.1177/1043659620967441

Zhou, M. (1997). Segmented assimilation: Issues, controversies, and recent research on the new second generation. *International Migration Review*, *31*(4), 975–1008. https://doi.org/10.1177/019791839703100408

References

Abbas, M., Aloudat, T., Bartolomei, J., Carballo, M., Durieux-Paillard, S., Gabus, L., Jablonka, A., Jackson, Y., Kaojaroen, K., Koch, D., Martinez, E., Mendelson, M., Petrova-Benedict, R., Tsiodras, S., Christie, D., Saam, M., Hargreaves, S., & Pittet, D. (2018). Migrant and refugee populations: A public health and policy perspective on a continuing global crisis. *Antimicrobial Resistance and Infection Control*, *7*, 113. https://doi.org/10.1186/s13756-018-0403-4

Abell, M. L., Manuel, J., & Schoeneman, A. (2015). Student attitudes toward religious diversity and implications for multicultural competence. *Journal of Religion & Spirituality in Social Work: Social Thought*, *34*(1), 91–104. https://doi.org/10.1080/15426432.2014.943920

Abrishami, D. (2018). The Need for Cultural Competency in Health Care. *Radiologic Technology*, *89*(5), 441–448.

Abud, T., Kounidas, G., Martin, K. R., Werth, M., Cooper, K., & Myint, P. K. (2022). Determinants of healthy ageing: A systematic review of contemporary literature. *Aging Clinical and Experimental Research*, *34*(6), 1215–1223. https://doi.org/10.1007/s40520-021-02049-w

Adamshick, P. (2010). The lived experience of girl-to-girl aggression in marginalized girls. *Qualitative Health Research*, *20*(4), 541–555. https://doi.org/10.1177/1049732310361611

Agoritsas, T., Heen, A. F., Brandt, L., Alonso-Coello, P., Kristiansen, A., Akl, E. A., Neumann, I., Tikkinen, K. A., Weijden, T. van der, Elwyn, G., Montori, V. M., Guyatt, G. H., & Vandvik, P. O. (2015). Decision aids that really promote shared

decision making: The pace quickens. *BMJ*, *350*, g7624. https://doi.org/10.1136/bmj.g7624

Ahmad, F., Mahmood, S., Pietkiewicz, I., McDonald, L., & Ginsburg, O. (2012). Concept mapping with South Asian immigrant women: Barriers to mammography and solutions. *Journal of Immigrant and Minority Health*, *14*(2), 242–250. https://doi.org/10.1007/s10903-011-9472-7

Ahmed, S., Lee, S., Shommu, N., Rumana, N., & Turin, T. (2017). Experiences of communication barriers between physicians and immigrant patients: A systematic review and thematic synthesis. *Patient Experience Journal*, *4*(1), 122–140. https://doi.org/10.35680/2372-0247.1181

Ahmed, S., Shommu, N. S., Rumana, N., Barron, G. R. S., Wicklum, S., & Turin, T. C. (2016). Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review. *Journal of Immigrant and Minority Health*, *18*(6), 1522–1540. https://doi.org/10.1007/s10903-015-0276-z

Akgul, F. (2017). Understanding Patriarchy. In F. Akgul (Ed.), *Patriarchal Theory Reconsidered: Torture and Gender-Based Violence in Turkey* (pp. 29–65). Springer International Publishing. https://doi.org/10.1007/978-3-319-49766-2_3

Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of Language Barriers for Healthcare: A Systematic Review. *Oman Medical Journal*, *35*(2), e122. https://doi.org/10.5001/omj.2020.40

Al-Amer, R., Ramjan, L., Glew, P., Darwish, M., & Salamonson, Y. (2015). Translation of interviews from a source language to a target language: Examining issues in

cross-cultural health care research. *Journal of Clinical Nursing*, *24*(9–10), 1151–1162. https://doi.org/10.1111/jocn.12681

Alba, R., & Nee, V. (2005). Remaking the American Mainstream: Assimilation and Contemporary Immigration. In *Remaking the American Mainstream*. Harvard University Press. https://doi.org/10.4159/9780674020115

Alden, D. L., Friend, J., Lee, P. Y., Lee, Y. K., Trevena, L., Ng, C. J., Kiatpongsan, S., Lim Abdullah, K., Tanaka, M., & Limpongsanurak, S. (2018). Who Decides: Me or We? Family Involvement in Medical Decision Making in Eastern and Western Countries. *Medical Decision Making*, *38*(1), 14–25. https://doi.org/10.1177/0272989X17715628

Aldridge, R. W., Nellums, L. B., Bartlett, S., Barr, A. L., Patel, P., Burns, R., Hargreaves, S., Miranda, J. J., Tollman, S., Friedland, J. S., & Abubakar, I. (2018). Global patterns of mortality in international migrants: A systematic review and meta-analysis. *Lancet (London, England)*, *392*(10164), 2553–2566. https://doi.org/10.1016/S0140-6736(18)32781-8

Alegría, M., Carson, N., Flores, M., Li, X., Shi, P., Lessios, A. S., Polo, A., Allen, M., Fierro, M., Interian, A., Jimenez, A., La Roche, M., Lee, C., Lewis-Fernández, R., Livas-Stein, G., Safar, L., Schuman, C., Storey, J., & Shrout, P. E. (2014). Activation, self-management, engagement, and retention in behavioral health care: A randomized clinical trial of the DECIDE intervention. *JAMA Psychiatry*, *71*(5), 557–565. https://doi.org/10.1001/jamapsychiatry.2013.4519

Alegria, M., Nakash, O., Johnson, K., Ault-Brutus, A., Carson, N., Fillbrunn, M., Wang, Y., Cheng, A., Harris, T., Polo, A., Lincoln, A., Freeman, E., Bostdorf, B.,

Rosenbaum, M., Epelbaum, C., LaRoche, M., Okpokwasili-Johnson, E., Carrasco, M., & Shrout, P. E. (2018). Effectiveness of the DECIDE Interventions on Shared Decision Making and Perceived Quality of Care in Behavioral Health With Multicultural Patients: A Randomized Clinical Trial. *JAMA Psychiatry*, *75*(4), 325–335. https://doi.org/10.1001/jamapsychiatry.2017.4585

Ali, P. A., & Watson, R. (2018). Language barriers and their impact on provision of care to patients with limited English proficiency: Nurses' perspectives. *Journal of Clinical Nursing*, *27*(5–6), e1152–e1160. https://doi.org/10.1111/jocn.14204

Al-Saadi, H. (2014). *Demystifying Ontology and Epistemology in Research Methods*.

Alvi, S., & Zaidi, A. U. (2017a). Invisible Voices: An Intersectional Exploration of Quality of Life for Elderly South Asian Immigrant Women in a Canadian Sample. *Journal of Cross-Cultural Gerontology*, *32*(2), 147–170. https://doi.org/10.1007/s10823-017-9315-7

Alvi, S., & Zaidi, A. U. (2017b). Invisible Voices: An Intersectional Exploration of Quality of Life for Elderly South Asian Immigrant Women in a Canadian Sample. *Journal of Cross-Cultural Gerontology*, *32*(2), 147–170. https://doi.org/10.1007/s10823-017-9315-7

Alvi, S., & Zaidi, A. U. (2017c). Invisible Voices: An Intersectional Exploration of Quality of Life for Elderly South Asian Immigrant Women in a Canadian Sample. *Journal of Cross-Cultural Gerontology*, *32*(2), 147–170. https://doi.org/10.1007/s10823-017-9315-7

Anand, S. S., Yusuf, S., Vuksan, V., Devanesen, S., Teo, K. K., Montague, P. A., Kelemen, L., Yi, C., Lonn, E., Gerstein, H., Hegele, R. A., & McQueen, M. (2000).

Differences in risk factors, atherosclerosis, and cardiovascular disease between ethnic groups in Canada: The Study of Health Assessment and Risk in Ethnic groups (SHARE. *Lancet (London, England)*, *356*(9226), 279–284. https://doi.org/10.1016/s0140-6736(00)02502-2

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, *36*(1), 1–10.

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, *24*(3, Supplement), 68–79. https://doi.org/10.1016/S0749-3797(02)00657-8

Annele, U., Satu, K. J., & Timo, E. S. (2019). Definitions of successful ageing: A brief review of a multidimensional concept. *Acta Bio Medica : Atenei Parmensis*, *90*(2), 359–363. https://doi.org/10.23750/abm.v90i2.8376

Archer, L., Hollingworth, S., & Halsall, A. (2007). "University's not for me--I'm a Nike person": Urban, working-class young people's negotiations of "style", identity and educational engagement. *Sociology*, *41*(2), 219–237. https://doi.org/10.1177/0038038507074798

Armstrong, M. J., Shulman, L. M., Vandigo, J., & Mullins, C. D. (2016). Patient engagement and shared decision-making. *Neurology: Clinical Practice*, *6*(2), 190–197. https://doi.org/10.1212/CPJ.0000000000000240

Aruguete, M., Slater, J., & Mwaikinda, S. (2017). The Effects of Professors' Race and Clothing Style on Student Evaluations. *The Journal of Negro Education*, *86*, 494. https://doi.org/10.7709/jnegroeducation.86.4.0494

Attum, B., Hafiz, S., Malik, A., & Shamoon, Z. (2023). Cultural Competence in the Care of Muslim Patients and Their Families. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK499933/

Baah, F. O., Teitelman, A. M., & Riegel, B. (2019). Marginalization: Conceptualizing patient vulnerabilities in the framework of social determinants of health – An integrative review. *Nursing Inquiry*, *26*(1), e12268. https://doi.org/10.1111/nin.12268

Bacal, V., Blinder, H., Momoli, F., Wu, K. Y., & McFaul, S. (2019). Is Immigrant Status Associated With Cervical Cancer Screening Among Women in Canada? Results From a Cross-Sectional Study. *Journal of Obstetrics and Gynaecology Canada: JOGC = Journal d'obstetrique et Gynecologie Du Canada: JOGC*, *41*(6), 824-831.e1. https://doi.org/10.1016/j.jogc.2018.07.010

Bailey, A. (2011). *On White Shame and Vulnerability* (SSRN Scholarly Paper 1958858). https://papers.ssrn.com/abstract=1958858

Bajgain, B. B., Bajgain, K. T., Badal, S., Aghajafari, F., Jackson, J., & Santana, M.-J. (2020). Patient-Reported Experiences in Accessing Primary Healthcare among Immigrant Population in Canada: A Rapid Literature Review. *International Journal of Environmental Research and Public Health*, *17*(23), 8724. https://doi.org/10.3390/ijerph17238724

Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In *Successful aging: Perspectives from the behavioral sciences* (pp. 1–34). Cambridge University Press. https://doi.org/10.1017/CBO9780511665684.003

Barclay, J. S., Blackhall, L. J., & Tulsky, J. A. (2007). Communication strategies and cultural issues in the delivery of bad news. *Journal of Palliative Medicine*, *10*(4), 958–977. https://doi.org/10.1089/jpm.2007.9929

Barello, S., Graffigna, G., & Vegni, E. (2012). Patient Engagement as an Emerging Challenge for Healthcare Services: Mapping the Literature. *Nursing Research and Practice*, *2012*, e905934. https://doi.org/10.1155/2012/905934

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making—Pinnacle of patient-centered care. *The New England Journal of Medicine*, *366*(9), 780–781. https://doi.org/10.1056/NEJMp1109283

Bar-Tur, L. (2021). Fostering Well-Being in the Elderly: Translating Theories on Positive Aging to Practical Approaches. *Frontiers in Medicine*, *8*. https://www.frontiersin.org/articles/10.3389/fmed.2021.517226

Battiste, M. (2000). *Reclaiming Indigenous Voice and Vision*. UBC Press; UBC Press. https://www.ubcpress.ca/reclaiming-indigenous-voice-and-vision

Bauman, A. E., Fardy, H. J., & Harris, P. G. (2003). Getting it right: Why bother with patient-centred care? *The Medical Journal of Australia*, *179*(5), 253–256. https://doi.org/10.5694/j.1326-5377.2003.tb05532.x

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of Biomedical Ethics*. Oxford University Press.

Behr, L. C., Simm, A., Kluttig, A., & Grosskopf Großkopf, A. (2023). 60 years of healthy aging: On definitions, biomarkers, scores and challenges. *Ageing Research Reviews*, *88*, 101934. https://doi.org/10.1016/j.arr.2023.101934

Bejan, R. (2022). Whiteness in Question: The Anatomy of a Taxonomy Across Transnational Contexts. *Dialectical Anthropology*, *46*(3), 347–372. https://doi.org/10.1007/s10624-022-09665-6

Bell, L. (2014). Patient-centered care. *American Journal of Critical Care: An Official Publication, American Association of Critical-Care Nurses*, *23*(4), 325. https://doi.org/10.4037/ajcc2014383

Bempong, N.-E., Sheath, D., Seybold, J., Flahault, A., Depoux, A., & Saso, L. (2019). Critical reflections, challenges and solutions for migrant and refugee health: 2nd M8 Alliance Expert Meeting. *Public Health Reviews*, *40*, 3. https://doi.org/10.1186/s40985-019-0113-3

Ben, J., Cormack, D., Harris, R., & Paradies, Y. (2017). Racism and health service utilisation: A systematic review and meta-analysis. *PloS One*, *12*(12), e0189900. https://doi.org/10.1371/journal.pone.0189900

Benn-John, J. (2019). *Decolonizing Western Medicine and Systems of Care: Implications for Education* (pp. 81–93). https://doi.org/10.1007/978-3-030-25320-2_6

Benuto, L. T., Singer, J., Gonzalez, F., Casas, J., & Ruork, A. (2021). How do clinicians define cultural sensitivity?: A mixed methods study. *International Journal of Mental Health*, *50*(2), 151–167. https://doi.org/10.1080/00207411.2020.1830611

Berry, J. W., & Hou, F. (20161031). Immigrant acculturation and wellbeing in Canada. *Canadian Psychology / Psychologie Canadienne*, *57*(4), 254. https://doi.org/10.1037/cap0000064

Bin-Sallik, M. (2003). Cultural Safety: Let's name it! *The Australian Journal of Indigenous Education*, *32*, 21–28. https://doi.org/10.1017/S1326011100003793

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing*, *13*(1), 68–75. https://doi.org/10.1177/1744987107081254

Bito, S., Matsumura, S., Singer, M. K., Meredith, L. S., Fukuhara, S., & Wenger, N. S. (2007). Acculturation and End-of-Life Decision Making: Comparison of Japanese and Japanese-American Focus Groups. *Bioethics*, *21*(5), 251–262. https://doi.org/10.1111/j.1467-8519.2007.00551.x

Blackhall, L. J., Murphy, S. T., Frank, G., Michel, V., & Azen, S. (1995). Ethnicity and Attitudes Toward Patient Autonomy. *JAMA*, *274*(10), 820–825. https://doi.org/10.1001/jama.1995.03530100060035

Blair, E. (2015). A reflexive exploration of two qualitative data coding techniques. *Journal of Methods and Measurement in the Social Sciences*, *6*(1), Article 1. https://doi.org/10.2458/v6i1.18772

Blunt, K. (2007). Social Work Education. *Journal of Teaching in Social Work*, *27*(3–4), 93–114. https://doi.org/10.1300/J067v27n03_07

Boersma, K. A. (2023). *RE: Is it Time for a Change in Western medicine?* https://www.cmaj.ca/content/re-it-time-change-western-medicine, /content/re-it-time-change-western-medicine

Bokhour, B. G., Fix, G. M., Mueller, N. M., Barker, A. M., Lavela, S. L., Hill, J. N., Solomon, J. L., & Lukas, C. V. (2018). How can healthcare organizations implement patient-centered care? Examining a large-scale cultural transformation. *BMC Health Services Research*, *18*(1), 168. https://doi.org/10.1186/s12913-018-2949-5

Boland, L., Kothari, A., McCutcheon, C., Graham, I. D., & for the Integrated Knowledge Translation Research Network. (2020). Building an integrated knowledge translation (IKT) evidence base: Colloquium proceedings and research direction. *Health Research Policy and Systems*, *18*(1), 8. https://doi.org/10.1186/s12961-019-0521-3

Bond, A. (2020). Margin notes from the COVID-19 pandemic for the future of healthcare innovation. *Healthcare Management Forum*, 08404704231185487. https://doi.org/10.1177/08404704231185487

Bournes, D. A. (2000). A commitment to honoring people's choices. *Nursing Science Quarterly*, *13*(1), 18–23. https://doi.org/10.1177/089431840001300108

Bowling, A. (2007). Aspirations for Older Age in the 21st Century: What is Successful Aging? *The International Journal of Aging and Human Development*, *64*(3), 263–297. https://doi.org/10.2190/L0K1-87W4-9R01-7127

Boyd, C. M., Darer, J., Boult, C., Fried, L. P., Boult, L., & Wu, A. W. (2005). Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: Implications for pay for performance. *JAMA*, *294*(6), 716–724. https://doi.org/10.1001/jama.294.6.716

Boyd, C., Smith, C. D., Masoudi, F. A., Blaum, C. S., Dodson, J. A., Green, A. R., Kelley, A., Matlock, D., Ouellet, J., Rich, M. W., Schoenborn, N. L., & Tinetti, M. E. (2019). Decision Making for Older Adults With Multiple Chronic Conditions: Executive Summary for the American Geriatrics Society Guiding Principles on the Care of Older Adults With Multimorbidity. *Journal of the American Geriatrics Society*, *67*(4), 665–673. https://doi.org/10.1111/jgs.15809

Boyle, R. C. (2022). We are not 'Mixed', we are 'All': Understanding the educational experiences of mixed ethnicity children to enhance learner agency. *Education 3-13*, *50*(4), 471–482. https://doi.org/10.1080/03004279.2022.2052237

Brah, A. (1992). Difference, Diversity, Differentiation. *Theories of Race and Racism*. https://doi.org/10.1080/03906701.1991.9971087

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Breuker, J., & Hoekstra, R. (2004). *Epistemology and ontology in core ontologies: FOLaw and LRI-Core, two core ontologies for law*.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press. http://www.gbv.de/dms/bowker/toc/9780674224568.pdf

Bronfenbrenner, U. (1994). Ecological models of human development (Vol. 3). *International Encyclopedia of Education*.

Brooks, L. A., Manias, E., & Bloomer, M. J. (2019). Culturally sensitive communication in healthcare: A concept analysis. *Collegian*, *26*(3), 383–391. https://doi.org/10.1016/j.colegn.2018.09.007

Broom, A., Good, P., Kirby, E., & Lwin, Z. (2013). Negotiating palliative care in the context of culturally and linguistically diverse patients. *Internal Medicine Journal*, *43*(9), 1043–1046. https://doi.org/10.1111/imj.12244

Brotman, S., Ferrer, I., Sussman, T., Ryan, B., & Richard, B. (2015). Access and equity in the design and delivery of health and social care to LGBTQ older adults: A

Canadian perspective. In *The lives of LGBT older adults: Understanding challenges and resilience* (pp. 111–140). American Psychological Association. https://doi.org/10.1037/14436-006

Brottman, M. R., Char, D. M., Hattori, R. A., Heeb, R., & Taff, S. D. (2020). Toward Cultural Competency in Health Care: A Scoping Review of the Diversity and Inclusion Education Literature. *Academic Medicine: Journal of the Association of American Medical Colleges*, *95*(5), 803–813. https://doi.org/10.1097/ACM.0000000000002995

Brown, E., Patel, R., Kaur, J., & Coad, J. (2013). The South Asian culture and palliative care for children, young people, and families—A discussion paper. *Issues in Comprehensive Pediatric Nursing*, *36*(1–2), 120–143. https://doi.org/10.3109/01460862.2013.787131

Bukamal, H. (2022). Deconstructing insider–outsider researcher positionality. *British Journal of Special Education*, *49*(3), 327–349. https://doi.org/10.1111/1467-8578.12426

Burawoy, M. (2021). Why is classical theory classical? Theorizing the canon and canonizing Du Bois. *Journal of Classical Sociology*, *21*(3–4), 245–259. https://doi.org/10.1177/1468795X211036955

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J., Rosser, S., Larson, S., Allen, M., Fu, S., & Kane, R. L. (2016a). *Improving Cultural Competence to Reduce Health Disparities*. Agency for Healthcare Research and Quality (US). http://www.ncbi.nlm.nih.gov/books/NBK361126/

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J., Rosser, S., Larson, S., Allen, M., Fu, S., & Kane, R. L. (2016b). *Improving Cultural Competence to Reduce Health Disparities*. Agency for Healthcare Research and Quality (US). http://www.ncbi.nlm.nih.gov/books/NBK361126/

Campbell, E., & Lawford, K. (2021). Combating Physician-Assisted Genocide and White Supremacy in Healthcare through Anti-Oppressive Pedagogies in Canadian Medical Schools to Prevent the Coercive and Forced Sterilization of Indigenous Women. *INYI Journal*, *11*(1), Article 1. https://doi.org/10.25071/1929-8471.86

Campbell-Stephens, R. M. (2021). Introduction: Global Majority Decolonising Narratives. In R. M. Campbell-Stephens (Ed.), *Educational Leadership and the Global Majority: Decolonising Narratives* (pp. 1–21). Springer International Publishing. https://doi.org/10.1007/978-3-030-88282-2_1

Carlson, E. (2017). Anti-colonial methodologies and practices for settler colonial studies. *Settler Colonial Studies*, *7*(4), 496–517. https://doi.org/10.1080/2201473X.2016.1241213

Carman, K. L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2013a). Patient And Family Engagement: A Framework For Understanding The Elements And Developing Interventions And Policies. *Health Affairs*, *32*(2), 223–231. https://doi.org/10.1377/hlthaff.2012.1133

Carman, K. L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2013b). Patient And Family Engagement: A Framework For Understanding The Elements And Developing Interventions And Policies. *Health Affairs*, *32*(2), 223–231. https://doi.org/10.1377/hlthaff.2012.1133

Cervantes-Ortega, M., Du, S., Biegler, K. A., Al-Majid, S., Davis, K. C., Chen, Y., Kobsa, A., Mukamel, D. B., & Sorkin, D. H. (2020). Participatory decision-making for cancer care in a high-risk sample of low income Mexican-American breast cancer survivors: The role of acculturation. *International Journal of Healthcare*, *6*(2), 35–43. https://doi.org/10.5430/ijh.v6n2p35

Chambers, R. (2012). *Revolutions in Development Inquiry*. Routledge.

Chan, A. (2008). Measuring cross-cultural values: A qualitative approach. *Proceedings of Ninth International Business Research Conference, Held in Melbourne, Vic., November 2008*. https://researchdirect.westernsydney.edu.au/islandora/object/uws%3A7684/

Charles, C., Gafni, A., Whelan, T., & O'Brien, M. A. (2006). Cultural influences on the physician-patient encounter: The case of shared treatment decision-making. *Patient Education and Counseling*, *63*(3), 262–267. https://doi.org/10.1016/j.pec.2006.06.018

Chen, G.-M. (2015). Theorizing global community as cultural home in the new century. *International Journal of Intercultural Relations*, *46*. https://doi.org/10.1016/j.ijintrel.2015.03.024

Chen, H.-Y., & Boore, J. R. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing*, *19*(1–2), 234–239. https://doi.org/10.1111/j.1365-2702.2009.02896.x

Cherry, M. J. (2015). Re-Thinking the Role of the Family in Medical Decision-Making. *The Journal of Medicine and Philosophy*, *40*(4), 451–472. https://doi.org/10.1093/jmp/jhv011

Chiarenza, A., Dauvrin, M., Chiesa, V., Baatout, S., & Verrept, H. (2019). Supporting access to healthcare for refugees and migrants in European countries under particular migratory pressure. *BMC Health Services Research*, *19*, 513. https://doi.org/10.1186/s12913-019-4353-1

Chiu, C., Feuz, M. A., McMahan, R. D., Miao, Y., & Sudore, R. L. (2016). "Doctor, Make My Decisions": Decision Control Preferences, Advance Care Planning, and Satisfaction With Communication Among Diverse Older Adults. *Journal of Pain and Symptom Management*, *51*(1), 33–40. https://doi.org/10.1016/j.jpainsymman.2015.07.018

Chiu, M., Austin, P. C., Manuel, D. G., & Tu, J. V. (2010). Comparison of cardiovascular risk profiles among ethnic groups using population health surveys between 1996 and 2007. *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *182*(8), E301-310. https://doi.org/10.1503/cmaj.091676

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a Field of Intersectionality Studies: Theory, Applications, and Praxis. *Signs: Journal of Women in Culture and Society*, *38*(4), 785–810. https://doi.org/10.1086/669608

Chopra, A., & Doiphode, V. V. (2002). Ayurvedic medicine: Core concept, therapeutic principles, and current relevance. *Medical Clinics*, *86*(1), 75–89. https://doi.org/10.1016/S0025-7125(03)00073-7

Chowdhury, D., Baiocco-Romano, L., Sacco, V., El Hajj, K., & Stolee, P. (2022). Cultural Competence Interventions for Health Care Providers Working With Racialized Foreign-born Older Adults: Protocol for a Systematic Review. *JMIR Research Protocols*, *11*(7), e31691. https://doi.org/10.2196/31691

Chun, K. M., Chesla, C. A., & Kwan, C. M. L. (2011). “So We Adapt Step by Step”: Acculturation experiences affecting diabetes management and perceived health for Chinese American immigrants. *Social Science & Medicine (1982)*, *72*(2), 256–264. https://doi.org/10.1016/j.socscimed.2010.11.010

Chung, G. S., Lawrence, R. E., Curlin, F. A., Arora, V., & Meltzer, D. O. (2012). Predictors of hospitalised patients’ preferences for physician-directed medical decision-making. *Journal of Medical Ethics*, *38*(2), 77–82. https://doi.org/10.1136/jme.2010.040618

Clair, M. (2021). CRIMINALIZED SUBJECTIVITY: Du Boisian Sociology and Visions for Legal Change. *Du Bois Review: Social Science Research on Race*, *18*(2), 289–319. https://doi.org/10.1017/S1742058X21000217

Claramita, M., Nugraheni, M. D. F., van Dalen, J., & van der Vleuten, C. (2013). Doctor–patient communication in Southeast Asia: A different culture? *Advances in Health Sciences Education*, *18*(1), 15–31. https://doi.org/10.1007/s10459-012-9352-5

Clark, M., & Anderson, B. G. (1967). *Culture and Aging: An Anthropological Study of Older Americans*. C. C. Thomas.

Clarke, J. N., & James, S. (2003). The radicalized self: The impact on the self of the contested nature of the diagnosis of chronic fatigue syndrome. *Social Science & Medicine (1982)*, *57*(8), 1387–1395. https://doi.org/10.1016/s0277-9536(02)00515-4

Clayman, M. L., Roter, D., Wissow, L. S., & Bandeen-Roche, K. (2005). Autonomy-related behaviors of patient companions and their effect on decision-making activity in geriatric primary care visits. *Social Science & Medicine (1982)*, *60*(7), 1583–1591. https://doi.org/10.1016/j.socscimed.2004.08.004

Cleary, M., Horsfall, J., & Escott, P. (2014). Marginalization and associated concepts and processes in relation to mental health/illness. *Issues in Mental Health Nursing*, *35*(3), 224–226. https://doi.org/10.3109/01612840.2014.883792

Cody, W. K. (2003). Paternalism in nursing and healthcare: Central issues and their relation to theory. *Nursing Science Quarterly*, *16*(4), 288–296. https://doi.org/10.1177/0894318403257170

Cohen, P. N., & Casper, L. M. (2002). In Whose Home? Multigenerational Families in the United States, 1998–2000. *Sociological Perspectives*, *45*(1), 1–20. https://doi.org/10.1525/sop.2002.45.1.1

Collins, P. H. (1990). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (2nd ed.). Routledge. https://doi.org/10.4324/9780203900055

Constand, M. K., MacDermid, J. C., Dal Bello-Haas, V., & Law, M. (2014). Scoping review of patient-centered care approaches in healthcare. *BMC Health Services Research*, *14*, 271. https://doi.org/10.1186/1472-6963-14-271

Cooper, A. (2007). The Hanging of Angélique. *Georgia Press*. https://ugapress.org/book/9780820329406/the-hanging-of-angelique

Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *JAMA*, *282*(6), 583–589. https://doi.org/10.1001/jama.282.6.583

Cordella, A., & Shaikh, M. (2006). *From Epistemology to Ontology: Challenging the Constructed Truth of ANT*. https://doi.org/10.13140/RG.2.1.1546.5367

Corneau, S., & Stergiopoulos, V. (2012). More than being against it: Anti-racism and anti-oppression in mental health services. *Transcultural Psychiatry*, *49*(2), 261–282. https://doi.org/10.1177/1363461512441594

Corntassel, J., & Gaudry, A. (2018). 8. Insurgent Education And Indigenous- Centred Research: Opening New Pathways To Community Resurgence. In *8. Insurgent Education And Indigenous- Centred Research: Opening New Pathways To Community Resurgence* (pp. 167–185). University of Toronto Press. https://doi.org/10.3138/9781442699397-014

Cosco, T. D., Prina, A. M., Perales, J., Stephan, B. C. M., & Brayne, C. (2014). Operational definitions of successful aging: A systematic review. *International Psychogeriatrics*, *26*(3), 373–381. https://doi.org/10.1017/S1041610213002287

Cosgrove, D. M., Fisher, M., Gabow, P., Gottlieb, G., Halvorson, G. C., James, B. C., Kaplan, G. S., Perlin, J. B., Petzel, R., Steele, G. D., & Toussaint, J. S. (2013). Ten strategies to lower costs, improve quality, and engage patients: The view from leading health system CEOs. *Health Affairs (Project Hope)*, *32*(2), 321–327. https://doi.org/10.1377/hlthaff.2012.1074

Coulter, A. (2005). What do patients and the public want from primary care? *BMJ (Clinical Research Ed.)*, *331*(7526), 1199–1201. https://doi.org/10.1136/bmj.331.7526.1199

Coulter, A., Edwards, A., Elwyn, G., & Thomson, R. (2011). Implementing shared decision making in the UK. *Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen*, *105*(4), 300–304. https://doi.org/10.1016/j.zefq.2011.04.014

Coulter, A., & Ellins, J. (2007a). Effectiveness of strategies for informing, educating, and involving patients. *BMJ (Clinical Research Ed.)*, *335*(7609), 24–27. https://doi.org/10.1136/bmj.39246.581169.80

Coulter, A., & Ellins, J. (2007b). Effectiveness of strategies for informing, educating, and involving patients. *BMJ (Clinical Research Ed.)*, *335*(7609), 24–27. https://doi.org/10.1136/bmj.39246.581169.80

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, *1989*(1). https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241–1299. https://doi.org/10.2307/1229039

Creswell, J. W., & Poth, C. N. (2013). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*. SAGE Publications.

Culley, L. (2006). Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry*, *13*(2), 144–153. https://doi.org/10.1111/j.1440-1800.2006.00311.x

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Daniels, N. (1982). Equity of access to health care: Some conceptual and ethical issues. *The Milbank Memorial Fund Quarterly. Health and Society*, *60*(1), 51–81.

Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work*, *18*(4), 410–430. https://doi.org/10.1177/1468017316654341

Datta, G., Siddiqi, A., & Lofters, A. (2021). Transforming race-based health research in Canada. *Canadian Medical Association Journal*, *193*(3), E99–E100. https://doi.org/10.1503/cmaj.201742

Datta, R. (2018). Decolonizing both researcher and research and its effectiveness in Indigenous research. *Research Ethics*, *14*(2), 1–24. https://doi.org/10.1177/1747016117733296

Davis, K. (2008). Intersectionality as Buzzword: A Sociology of Science Perspective on What Makes a Feminist Theory Successful. *Feminist Theory*, *9*(1), 67–85. https://doi.org/10.1177/1464700108086364

Dawson, J., Laccos-Barrett, K., Hammond, C., & Rumbold, A. (2022). Reflexive Practice as an Approach to Improve Healthcare Delivery for Indigenous Peoples: A Systematic Critical Synthesis and Exploration of the Cultural Safety Education Literature. *International Journal of Environmental Research and Public Health*, *19*(11), 6691. https://doi.org/10.3390/ijerph19116691

De Maio, F. G. (2010). Immigration as pathogenic: A systematic review of the health of immigrants to Canada. *International Journal for Equity in Health*, *9*(1), 27. https://doi.org/10.1186/1475-9276-9-27

De Maio, F. G., & Kemp, E. (2010). The deterioration of health status among immigrants to Canada. *Global Public Health*, *5*(5), 462–478. https://doi.org/10.1080/17441690902942480

de Moissac, D., & Bowen, S. (2017). Impact of language barriers on access to healthcare for official language minority Francophones in Canada. *Healthcare Management Forum*, *30*(4), 207–212. https://doi.org/10.1177/0840470417706378

de Moissac, D., & Bowen, S. (2019). Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada. *Journal of Patient Experience*, *6*(1), 24–32. https://doi.org/10.1177/2374373518769008

Dei, G., & Asgharzadeh, A. (2001). The Power of Social Theory: The Anti-Colonial Discursive Framework. *The Journal of Educational Thought (JET) / Revue de La Pensée Éducative*, *35*(3), 297–323.

Dei, G. J. S. (2000). Rethinking the role of Indigenous knowledges in the academy. *International Journal of Inclusive Education*, *4*(2), 111–132. https://doi.org/10.1080/136031100284849

Dei, G. S. (2012). Indigenous anti-colonial knowledge as 'heritage knowledge' for promoting Black/African education in diasporic contexts. *Decolonization: Indigeneity, Education & Society*, *1*(1), Article 1. https://jps.library.utoronto.ca/index.php/des/article/view/18631

Delgado, R., & Stefancic, J. (2023). *Critical Race Theory, Fourth Edition: An Introduction*. NYU Press.

Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry*, *14*(1), 6–20. https://doi.org/10.1097/01.JGP.0000192501.03069.bc

Dhamoon, R. K., & Hankivsky, O. (2011). Why the theory and practice of intersectionality matter to health research and policy. *Health Inequities in Canada: Intersectional Frameworks and Practices*, 16–50.

Díaz-Venegas, C. (2014). Identifying the Confounders of Marginalization and Mortality in Mexico, 2003–2007. *Social Indicators Research*, *118*(2), 851–875. https://doi.org/10.1007/s11205-013-0445-1

DiCristina, B. (2015). *The Birth of Criminology: Readings from the Eighteenth and Nineteenth Centuries*. Aspen Publishing.

Dill, B. T., & Zambrana, R. E. (2009). Critical Thinking About Inequality: An Emerging Lens. In *Feminist Theory Reader* (5th ed.). Routledge.

Dilworth-Anderson, P., Moon, H., & Aranda, M. P. (2020). Dementia Caregiving Research: Expanding and Reframing the Lens of Diversity, Inclusivity, and Intersectionality. *The Gerontologist*, *60*(5), 797–805. https://doi.org/10.1093/geront/gnaa050

Dilworth-Anderson, P., Pierre, G., & Hilliard, T. S. (2012). Social Justice, Health Disparities, and Culture in the Care of the Elderly. *Journal of Law, Medicine & Ethics*, *40*(1), 26–32. https://doi.org/10.1111/j.1748-720X.2012.00642.x

Donnelly, T. T., McKellin, W., Hislop, G., & Long, B. (2009). Socioeconomic influences on Vietnamese-Canadian women's breast and cervical cancer prevention practices: A social determinant's perspective. *Social Work in Public Health*, *24*(5), 454–476. https://doi.org/10.1080/19371910802678772

Dowd, J. J., & Bengtson, V. L. (1978). Aging in minority populations. An examination of the double jeopardy hypothesis. *Journal of Gerontology*, *33*(3), 427–436. https://doi.org/10.1093/geronj/33.3.427

Edwards, M., Davies, M., & Edwards, A. (2009). What are the external influences on information exchange and shared decision-making in healthcare consultations: A meta-synthesis of the literature. *Patient Education and Counseling*, *75*(1), 37–52. https://doi.org/10.1016/j.pec.2008.09.025

Ellis, C. S., & Bochner, A. (2000). *Autoethnography, Personal Narrative, Reflexivity: Researcher as Subject*. https://works.bepress.com/carolyn_ellis/49/

Elshahat, S., Moffat, T., & Newbold, K. B. (2021). Understanding the Healthy Immigrant Effect in the Context of Mental Health Challenges: A Systematic Critical Review. *Journal of Immigrant and Minority Health*, 1–16. https://doi.org/10.1007/s10903-021-01313-5

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. (2012). Shared Decision Making: A Model for Clinical Practice. *Journal of General Internal Medicine*, *27*(10), 1361–1367. https://doi.org/10.1007/s11606-012-2077-6

Elwyn, G., Laitner, S., Coulter, A., Walker, E., Watson, P., & Thomson, R. (2010). Implementing shared decision making in the NHS. *BMJ (Clinical Research Ed.)*, *341*, c5146. https://doi.org/10.1136/bmj.c5146

Emanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician-patient relationship. *JAMA*, *267*(16), 2221–2226.

Engel, G. L. (2012). The need for a new medical model: A challenge for biomedicine. *Psychodynamic Psychiatry*, *40*(3), 377–396. https://doi.org/10.1521/pdps.2012.40.3.377

Engstrom, D. W., Piedra, L. M., & Min, J. W. (2009). Bilingual Social Workers: Language and Service Complexities. *Administration in Social Work*, *33*(2), 167–185. https://doi.org/10.1080/03643100902768832

Eni, R., Phillips-Beck, W., Achan, G. K., Lavoie, J. G., Kinew, K. A., & Katz, A. (2021). Decolonizing health in Canada: A Manitoba first nation perspective. *International Journal for Equity in Health*, *20*(1), 206. https://doi.org/10.1186/s12939-021-01539-7

Epner, D. E. (2012). Patient-centered care: The key to cultural competence. *Annals of Oncology*, *23*, 33–42.

Epner, D. E., & Baile, W. F. (2012a). Patient-centered care: The key to cultural competence. *Annals of Oncology*, *23*, 33–42. https://doi.org/10.1093/annonc/mds086

Epner, D. E., & Baile, W. F. (2012b). Patient-centered care: The key to cultural competence. *Annals of Oncology: Official Journal of the European Society for Medical Oncology*, *23 Suppl 3*, 33–42. https://doi.org/10.1093/annonc/mds086

Epstein, R. M. (2013). Whole mind and shared mind in clinical decision-making. *Patient Education and Counseling*, *90*(2), 200–206. https://doi.org/10.1016/j.pec.2012.06.035

Fang, M. L., Sixsmith, J., Sinclair, S., & Horst, G. (2016). A knowledge synthesis of culturally- and spiritually-sensitive end-of-life care: Findings from a scoping review. *BMC Geriatrics*, *16*(1), 107. https://doi.org/10.1186/s12877-016-0282-6

Fenton, S. (1999). Ethnicity and Racism. In S. Fenton, *Ethnicity* (pp. 61–87). Macmillan Education UK. https://doi.org/10.1007/978-1-349-27560-1_3

Ferrer, I., Grenier, A., Brotman, S., & Koehn, S. (2017a). Understanding the experiences of racialized older people through an intersectional life course perspective. *Journal of Aging Studies*, *41*, 10–17. https://doi.org/10.1016/j.jaging.2017.02.001

Ferrer, I., Grenier, A., Brotman, S., & Koehn, S. (2017b). Understanding the experiences of racialized older people through an intersectional life course perspective. *Journal of Aging Studies*, *41*, 10–17. https://doi.org/10.1016/j.jaging.2017.02.001

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, *34*(2), 165–181. https://doi.org/10.1080/02615479.2014.977244

Fitzpatrick, A. L., Powe, N. R., Cooper, L. S., Ives, D. G., & Robbins, J. A. (2004). Barriers to Health Care Access Among the Elderly and Who Perceives Them. *American Journal of Public Health*, *94*(10), 1788–1794.

Fix, G. M., VanDeusen Lukas, C., Bolton, R. E., Hill, J. N., Mueller, N., LaVela, S. L., & Bokhour, B. G. (2018). Patient-centred care is a way of doing things: How healthcare employees conceptualize patient-centred care. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *21*(1), 300–307. https://doi.org/10.1111/hex.12615

Flowers, D. L. (2004). Culturally Competent Nursing Care: A Challenge for the 21st Century. *Critical Care Nurse*, *24*(4), 48–52. https://doi.org/10.4037/ccn2004.24.4.48

Floyd, A., & Sakellariou, D. (2017). Healthcare access for refugee women with limited literacy: Layers of disadvantage. *International Journal for Equity in Health*, *16*(1), 195. https://doi.org/10.1186/s12939-017-0694-8

Ford, C., & Harawa, N. T. (2010). A NEW CONCEPTUALIZATION OF ETHNICITY FOR SOCIAL EPIDEMIOLOGIC AND HEALTH EQUITY RESEARCH. *Social Science & Medicine (1982)*, *71*(2), 251–258. https://doi.org/10.1016/j.socscimed.2010.04.008

Ford, S. (2004). Patient-centered Medicine, Transforming the Clinical Method (2nd edition). *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, *7*(2), 181–182. https://doi.org/10.1111/j.1369-7625.2004.00270.x

Foronda, C., Baptiste, D.-L., Reinholdt, M. M., & Ousman, K. (2016). Cultural Humility: A Concept Analysis. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society*, *27*(3), 210–217. https://doi.org/10.1177/1043659615592677

Franz, B., & Murphy, J. W. (2018). Reconsidering the role of language in medicine. *Philosophy, Ethics, and Humanities in Medicine*, *13*(1), 5. https://doi.org/10.1186/s13010-018-0058-z

Frenk, J. (1985). [Concept and measurement of accessibility]. *Salud Publica De Mexico*, *27*(5), 438–453.

Friedman, S. M., Mulhausen, P., Cleveland, M. L., Coll, P. P., Daniel, K. M., Hayward, A. D., Shah, K., Skudlarska, B., & White, H. K. (2019). Healthy Aging: American

Geriatrics Society White Paper Executive Summary. *Journal of the American Geriatrics Society*, *67*(1), 17–20. https://doi.org/10.1111/jgs.15644

Friedman, S. M., Shah, K., & Hall, W. J. (2015). Failing to Focus on Healthy Aging: A Frailty of Our Discipline? *Journal of the American Geriatrics Society*, *63*(7), 1459–1462. https://doi.org/10.1111/jgs.13512

Fung, H. H. (2013a). Aging in Culture. *The Gerontologist*, *53*(3), 369–377. https://doi.org/10.1093/geront/gnt024

Fung, H. H. (2013b). Aging in Culture. *The Gerontologist*, *53*(3), 369–377. https://doi.org/10.1093/geront/gnt024

Furlong, M., & Wight, J. (2011). Promoting "Critical Awareness" and Critiquing "Cultural Competence": Towards Disrupting Received Professional Knowledges. *Australian Social Work*, *64*(1), 38–54. https://doi.org/10.1080/0312407X.2010.537352

Furness, S. (2005). Shifting sands: Developing cultural competence. *Practice*, *17*(4), 247–256. https://doi.org/10.1080/09503150500425638

Gahayr, S. (2011). *Invisibility, disappearance and reclamation: A sociological investigation into the locations(s) of Aboriginal and African women in Canada*. 133.

Galanti, G.-A. (2000). An introduction to cultural differences. *Western Journal of Medicine*, *172*(5), 335–336.

Gallagher, S. M. (1998). Paternalism in healthcare decision making. *Ostomy/Wound Management*, *44*(4), 22, 24–25.

Galletta, M., Piazza, M. F., Meloni, S. L., Chessa, E., Piras, I., Arnetz, J. E., & D'Aloja, E. (2022). Patient Involvement in Shared Decision-Making: Do Patients Rate

Physicians and Nurses Differently? *International Journal of Environmental Research and Public Health*, *19*(21), 14229. https://doi.org/10.3390/ijerph192114229

Garran, A. M., & Rozas, L. (2013). Cultural Competence Revisited. *Journal of Ethnic & Cultural Diversity in Social Work*, *22*(2), 97–111. https://doi.org/10.1080/15313204.2013.785337

Garran, A. M., & Werkmeister Rozas, L. (2013). Cultural Competence Revisited. *Journal of Ethnic & Cultural Diversity in Social Work*, *22*(2), 97–111. https://doi.org/10.1080/15313204.2013.785337

Gauthier, N., Ellis, K., Bol, N., & Stolee, P. (2005). Beyond Knowledge Transfer: A Model of Knowledge Integration in a Clinical Setting. *Healthcare Management Forum*, *18*(4), 33–37. https://doi.org/10.1016/S0840-4704(10)60067-1

Gee, E. M., Kobayashi, K. M., & Prus, S. G. (2004). Examining the healthy immigrant effect in mid- to later life: Findings from the Canadian Community Health Survey. *Canadian Journal on Aging = La Revue Canadienne Du Vieillissement*, *23 Suppl 1*, S61-69.

Geertz, C. (1976). *The Religion of Java*. University of Chicago Press.

George, G., & Selimos, E. D. (2019). Searching for belonging and confronting exclusion: A person-centred approach to immigrant settlement experiences in Canada. *Social Identities*, *25*(2), 125–140. https://doi.org/10.1080/13504630.2017.1381834

George, P., Lennox Terrion, J., & Ahmed, R. (2014). Reproductive health behaviour of Muslim immigrant women in Canada. *International Journal of Migration, Health and Social Care*, *10*(2), 88–101. https://doi.org/10.1108/IJMHSC-09-2013-0032

Gerber, M., Barker, D., & Pühse, U. (2012). Acculturation and physical activity among immigrants: A systematic review. *Journal of Public Health*, *20*(3), 313–341. https://doi.org/10.1007/s10389-011-0443-1

Gerlach, A. J. (2015). Sharpening our critical edge: Occupational therapy in the context of marginalized populations. *Canadian Journal of Occupational Therapy. Revue Canadienne D'ergotherapie*, *82*(4), 245–253. https://doi.org/10.1177/0008417415571730

Gillon, R. (1985). Paternalism and medical ethics. *British Medical Journal (Clinical Research Ed.)*, *290*(6486), 1971–1972. https://doi.org/10.1136/bmj.290.6486.1971

Glasgow, N. J., Jeon, Y.-H., Kraus, S. G., & Pearce-Brown, C. L. (2008). Chronic disease self-management support: The way forward for Australia. *The Medical Journal of Australia*, *189*(S10), S14-16. https://doi.org/10.5694/j.1326-5377.2008.tb02203.x

Golash-Boza, T., Duenas, M. D., & Xiong, C. (2019). White Supremacy, Patriarchy, and Global Capitalism in Migration Studies. *American Behavioral Scientist*, *63*(13), 1741–1759. https://doi.org/10.1177/0002764219842624

Gopalkrishnan, N. (2018a). Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in Public Health*, *6*, 179. https://doi.org/10.3389/fpubh.2018.00179

Gopalkrishnan, N. (2018b). Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in Public Health*, *6*, 179. https://doi.org/10.3389/fpubh.2018.00179

Goranson, A., Sheeran, P., Katz, J., & Gray, K. (2020). Doctors are seen as Godlike: Moral typecasting in medicine. *Social Science & Medicine*, *258*, 113008. https://doi.org/10.1016/j.socscimed.2020.113008

Government of Canada. (2021, April 29). *Significant events in the history of Asian communities in Canada*. https://www.canada.ca/en/canadian-heritage/campaigns/asian-heritage-month/important-events.html

Government of Canada, S. C. (2022, September 8). *The Daily — Canada in 2041: A larger, more diverse population with greater differences between regions*. https://www150.statcan.gc.ca/n1/daily-quotidien/220908/dq220908a-eng.htm

Greene, J., Hibbard, J. H., Sacks, R., Overton, V., & Parrotta, C. D. (2015). When Patient Activation Levels Change, Health Outcomes And Costs Change, Too. *Health Affairs*, *34*(3), 431–437. https://doi.org/10.1377/hlthaff.2014.0452

Grenier, M.-L. (2020a). Cultural competency and the reproduction of White supremacy in occupational therapy education. *Health Education Journal*, *79*(6), 633–644. https://doi.org/10.1177/0017896920902515

Grenier, M.-L. (2020b). Cultural competency and the reproduction of White supremacy in occupational therapy education. *Health Education Journal*, *79*(6), 633–644. https://doi.org/10.1177/0017896920902515

Guest, G., MacQueen, K., & Namey, E. (2012). *Applied Thematic Analysis*. SAGE Publications, Inc. https://doi.org/10.4135/9781483384436

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does "access to health care" mean? *Journal of Health*

Services Research & Policy, *7*(3), 186–188. https://doi.org/10.1258/135581902760082517

Gupta, M., Doobay, A. V., Singh, N., Anand, S. S., Raja, F., Mawji, F., Kho, J., Karavetian, A., Yi, Q., & Yusuf, S. (2002). Risk factors, hospital management and outcomes after acute myocardial infarction in South Asian Canadians and matched control subjects. *CMAJ: Canadian Medical Association Journal*, *166*(6), 717–722.

Guruge, S., & Khanlou, N. (2004). Intersectionalities of influence: Researching the health of immigrant and refugee women. *The Canadian Journal of Nursing Research = Revue Canadienne De Recherche En Sciences Infirmieres*, *36*(3), 32–47.

Guruge, S., Thomson, M. S., George, U., & Chaze, F. (2015). Social support, social conflict, and immigrant women's mental health in a Canadian context: A scoping review. *Journal of Psychiatric and Mental Health Nursing*, *22*(9), 655–667. https://doi.org/10.1111/jpm.12216

Gurung, R. A. R., Stoa, R., Livingston, N., & Mather, H. (2021). Can success deflect racism? Clothing and perceptions of African American men. *Journal of Social Psychology*, *161*(1), 119–128. https://doi.org/10.1080/00224545.2020.1787938

Hackl, A. (2022). Good immigrants, permitted outsiders: Conditional inclusion and citizenship in comparison. *Ethnic and Racial Studies*, *45*(6), 989–1010. https://doi.org/10.1080/01419870.2021.2011938

Hall, J. M., Stevens, P. E., & Meleis, A. I. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *ANS. Advances in Nursing Science*, *16*(4), 23–41. https://doi.org/10.1097/00012272-199406000-00005

Hamilton, T. G., & Hagos, R. (2020). Race and the Healthy Immigrant Effect. *The Public Policy and Aging Report*, *31*(1), 14–18. https://doi.org/10.1093/ppar/praa042

Hancock, A.-M. (2007). When Multiplication Doesn't Equal Quick Addition: Examining Intersectionality as a Research Paradigm. *Perspectives on Politics*, *5*(1), 63–79. https://doi.org/10.1017/S1537592707070065

Hankivsky, O. (Ed.). (2011). *Health Inequities in Canada: Intersectional Frameworks and Practices* (1st edition). UBC Press.

Hannerz, U. (1992). *Cultural Complexity: Studies in the Social Organization of Meaning*. Columbia University Press.

Hardcastle, L., & Ogbogu, U. (2020). Virtual care: Enhancing access or harming care? *Healthcare Management Forum*, *33*(6), 288–292. https://doi.org/10.1177/0840470420938818

Harlap, Y., & Riese, H. (2021). Race talk and white normativity: Classroom discourse and narratives in Norwegian higher education. *Teaching in Higher Education*, *0*(0), 1–17. https://doi.org/10.1080/13562517.2021.1940925

Harmsen, H., Meeuwesen, L., van Wieringen, J., Bernsen, R., & Bruijnzeels, M. (2003). When cultures meet in general practice: Intercultural differences between GPs and parents of child patients. *Patient Education and Counseling*, *51*(2), 99–106. https://doi.org/10.1016/s0738-3991(02)00195-7

Hasnain, M., Schwartz, A., Girotti, J., Bixby, A., Rivera, L., & UIC Experiences of Care Project Group. (2013). Differences in patient-reported experiences of care by race and acculturation status. *Journal of Immigrant and Minority Health*, *15*(3), 517–524. https://doi.org/10.1007/s10903-012-9728-x

Helmich, E., Cristancho, S., Diachun, L., & Lingard, L. (2017). 'How would you call this in English?' *Perspectives on Medical Education*, *6*(2), 127–132. https://doi.org/10.1007/s40037-017-0329-1

Henderson, E. A. (2017). The Revolution Will Not Be Theorised: Du Bois, Locke, and the Howard School's Challenge to White Supremacist IR Theory. *Millennium*, *45*(3), 492–510. https://doi.org/10.1177/0305829817694246

Herring, S., Spangaro, J., Lauw, M., & McNamara, L. (2013). The Intersection of Trauma, Racism, and Cultural Competence in Effective Work with Aboriginal People: Waiting for Trust. *Australian Social Work*, *66*(1), 104–117. https://doi.org/10.1080/0312407X.2012.697566

Hester, R. J. (2012). The promise and paradox of cultural competence. *HEC Forum: An Interdisciplinary Journal on Hospitals' Ethical and Legal Issues*, *24*(4), 279–291. https://doi.org/10.1007/s10730-012-9200-2

Hibbard, J. H., & Cunningham, P. J. (2008). How engaged are consumers in their health and health care, and why does it matter? *Research Brief*, *8*, 1–9.

Hibbard, J. H., & Greene, J. (2013a). What the evidence shows about patient activation: Better health outcomes and care experiences; fewer data on costs. *Health Affairs (Project Hope)*, *32*(2), 207–214. https://doi.org/10.1377/hlthaff.2012.1061

Hibbard, J. H., & Greene, J. (2013b). What the evidence shows about patient activation: Better health outcomes and care experiences; fewer data on costs. *Health Affairs (Project Hope)*, *32*(2), 207–214. https://doi.org/10.1377/hlthaff.2012.1061

Higginbottom, G., & Safipour, J. (2015). Access to Primary Health Care by New and Established Immigrants in Canada. *Journal of Family Medicine & Community Health*, *2*, 1046.

Hilty, D. M., Gentry, M. T., McKean, A. J., Cowan, K. E., Lim, R. F., & Lu, F. G. (2020). Telehealth for rural diverse populations: Telebehavioral and cultural competencies, clinical outcomes and administrative approaches. *MHealth*, *6*, 20. https://doi.org/10.21037/mhealth.2019.10.04

Hogan, C., Lunney, J., Gabel, J., & Lynn, J. (2001). Medicare beneficiaries' costs of care in the last year of life. *Health Affairs (Project Hope)*, *20*(4), 188–195. https://doi.org/10.1377/hlthaff.20.4.188

Holroyd-Leduc, J., Resin, J., Ashley, L., Barwich, D., Elliott, J., Huras, P., Légaré, F., Mahoney, M., Maybee, A., McNeil, H., Pullman, D., Sawatzky, R., Stolee, P., & Muscedere, J. (2016). Giving voice to older adults living with frailty and their family caregivers: Engagement of older adults living with frailty in research, health care decision making, and in health policy. *Research Involvement and Engagement*, *2*, 23. https://doi.org/10.1186/s40900-016-0038-7

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr., E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366. https://doi.org/10.1037/a0032595

Hooks, B. (2000). *Feminist Theory: From Margin to Center*. Pluto Press.

Horrill, T., McMillan, D. E., Schultz, A. S. H., & Thompson, G. (2018). Understanding access to healthcare among Indigenous peoples: A comparative analysis of

biomedical and postcolonial perspectives. *Nursing Inquiry*, *25*(3), e12237. https://doi.org/10.1111/nin.12237

Hsieh, E. (2006). Understanding Medical Interpreters: Reconceptualizing Bilingual Health Communication. *Health Communication*, *20*(2), 177–186. https://doi.org/10.1207/s15327027hc2002_9

Hsueh, L., Hirsh, A. T., Maupomé, G., & Stewart, J. C. (2021a). Patient-Provider Language Concordance and Health Outcomes: A Systematic Review, Evidence Map, and Research Agenda. *Medical Care Research and Review: MCRR*, *78*(1), 3–23. https://doi.org/10.1177/1077558719860708

Hsueh, L., Hirsh, A. T., Maupomé, G., & Stewart, J. C. (2021b). Patient–Provider Language Concordance and Health Outcomes: A Systematic Review, Evidence Map, and Research Agenda. *Medical Care Research and Review*, *78*(1), 3–23. https://doi.org/10.1177/1077558719860708

Hudelson, P. (2005). Improving patient–provider communication: Insights from interpreters. *Family Practice*, *22*(3), 311–316. https://doi.org/10.1093/fampra/cmi015

Hunnicutt, G. (2009). Varieties of Patriarchy and Violence Against Women: Resurrecting "Patriarchy" as a Theoretical Tool. *Violence Against Women*, *15*(5), 553–573. https://doi.org/10.1177/1077801208331246

Igwe, P. A., Madichie, N. O., & Rugara, D. G. (2022). Decolonising research approaches towards non-extractive research. *Qualitative Market Research: An International Journal*, *25*(4), 453–468. https://doi.org/10.1108/QMR-11-2021-0135

Inhetveen, K. (2012). Translation Challenges: Qualitative Interviewing in a Multi-Lingual Field. *Qualitative Sociology Review*, *8*(2), 28–45. https://doi.org/10.18778/1733-8077.8.2.03

Islam, F., Multani, A., Hynie, M., Shakya, Y., & McKenzie, K. (2017). Mental health of South Asian youth in Peel Region, Toronto, Canada: A qualitative study of determinants, coping strategies and service access. *BMJ Open*, *7*(11), e018265. https://doi.org/10.1136/bmjopen-2017-018265

Jackson, M., & Niblo, D. (2003). The role of qualitative methodology in cross-cultural research. *Qualitative Research Journal*. https://www.semanticscholar.org/paper/The-role-of-qualitative-methodology-in-research-Jackson-Niblo/89481f606e79c0b24d2c20bd6f972f2ea02649d4

Jackson, S. A., Shiferaw, B., Anderson, R. T., Heuser, M. D., Hutchinson, K. M., & Mittelmark, M. B. (2002). Racial differences in service utilization: The Forsyth County Aging Study. *Journal of Health Care for the Poor and Underserved*, *13*(3), 320–333. https://doi.org/10.1353/hpu.2010.0721

Jakab, Z., Severoni, S., Ostlin, P., Verschuuren, M., & Stein, C. E. (2015). Refugee and migrant health: A priority in the WHO European Region. *Lancet (London, England)*, *386*(10012), 2477–2478. https://doi.org/10.1016/S0140-6736(15)01102-2

Jass, G., & Massey, D. S. (2004). *Immigrant health: Selectivity and acculturation* (Working Paper 04/23). IFS Working Papers. https://doi.org/10.1920/wp.ifs.2004.0423

Jimenez, D. E., Park, M., Rosen, D., Joo, J. hui, Garza, D. M., Weinstein, E. R., Conner, K., Silva, C., & Okereke, O. (2022). Centering Culture in Mental Health:

Differences in Diagnosis, Treatment, and Access to Care Among Older People of Color. *The American Journal of Geriatric Psychiatry*, *30*(11), 1234–1251. https://doi.org/10.1016/j.jagp.2022.07.001

Jiménez, T. R. (2010). *Replenished Ethnicity: Mexican Americans, Immigration, and Identity*. University of California Press.

Jin, K., Ding, D., Gullick, J., Koo, F., & Neubeck, L. (2015). A Chinese Immigrant Paradox? Low Coronary Heart Disease Incidence but Higher Short-Term Mortality in Western-Dwelling Chinese Immigrants: A Systematic Review and Meta-Analysis. *Journal of the American Heart Association*, *4*(12), e002568. https://doi.org/10.1161/JAHA.115.002568

Johnson, J. L., Bottorff, J. L., Browne, A. J., Grewal, S., Hilton, B. A., & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Communication*, *16*(2), 255–271. https://doi.org/10.1207/S15327027HC1602_7

Johnson, Y. M., & Munch, S. (2009). Fundamental contradictions in cultural competence. *Social Work*, *54*(3), 220–231. https://doi.org/10.1093/sw/54.3.220

Jones, A. M., Fan, J., Thomas-Olson, L., Zhang, W., & McLeod, C. B. (2023). Continuation of telework in the post-pandemic era: Healthcare employees' preference and determinants. *Healthcare Management Forum*, *36*(4), 256–262. https://doi.org/10.1177/08404704231170733

Jordan, J. E., Briggs, A. M., Brand, C. A., & Osborne, R. H. (2008). Enhancing patient engagement in chronic disease self-management support initiatives in Australia: The need for an integrated approach. *The Medical Journal of Australia*, *189*(S10), S9–S13. https://doi.org/10.5694/j.1326-5377.2008.tb02202.x

Joseph, T., & Golash-Boza, T. (2021). Double Consciousness in the 21st Century: Du Boisian Theory and the Problem of Racialized Legal Status. *Social Sciences*, *10*(9), Article 9. https://doi.org/10.3390/socsci10090345

Joshi, C., Russell, G., Cheng, I.-H., Kay, M., Pottie, K., Alston, M., Smith, M., Chan, B., Vasi, S., Lo, W., Wahidi, S. S., & Harris, M. F. (2013). A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. *International Journal for Equity in Health*, *12*(1), 88. https://doi.org/10.1186/1475-9276-12-88

Kaehne, A. (2018). Care Integration - From "One Size Fits All" to Person Centred Care Comment on "Achieving Integrated Care for Older People: Shuffling the Deckchairs or Making the System Watertight for the Future?" *International Journal of Health Policy and Management*, *7*(10), 955–957. https://doi.org/10.15171/ijhpm.2018.51

Kahn, K., & Davies, P. (2017). What Influences Shooter Bias? The Effects of Suspect Race, Neighborhood, and Clothing on Decisions to Shoot: Suspect Race, Neighborhood, and Clothing on Decisions to Shoot. *Journal of Social Issues*, *73*, 723–743. https://doi.org/10.1111/josi.12245

Kalich, A., Heinemann, L., & Ghahari, S. (2016). A Scoping Review of Immigrant Experience of Health Care Access Barriers in Canada. *Journal of Immigrant and Minority Health*, *18*(3), 697–709. https://doi.org/10.1007/s10903-015-0237-6

Kambhampati, S., Ashvetiya, T., Stone, N. J., Blumenthal, R. S., & Martin, S. S. (2016). Shared Decision-Making and Patient Empowerment in Preventive Cardiology. *Current Cardiology Reports*, *18*(5), 49. https://doi.org/10.1007/s11886-016-0729-6

Kang, H., & Kim, H. (2022). Ageism and Psychological Well-Being Among Older Adults: A Systematic Review. *Gerontology and Geriatric Medicine*, *8*, 23337214221087024. https://doi.org/10.1177/23337214221087023

Kang, M., Lessard, D., Heston, L., & Nordmaken, S. (2017). Introduction to Women, Gender, Sexuality Studies. *Women, Gender, Sexuality Studies Educational Materials*. https://doi.org/10.7275/R5QZ284K

Karnilowicz, W. (2011). Identity and psychological ownership in chronic illness and disease state. *European Journal of Cancer Care*, *20*(2), 276–282. https://doi.org/10.1111/j.1365-2354.2010.01220.x

Katz, S., & Calasanti, T. (2015). Critical Perspectives on Successful Aging: Does It "Appeal More Than It Illuminates"? *The Gerontologist*, *55*(1), 26–33. https://doi.org/10.1093/geront/gnu027

Kealy, D., & Ogrodniczuk, J. S. (2010). Marginalization of borderline personality disorder. *Journal of Psychiatric Practice*, *16*(3), 145–154. https://doi.org/10.1097/01.pra.0000375710.39713.4d

Ketay, S., Aron, A., & Hedden, T. (2009). Culture and attention: Evidence from brain and behavior. *Progress in Brain Research*, *178*, 79–92. https://doi.org/10.1016/S0079-6123(09)17806-8

Khan, T., Abimbola, S., Kyobutungi, C., & Pai, M. (2022). How we classify countries and people—And why it matters. *BMJ Global Health*, *7*(6), e009704. https://doi.org/10.1136/bmjgh-2022-009704

Kim, I.-H., Carrasco, C., Muntaner, C., McKenzie, K., & Noh, S. (2013). Ethnicity and Postmigration Health Trajectory in New Immigrants to Canada. *American Journal of Public Health*, *103*(4), e96–e104. https://doi.org/10.2105/AJPH.2012.301185

Kingori, C., Ice, G. H., Hassan, Q., Elmi, A., & Perko, E. (2018). 'If I went to my mom with that information, I'm dead': Sexual health knowledge barriers among immigrant and refugee Somali young adults in Ohio. *Ethnicity & Health*, *23*(3), 339–352. https://doi.org/10.1080/13557858.2016.1263285

Kirby, E., Lwin, Z., Kenny, K., Broom, A., Birman, H., & Good, P. (2018). "It doesn't exist…": Negotiating palliative care from a culturally and linguistically diverse patient and caregiver perspective. *BMC Palliative Care*, *17*(1), 90. https://doi.org/10.1186/s12904-018-0343-z

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Kobayashi, K. M., & Prus, S. G. (2012). Examining the gender, ethnicity, and age dimensions of the healthy immigrant effect: Factors in the development of equitable health policy. *International Journal for Equity in Health*, *11*(1), 8. https://doi.org/10.1186/1475-9276-11-8

Kobayashi, K. M., Prus, S., & Lin, Z. (2008). Ethnic differences in self-rated and functional health: Does immigrant status matter? *Ethnicity & Health*, *13*(2), 129–147. https://doi.org/10.1080/13557850701830299

Koehn, S. (2009). Negotiating candidacy: Ethnic minority seniors' access to care. *Ageing and Society*, *29*(4), 585–608. https://doi.org/10.1017/S0144686X08007952

Koehn, S., Neysmith, S., Kobayashi, K., & Khamisa, H. (2013). Revealing the shape of knowledge using an intersectionality lens: Results of a scoping review on the health and health care of ethnocultural minority older adults. *Ageing & Society*, *33*(3), 437–464. https://doi.org/10.1017/S0144686X12000013

Kools, S., Chimwaza, A., & Macha, S. (2015). Cultural humility and working with marginalized populations in developing countries. *Global Health Promotion*, *22*(1), 52–59. https://doi.org/10.1177/1757975914528728

Kothari, A., McCutcheon, C., & Graham, I. D. (2017). Defining Integrated Knowledge Translation and Moving Forward: A Response to Recent Commentaries. *International Journal of Health Policy and Management*, *6*(5), 299–300. https://doi.org/10.15171/ijhpm.2017.15

Kouritzin, S., & Nakagawa, S. (2018). Toward a non-extractive research ethics for transcultural, translingual research: Perspectives from the coloniser and the colonised. *Journal of Multilingual and Multicultural Development*, *39*(8), 675–687. https://doi.org/10.1080/01434632.2018.1427755

Krist, A. H., Tong, S. T., Aycock, R. A., & Longo, D. R. (2017a). Engaging patients in decision-making and behavior change to promote prevention. *Studies in Health Technology and Informatics*, *240*, 284–302.

Krist, A. H., Tong, S. T., Aycock, R. A., & Longo, D. R. (2017b). Engaging Patients in Decision-Making and Behavior Change to Promote Prevention. *Studies in Health Technology and Informatics*, *240*, 284–302.

Krohn, M. D., Schmidt, N. M., Lizotte, A. J., & Baldwin, J. M. (2011). The Impact of Multiple Marginality on Gang Membership and Delinquent Behavior for Hispanic,

African American, and White Male Adolescents. *Journal of Contemporary Criminal Justice*, *27*(1), 18–42. https://doi.org/10.1177/1043986211402183

Ku, L. (2007). Improving Health Insurance and Access to Care for Children in Immigrant Families. *Ambulatory Pediatrics*, *7*(6), 412–420. https://doi.org/10.1016/j.ambp.2007.08.002

Lai, D. W. L., & Chau, S. B. Y. (2007a). Predictors of health service barriers for older Chinese immigrants in Canada. *Health & Social Work*, *32*(1), 57–65. https://doi.org/10.1093/hsw/32.1.57

Lai, D. W. L., & Chau, S. B. Y. (2007b). Predictors of health service barriers for older Chinese immigrants in Canada. *Health and Social Work*, *32*(1), 57–66.

Laidsaar-Powell, R. C., Butow, P. N., Bu, S., Charles, C., Gafni, A., Lam, W. W. T., Jansen, J., McCaffery, K. J., Shepherd, H. L., Tattersall, M. H. N., & Juraskova, I. (2013). Physician-patient-companion communication and decision-making: A systematic review of triadic medical consultations. *Patient Education and Counseling*, *91*(1), 3–13. https://doi.org/10.1016/j.pec.2012.11.007

Larson, G. (2008). Anti-oppressive Practice in Mental Health. *Journal of Progressive Human Services*, *19*(1), 39–54. https://doi.org/10.1080/10428230802070223

Larson, M. L. (1984). *Meaning-based translation: A guide to cross-language equivalence / Mildred L. Larson.* University Press of America.

Lash, S. (2003). Reflexivity as Non-Linearity. *Theory, Culture & Society*, *20*(2), 49–57. https://doi.org/10.1177/0263276403020002003

Laurance, J., Henderson, S., Howitt, P. J., Matar, M., Al Kuwari, H., Edgman-Levitan, S., & Darzi, A. (2014). Patient engagement: Four case studies that highlight the

potential for improved health outcomes and reduced costs. *Health Affairs (Project Hope)*, *33*(9), 1627–1634. https://doi.org/10.1377/hlthaff.2014.0375

Lebrun, L. A., & Dubay, L. C. (2010). Access to primary and preventive care among foreign-born adults in Canada and the United States. *Health Services Research*, *45*(6 Pt 1), 1693–1719. https://doi.org/10.1111/j.1475-6773.2010.01163.x

Lee, B. A., Ogunfemi, N., Neville, H. A., & Tettegah, S. (2023). Resistance and restoration: Healing research methodologies for the global majority. *Cultural Diversity and Ethnic Minority Psychology*, *29*(1), 6–14. https://doi.org/10.1037/cdp0000394

Lee, J., & Bean, F. D. (2007). Reinventing the Color Line Immigration and America's New Racial/Ethnic Divide. *Social Forces*, *86*(2), 561–586. https://doi.org/10.1093/sf/86.2.561

Lees, N. (2021). The Brandt Line after forty years: The more North–South relations change, the more they stay the same? *Review of International Studies*, *47*(1), 85–106. https://doi.org/10.1017/S026021052000039X

Lesch, H., Burcher, K., Wharton, T., Chapple, R., & Chapple, K. (2019). Barriers to healthcare services and supports for signing deaf older adults. *Rehabilitation Psychology*, *64*(2), 237–244. https://doi.org/10.1037/rep0000252

Levesque, J.-F., Harris, M. F., & Russell, G. (2013a). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Levesque, J.-F., Harris, M. F., & Russell, G. (2013b). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Levinson, W., Kao, A., Kuby, A., & Thisted, R. A. (2005). Not all patients want to participate in decision making. A national study of public preferences. *Journal of General Internal Medicine*, *20*(6), 531–535. https://doi.org/10.1111/j.1525-1497.2005.04101.x

Lévy, R., & Jobard, F. (2011). Racial Profiling: The Parisian Police Experience. *Canadian Journal of Criminology and Criminal Justice - CAN J CRIMINOL CRIM JUSTICE*, *53*, 87–93. https://doi.org/10.3138/cjccj.53.1.87

Liamputtong, P. (2008). Doing Research in a Cross-Cultural Context: Methodological and Ethical Challenges. In P. Liamputtong (Ed.), *Doing Cross-Cultural Research* (Vol. 34, pp. 3–20). Springer Netherlands. https://doi.org/10.1007/978-1-4020-8567-3_1

Liamputtong, P. (2010). Cross-Cultural Research and Qualitative Inquiry. *Turkish Online Journal of Qualitative Inquiry*.

Lin, S. (Lamson). (2021). Access to health care among racialised immigrants to Canada in later life: A theoretical and empirical synthesis. *Ageing & Society*, *42*(8), 1735–1759. https://doi.org/10.1017/S0144686X20001841

Lin, S. (Lamson). (2023). Inequities in Mental Health Care Facing Racialized Immigrant Older Adults With Mental Disorders Despite Universal Coverage: A Population-

Based Study in Canada. *The Journals of Gerontology: Series B*, gbad036. https://doi.org/10.1093/geronb/gbad036

Liu, R., So, L., Mohan, S., Khan, N., King, K., & Quan, H. (2010). Cardiovascular risk factors in ethnic populations within Canada: Results from national cross-sectional surveys. *Open Medicine*, *4*(3), e143–e153.

Livingston, N., & Gurung, R. (2019). *Trumping Racism: The Interactions of Stereotype Incongruent Clothing, Political Racial Rhetoric, and Prejudice Toward African Americans*. *24*, 52–60. https://doi.org/10.24839/2325-7342.JN24.1.52

Livingston, R. W., & Pearce, N. A. (2009). The Teddy-Bear Effect: Does Having a Baby Face Benefit Black Chief Executive Officers? *Psychological Science*, *20*(10), 1229–1236. https://doi.org/10.1111/j.1467-9280.2009.02431.x

Lofland, J., Snow, D., Anderson, L., & Lofland, L. H. (2006). *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis, Fourth Edition*. Waveland Press.

Lor, M., Crooks, N., & Tluczek, A. (2016). A proposed model of person-, family-, and culture-centered nursing care. *Nursing Outlook*, *64*(4), 352–366. https://doi.org/10.1016/j.outlook.2016.02.006

Lorenz, T. (2020, March 20). 'Zoombombing': When Video Conferences Go Wrong. *The New York Times*. https://www.nytimes.com/2020/03/20/style/zoombombing-zoom-trolling.html

Lu, W., Pikhart, H., & Sacker, A. (2019). Domains and Measurements of Healthy Aging in Epidemiological Studies: A Review. *The Gerontologist*, *59*(4), e294–e310. https://doi.org/10.1093/geront/gny029

Lum, T. Y., & Vanderaa, J. P. (2010). Health Disparities Among Immigrant and Non-immigrant Elders: The Association of Acculturation and Education. *Journal of Immigrant and Minority Health*, *12*(5), 743–753. https://doi.org/10.1007/s10903-008-9225-4

MacLin, M. K., & Herrera, V. (2006). The Criminal Stereotype. *North American Journal of Psychology*, *8*(2), 197–207.

Mahbub, T. (2017). Case Study 2. In H. Kidwai, R. Iyengar, M. A. Witenstein, E. J. Byker, & R. Setty (Eds.), *Participatory Action Research and Educational Development: South Asian Perspectives* (pp. 235–246). Springer International Publishing. https://doi.org/10.1007/978-3-319-48905-6_11

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Marczak, B., & Scott-Railton, J. (2020). *Move Fast and Roll Your Own Crypto: A Quick Look at the Confidentiality of Zoom Meetings* (Citizen Lab Research Report No. 126). University of Toronto. https://citizenlab.ca/2020/04/move-fast-roll-your-own-crypto-a-quick-look-at-the-confidentiality-of-zoom-meetings/

Markides, K. S., & Rote, S. (2019). The Healthy Immigrant Effect and Aging in the United States and Other Western Countries. *The Gerontologist*, *59*(2), 205–214. https://doi.org/10.1093/geront/gny136

Markle-Reid, M., Ganann, R., Ploeg, J., Heald-Taylor, G., Kennedy, L., McAiney, C., & Valaitis, R. (2021). Engagement of older adults with multimorbidity as patient research partners: Lessons from a patient-oriented research program. *Journal of*

Multimorbidity and Comorbidity, *11*, 2633556521999508. https://doi.org/10.1177/2633556521999508

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, *98*, 224–253. https://doi.org/10.1037/0033-295X.98.2.224

Marmamula, S., Barrenkala, N. R., Challa, R., Kumbham, T. R., Modepalli, S. B., Yellapragada, R., Bhakki, M., Friedman, D. S., & Khanna, R. C. (2020). Falls and visual impairment among elderly residents in "homes for the aged" in India. *Scientific Reports*, *10*(1), 13389. https://doi.org/10.1038/s41598-020-70066-2

Martin, P., Kelly, N., Kahana, B., Kahana, E., Willcox, B. J., Willcox, D. C., & Poon, L. W. (2015). Defining successful aging: A tangible or elusive concept? *The Gerontologist*, *55*(1), 14–25. https://doi.org/10.1093/geront/gnu044

Mason, W. (2018). 'Swagger': Urban Youth Culture, Consumption and Social Positioning. *Sociology*, *52*(6), 1117–1133. https://doi.org/10.1177/0038038517698638

Mayrl, D. (2023). The Funk of White Souls: Toward a Du Boisian Theory of the White Church. *Sociology of Religion*, *84*(1), 16–41. https://doi.org/10.1093/socrel/srac009

Mazzocchi, F. (2006). Western science and traditional knowledge: Despite their variations, different forms of knowledge can learn from each other. *EMBO Reports*, *7*(5), 463–466. https://doi.org/10.1038/sj.embor.7400693

McAlpine, A. A., George, U., Kobayashi, K., & Fuller-Thomson, E. (2022). Physical Health of Older Canadians: Do Intersections Between Immigrant and Refugee Status, Racialized Status, and Socioeconomic Position Matter? *The International*

Journal of Aging and Human Development, *95*(3), 326–348. https://doi.org/10.1177/00914150211065408

McCall, L. (2005). The Complexity of Intersectionality. *Signs: Journal of Women in Culture and Society*, *30*(3), 1771–1800. https://doi.org/10.1086/426800

McDonald, J. T., Queen's University (Kingston, Ont.), & Metropolis Project (Eds.). (2010). *Canadian immigration: Economic evidence for a dynamic policy environment*. School of Policy Studies, Queen's University.

McGibbon, E. (2018). Decolonizing Health Care: Reconciliation Roles and Responsibilities for White Settlers. *Critical Studies: An International and Interdisciplinary Journal*, *13*(2), Article 2. https://doi.org/10.51357/cs.v13i2.127

McGibbon, E. (2019). Truth and reconciliation: Healthcare organizational leadership. *Healthcare Management Forum*, *32*(1), 20–24. https://doi.org/10.1177/0840470418803379

McKenna, L. (2022a). Translation of research interviews: Do we have a problem with qualitative rigor? *Nurse Author & Editor*, *32*(1), 1–3. https://doi.org/10.1111/nae2.31

McKenna, L. (2022b). Translation of research interviews: Do we have a problem with qualitative rigor? *Nurse Author & Editor*, *32*(1), 1–3. https://doi.org/10.1111/nae2.31

McLaughlin, S. J., Jette, A. M., & Connell, C. M. (2012). An examination of healthy aging across a conceptual continuum: Prevalence estimates, demographic patterns, and validity. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, *67*(7), 783–789. https://doi.org/10.1093/gerona/glr234

McNeil, H., Elliott, J., Huson, K., Ashbourne, J., Heckman, G., Walker, J., & Stolee, P. (2016). Engaging older adults in healthcare research and planning: A realist synthesis. *Research Involvement and Engagement*, *2*(1), 10. https://doi.org/10.1186/s40900-016-0022-2

Mehrotra, G. (2010). Toward a continuum of intersectionality theorizing for feminist social work scholarship. *Affilia: Journal of Women & Social Work*, *25*(4), 417–430. https://doi.org/10.1177/0886109910384190

Meng, X., & D'Arcy, C. (2014). Successful aging in Canada: Prevalence and predictors from a population-based sample of older adults. *Gerontology*, *60*(1), 65–72. https://doi.org/10.1159/000354538

Menichetti, J., Graffigna, G., & Steinsbekk, A. (2018). What are the contents of patient engagement interventions for older adults? A systematic review of randomized controlled trials. *Patient Education and Counseling*, *101*(6), 995–1005. https://doi.org/10.1016/j.pec.2017.12.009

Miles, R. (1989). *Racism*. Routledge. https://doi.org/10.4324/9780203633663

Mills, C. W. (2014). The Racial Contract. In *The Racial Contract*. Cornell University Press. https://doi.org/10.7591/9780801471353

Mishra, A., Gupta, A., Gupta, V., Sannd, R., & Bansal, P. (2010). Asava and Aristha: An Ayurvedic Medicine – An Overview. *Int J Pharm Biol Arch*, *1*.

Molina, R. L., & Kasper, J. (2019). The power of language-concordant care: A call to action for medical schools. *BMC Medical Education*, *19*(1), 378. https://doi.org/10.1186/s12909-019-1807-4

Monteiro, L., & Haan, M. (2022). The Life Satisfaction of Immigrants in Canada: Does Time Since Arrival Matter more than Income? *Journal of International Migration and Integration*, *23*(3), 1397–1420. https://doi.org/10.1007/s12134-021-00899-x

Mooney, G. H. (1983). Equity in health care: Confronting the confusion. *Effective Health Care*, *1*(4), 179–185.

Moore, K. N. (1995). Compliance or collaboration? The meaning for the patient. *Nursing Ethics*, *2*(1), 71–77. https://doi.org/10.1177/096973309500200109

Morris, M. (2016). Standard White: Dismantling White Normativity. *California Law Review*, *104*(4), 949–978.

Morris, N. (2021). *Mixed/Other: Explorations of Multiraciality in Modern Britain*. Orion.

Morrissey, M. B. Q., Brownell, P., & Caprio, T. (2022). Intersectionality of Race, Ethnicity, and Culture in Neglect, Abuse, and Violence Against Older Persons: Human Rights, Global Health, and Systems Approaches in Pandemics. In R. Geffner, J. W. White, L. K. Hamberger, A. Rosenbaum, V. Vaughan-Eden, & V. I. Vieth (Eds.), *Handbook of Interpersonal Violence and Abuse Across the Lifespan: A project of the National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV)* (pp. 4699–4719). Springer International Publishing. https://doi.org/10.1007/978-3-319-89999-2_337

Morse, J. M. (2010). How different is qualitative health research from qualitative research? Do we have a subdiscipline? *Qualitative Health Research*, *20*(11), 1459–1464. https://doi.org/10.1177/1049732310379116

Morse, J. M. (2015). Critical Analysis of Strategies for Determining Rigor in Qualitative Inquiry. *Qualitative Health Research*, *25*(9), 1212–1222. https://doi.org/10.1177/1049732315588501

Mullings, D. V., & Gien, L. (2013). *Culturally Competent i (Appropriate) Health and Long-Term Care Services for Older Immigrants in a Small Urban Center Of Newfoundland*. 81–89.

Nair, L., & Adetayo, O. A. (2019). Cultural Competence and Ethnic Diversity in Healthcare. *Plastic and Reconstructive Surgery Global Open*, *7*(5), e2219. https://doi.org/10.1097/GOX.0000000000002219

Nee, R. A., Victor. (2002). Rethinking Assimilation Theory for a New Era of Immigration 1. In *The New Immigrant in American Society*. Routledge.

Negrón-Gonzales, G. M. (2011). *The Making & Unmaking of Common Sense: Undocumented Latino Youth & Political Consciousness* [UC Berkeley]. https://escholarship.org/uc/item/1jx9x582

Newbold, B. (2005). Health status and health care of immigrants in Canada: A longitudinal analysis. *Journal of Health Services Research & Policy*, *10*(2), 77–83. https://doi.org/10.1258/1355819053559074

Newbold, K. B. (2006). Self-rated health within the Canadian immigrant population: Risk and the healthy immigrant effect. *Social Science & Medicine (1982)*, *60*(6), 1359–1370. https://doi.org/10.1016/j.socscimed.2004.06.048

Ng, E., & Zhang, H. (2020). The mental health of immigrants and refugees: Canadian evidence from a nationally linked database. *Health Reports*, *31*(8), 3–12. https://doi.org/10.25318/82-003-x202000800001-eng

Nguyen, G., Hsu, L., Kue, K. N., Nguyen, T., & Yuen, E. J. (2010). Partnering to collect health services and public health data in hard-to-reach communities: A community-based participatory research approach for collecting community health data. *Progress in Community Health Partnerships: Research, Education, and Action*, *4*(2), 115–119. https://doi.org/10.1353/cpr.0.0120

Nolan, M. T., Hughes, M., Narendra, D. P., Sood, J. R., Terry, P. B., Astrow, A. B., Kub, J., Thompson, R. E., & Sulmasy, D. P. (2005). When patients lack capacity: The roles that patients with terminal diagnoses would choose for their physicians and loved ones in making medical decisions. *Journal of Pain and Symptom Management*, *30*(4), 342–353. https://doi.org/10.1016/j.jpainsymman.2005.04.010

Nys, T. R. V. (2008). Paternalism in Public Health Care. *Public Health Ethics*, *1*(1), 64–72. https://doi.org/10.1093/phe/phn002

Omariba, D. W. R. (2015). Immigration, ethnicity, and avoidable mortality in Canada, 1991-2006. *Ethnicity & Health*, *20*(4), 409–436. https://doi.org/10.1080/13557858.2014.995155

Ong, L. M., de Haes, J. C., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine (1982)*, *40*(7), 903–918. https://doi.org/10.1016/0277-9536(94)00155-m

Ortiz, M. R. (2018). Patient-Centered Care: Nursing Knowledge and Policy. *Nursing Science Quarterly*, *31*(3), 291–295. https://doi.org/10.1177/0894318418774906

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed

method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Pandey, M., Maina, R. G., Amoyaw, J., Li, Y., Kamrul, R., Michaels, C. R., & Maroof, R. (2021). Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: A qualitative study. *BMC Health Services Research*, *21*(1), 741. https://doi.org/10.1186/s12913-021-06750-4

Papic, O., Malak, Z., & Rosenberg, E. (2012). Survey of family physicians' perspectives on management of immigrant patients: Attitudes, barriers, strategies, and training needs. *Patient Education and Counseling*, *86*(2), 205–209. https://doi.org/10.1016/j.pec.2011.05.015

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS ONE*, *10*(9), e0138511. https://doi.org/10.1371/journal.pone.0138511

Paradies, Y. C. (2007). Defining, conceptualizing and characterizing racism in health research. *Critical Public Health*, *16*(2), 143–157. https://doi.org/10.1080/09581590600828881

Paradies, Y., Truong, M., & Priest, N. (2014). A Systematic Review of the Extent and Measurement of Healthcare Provider Racism. *Journal of General Internal Medicine*, *29*(2), 364–387. https://doi.org/10.1007/s11606-013-2583-1

Park, S., Lee, H., & Kang, M. (2018). Factors affecting health literacy among immigrants—Systematic review. *European Journal of Public Health*, *28*(suppl_4), cky214.283. https://doi.org/10.1093/eurpub/cky214.283

Parker, M., Fang, X., & Bradlyn, A. (2020). Costs and effectiveness of a culturally tailored communication training program to increase cultural competence among multi-disciplinary care management teams. *BMC Health Services Research*, *20*(1), 784. https://doi.org/10.1186/s12913-020-05662-z

Parsons, S., Winterbottom, A., Cross, P., & Redding, D. (n.d.). *The quality of patient engagement and involvement in primary care*. 100.

Patel, S. R., & Bakken, S. (2010). Preferences for participation in decision making among ethnically diverse patients with anxiety and depression. *Community Mental Health Journal*, *46*(5), 466–473. https://doi.org/10.1007/s10597-010-9323-3

Pearson, O., Schwartzkopff, K., Dawson, A., Hagger, C., Karagi, A., Davy, C., Brown, A., Braunack-Mayer, A., & on behalf of the Leadership Group guiding the Centre for Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE). (2020). Aboriginal community controlled health organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia. *BMC Public Health*, *20*(1), 1859. https://doi.org/10.1186/s12889-020-09943-4

Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care*, *19*(2), 127–140. https://doi.org/10.1097/00005650-198102000-00001

Pérez-Stable, E. J., Nápoles-Springer, A., & Miramontes, J. M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical Care*, *35*(12), 1212–1219. https://doi.org/10.1097/00005650-199712000-00005

Phillippi, J., & Lauderdale, J. (2018). A Guide to Field Notes for Qualitative Research: Context and Conversation. *Qualitative Health Research*, *28*(3), 381–388. https://doi.org/10.1177/1049732317697102

Phillips-Beck, W., Eni, R., Lavoie, J. G., Avery Kinew, K., Kyoon Achan, G., & Katz, A. (2020). Confronting Racism within the Canadian Healthcare System: Systemic Exclusion of First Nations from Quality and Consistent Care. *International Journal of Environmental Research and Public Health*, *17*(22), 8343. https://doi.org/10.3390/ijerph17228343

Pierce, J. L., Kostova, T., & Dirks, K. T. (2003). The State of Psychological Ownership: Integrating and Extending a Century of Research. *Review of General Psychology*, *7*(1), 84–107. https://doi.org/10.1037/1089-2680.7.1.84

Pittman, P. M. (1999). Gendered experiences of health care. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*, *11*(5), 397–405. https://doi.org/10.1093/intqhc/11.5.397

Pitts, A. (2015). White Supremacy, Mass Incarceration, and Clinical Medicine: A Critical Analysis of U.S. Correctional Healthcare. *Radical Philosophy Review*, *18*(2), 267–285. https://doi.org/10.5840/radphilrev201412827

Pollock, G., Newbold, K. B., Lafrenière, G., & Edge, S. (2012). Discrimination in the Doctor's Office: Immigrants and Refugee Experiences. *Critical Social Work*, *13*(2). https://doi.org/10.22329/csw.v13i2.5866

Pon, G. (2009). Cultural Competency as New Racism: An Ontology of Forgetting. *Journal of Progressive Human Services*, *20*(1), 59–71. https://doi.org/10.1080/10428230902871173

Pon, G., Gosine, K., & Phillips, D. (2011). IMMEDIATE RESPONSE: ADDRESSING ANTI-NATIVE AND ANTI-BLACK RACISM IN CHILD WELFARE. *International Journal of Child, Youth and Family Studies*, *2*(3/4), Article 3/4. https://doi.org/10.18357/ijcyfs23/420117763

Pope, W. (1975). Durkheim as a Functionalist. *The Sociological Quarterly*, *16*(3), 361–379.

Porta, M., & Last, J. (2018). A Dictionary of Public Health. In *A Dictionary of Public Health*. Oxford University Press. https://

Portes, P. A., & Rumbaut, P. R. G. (2001). *Legacies: The Story of the Immigrant Second Generation*. University of California Press.

Prasad, K., Dwivedi, S. N., Kant, S., Vibha, D., Pandit, A. K., Karthikeyan, G., Tripathi, M., Srivastava, A. K., Nehra, A., Vivekanandhan, S., Garg, A., Chutani, A. M., Verma, V., Kumar, S., Kumar, A., Gulati, K., Gulati, A., Makharia, G., Seth, T., … Tiemeier, H. (2022). Cohort Profile: The LoCARPoN-a population-based prospective cohort study in middle-aged and older adults in India. *International Journal of Epidemiology*, *51*(1), 29–30m. https://doi.org/10.1093/ije/dyab078

Quay, T. A., Frimer, L., Janssen, P. A., & Lamers, Y. (2017). Barriers and facilitators to recruitment of South Asians to health research: A scoping review. *BMJ Open*, *7*(5), e014889. https://doi.org/10.1136/bmjopen-2016-014889

Radich, J. (2021). Cultural competence: Working towards Reconciliation. *Every Child*, *18*(2), 22–24. https://doi.org/10.3316/aeipt.193560

Raeff, C., Fasoli, A. D., Reddy, V., & Mascolo, M. F. (2020). The concept of culture: Introduction to spotlight series on conceptualizing culture. *Applied Developmental Science*, *24*(4), 295–298. https://doi.org/10.1080/10888691.2020.1789344

Ramirez, A. G. (2003). Consumer-provider communication research with special populations. *Patient Education and Counseling*, *50*(1), 51–54. https://doi.org/10.1016/s0738-3991(03)00080-6

Rao, V., Warburton, J., & Bartlett, H. (2006). Health and social needs of older Australians from culturally and linguistically diverse backgrounds: Issues and implications. *Australasian Journal on Ageing*, *25*(4), 174–179.

Rasi, S. (2020). Impact of language barriers on access to healthcare services by immigrant patients: A systematic review. *Asia Pacific Journal of Health Management*, *15*(1), 35–48. https://doi.org/10.3316/ielapa.057892660325679

Rastogi, S. (2010). Building bridges between Ayurveda and Modern Science. *International Journal of Ayurveda Research*, *1*(1), 41–46. https://doi.org/10.4103/0974-7788.59943

Reich, A. J., Claunch, K. D., Verdeja, M. A., Dungan, M. T., Anderson, S., Clayton, C. K., Goates, M. C., & Thacker, E. L. (2020). What Does "Successful Aging" Mean to you? - Systematic Review and Cross-Cultural Comparison of Lay Perspectives of Older Adults in 13 Countries, 2010-2020. *Journal of Cross-Cultural Gerontology*, *35*(4), 455–478. https://doi.org/10.1007/s10823-020-09416-6

Resane, K. T. (n.d.). White fragility, white supremacy and white normativity make theological dialogue on race difficult. *In Die Skriflig*, *55*(1), 2661. https://doi.org/10.4102/ids.v55i1.2661

Richard, L., Furler, J., Densley, K., Haggerty, J., Russell, G., Levesque, J.-F., & Gunn, J. (2016). Equity of access to primary healthcare for vulnerable populations: The IMPACT international online survey of innovations. *International Journal for Equity in Health*, *15*, 64. https://doi.org/10.1186/s12939-016-0351-7

Ridley, C. R., Baker, D. M., & Hill, C. L. (2001). Critical issues concerning cultural competence. *The Counseling Psychologist*, *29*(6), 822–832. https://doi.org/10.1177/0011000001296003

Riemer, H., Shavitt, S., Koo, M., & Markus, H. R. (2014). Preferences don't have to be personal: Expanding attitude theorizing with a cross-cultural perspective. *Psychological Review*, *121*(4), 619–648. https://doi.org/10.1037/a0037666

Ritchie, J., Lewis, J., Lewis, P. of S. P. J., Nicholls, C. M., & Ormston, R. (2003). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. SAGE.

Rodriguez, K. L., Appelt, C. J., Switzer, G. E., Sonel, A. F., & Arnold, R. M. (2008). Veterans' decision-making preferences and perceived involvement in care for chronic heart failure. *Heart & Lung: The Journal of Critical Care*, *37*(6), 440–448. https://doi.org/10.1016/j.hrtlng.2008.02.003

Romanelli, M., & Hudson, K. D. (2017). Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults. *The American Journal of Orthopsychiatry*, *87*(6), 714–728. https://doi.org/10.1037/ort0000306

Romero, M. (2017). *Introducing Intersectionality*. John Wiley & Sons.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, *37*(4), 433–440. https://doi.org/10.1093/geront/37.4.433

Rudnicka, E., Napierała, P., Podfigurna, A., Męczekalski, B., Smolarczyk, R., & Grymowicz, M. (2020). The World Health Organization (WHO) approach to healthy ageing. *Maturitas*, *139*, 6–11. https://doi.org/10.1016/j.maturitas.2020.05.018

Sacks, R. M., Greene, J., Hibbard, J., Overton, V., & Parrotta, C. D. (2017). Does patient activation predict the course of type 2 diabetes? A longitudinal study. *Patient Education and Counseling*, *100*(7), 1268–1275. https://doi.org/10.1016/j.pec.2017.01.014

Sadavoy, J., Meier, R., & Ong, A. Y. M. (2004). Barriers to access to mental health services for ethnic seniors: The Toronto study. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, *49*(3), 192–199. https://doi.org/10.1177/070674370404900307

Sadler, G. R., Lee, H.-C., Lim, R. S.-H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing & Health Sciences*, *12*(3), 369–374. https://doi.org/10.1111/j.1442-2018.2010.00541.x

Sáenz, R., & Douglas, K. (2015). A Call for the Racialization of Immigration Studies: On the Transition of Ethnic Immigrants to Racialized Immigrants. *Sociology of Race and Ethnicity*, *1*(1), 166–180. https://doi.org/10.1177/2332649214559287

Sagong, H., & Yoon, J. Y. (2021). Pathways among Frailty, Health Literacy, Acculturation, and Social Support of Middle-Aged and Older Korean Immigrants in the USA. *International Journal of Environmental Research and Public Health*, *18*(3), 1245. https://doi.org/10.3390/ijerph18031245

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient Centeredness, Cultural Competence and Healthcare Quality. *Journal of the National Medical Association*, *100*(11), 1275–1285.

Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine*, *159*(9), 997–1004. https://doi.org/10.1001/archinte.159.9.997

Sakamoto, I. (2007). An anti-oppressive approach to cultural competence. *Canadian Social Work Review / Revue Canadienne de Service Social*, *24*(1), 105–114.

Salant, T., & Lauderdale, D. S. (2003). Measuring culture: A critical review of acculturation and health in Asian immigrant populations. *Social Science & Medicine*, *57*(1), 71–90. https://doi.org/10.1016/S0277-9536(02)00300-3

Salkever, D. S. (1976). Accessibility and the demand for preventive care. *Social Science & Medicine*, *10*(9–10), 469–475. https://doi.org/10.1016/0037-7856(76)90114-1

Sallis, J. F., & Owen, N. (2015). Ecological models of health behavior. In *Health behavior: Theory, research, and practice, 5th ed* (pp. 43–64). Jossey-Bass/Wiley.

Sampaio, D. (2021). Ageing, agency and work: Brazilian older adults building spaces of opportunity in the United States. *Social & Cultural Geography*, *0*(0), 1–17. https://doi.org/10.1080/14649365.2022.2121983

Sampson, L., Dasgupta, K., & Ross, N. A. (2014). The association between socio-demographic marginalization and plasma glucose levels at diagnosis of gestational diabetes. *Diabetic Medicine: A Journal of the British Diabetic Association*, *31*(12), 1563–1567. https://doi.org/10.1111/dme.12529

Santos, H. P. O., Black, A. M., & Sandelowski, M. (2015). Timing of translation in cross-language qualitative research. *Qualitative Health Research*, *25*(1), 134–144. https://doi.org/10.1177/1049732314549603

Saunders, J. A., Haskins, M., & Vasquez, M. (2015). Cultural Competence: A Journey to an Elusive Goal. *Journal of Social Work Education*, *51*(1), 19–34. https://doi.org/10.1080/10437797.2015.977124

Savignon, S. J. (1976). *Communicative Competence: Theory and Classroom Practice.* https://eric.ed.gov/?id=ed135245

Schirato, T., & Webb, J. (2003). *Understanding Globalization* (p. 232). https://doi.org/10.4135/9781446216552

Schwei, R. J., Del Pozo, S., Agger-Gupta, N., Alvarado-Little, W., Bagchi, A., Chen, A. H., Diamond, L., Gany, F., Wong, D., & Jacobs, E. A. (2016). Changes in research on language barriers in health care since 2003: A cross-sectional review study. *International Journal of Nursing Studies*, *54*, 36–44. https://doi.org/10.1016/j.ijnurstu.2015.03.001

Searight, H. R., & Gafford, J. (2005). Cultural diversity at the end of life: Issues and guidelines for family physicians. *American Family Physician*, *71*(3), 515–522.

Seeleman, C., Suurmond, J., & Stronks, K. (2009). Cultural competence: A conceptual framework for teaching and learning. *Medical Education*, *43*(3), 229–237. https://doi.org/10.1111/j.1365-2923.2008.03269.x

Setia, M. S., Quesnel-Vallee, A., Abrahamowicz, M., Tousignant, P., & Lynch, J. (2011). Access to health-care in Canadian immigrants: A longitudinal study of the National

Population Health Survey. *Health & Social Care in the Community*, *19*(1), 70–79. https://doi.org/10.1111/j.1365-2524.2010.00950.x

Shah, S. L., & Siegel, C. A. (2015). Increasing Patient Activation Could Improve Outcomes for Patients with Inflammatory Bowel Disease. *Inflammatory Bowel Diseases*, *21*(12), 2975–2978. https://doi.org/10.1097/MIB.0000000000000575

Shay, L. A., & Lafata, J. E. (2015). Where Is the Evidence? A Systematic Review of Shared Decision Making and Patient Outcomes. *Medical Decision Making*, *35*(1), 114–131. https://doi.org/10.1177/0272989X14551638

Sheath, D., Flahault, A., Seybold, J., & Saso, L. (2020). Diverse and Complex Challenges to Migrant and Refugee Mental Health: Reflections of the M8 Alliance Expert Group on Migrant Health. *International Journal of Environmental Research and Public Health*, *17*(10), 3530. https://doi.org/10.3390/ijerph17103530

Shengelia, B., Tandon, A., Adams, O. B., & Murray, C. J. L. (2005). Access, utilization, quality, and effective coverage: An integrated conceptual framework and measurement strategy. *Social Science & Medicine (1982)*, *61*(1), 97–109. https://doi.org/10.1016/j.socscimed.2004.11.055

Shommu, N. S., Ahmed, S., Rumana, N., Barron, G. R. S., McBrien, K. A., & Turin, T. C. (2016). What is the scope of improving immigrant and ethnic minority healthcare using community navigators: A systematic scoping review. *International Journal for Equity in Health*, *15*(1), 6. https://doi.org/10.1186/s12939-016-0298-8

Shooshtari, S., Menec, V., Swift, A., & Tate, R. (2020). Exploring ethno-cultural variations in how older Canadians define healthy aging: The Canadian Longitudinal

Study on Aging (CLSA). *Journal of Aging Studies*, *52*, 100834. https://doi.org/10.1016/j.jaging.2020.100834

Shuford, J. (2010). Four Du Boisian Contributions to Critical Race Theory*. In *W.E.B. Du Bois*. Routledge.

Siegler, M. (1985). Who Should Decide? Paternalism in Health Care, by James F. Childress. *Perspectives in Biology and Medicine*, *28*(3), 452–456. https://doi.org/10.1353/pbm.1985.0033

Simmons, L. A., Wolever, R. Q., Bechard, E. M., & Snyderman, R. (2014). Patient engagement as a risk factor in personalized health care: A systematic review of the literature on chronic disease. *Genome Medicine*, *6*(2), 16. https://doi.org/10.1186/gm533

Sims, K. D., Smit, E., Batty, G. D., Hystad, P. W., & Odden, M. C. (2022). Intersectional Discrimination and Change in Blood Pressure Control Among Older Adults: The Health and Retirement Study. *The Journals of Gerontology: Series A*, *77*(2), 375–382. https://doi.org/10.1093/gerona/glab234

Søgaard, M. B., Andresen, K., & Kristiansen, M. (2021). Systematic review of patient-engagement interventions: Potentials for enhancing person-centred care for older patients with multimorbidity. *BMJ Open*, *11*(12), e048558. https://doi.org/10.1136/bmjopen-2020-048558

Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women*, *11*(1), 38–64. https://doi.org/10.1177/1077801204271476

Spears, A. K. (2021). White Supremacy and Antiblackness: Theory and Lived Experience. *Journal of Linguistic Anthropology*, *31*(2), 157–179. https://doi.org/10.1111/jola.12318

Squires, A. (2008). Language barriers and qualitative nursing research: Methodological considerations. *International Nursing Review*, *55*(3), 265–273. https://doi.org/10.1111/j.1466-7657.2008.00652.x

Statistics Canada. (2021, October 25). *Census in Brief: Ethnic and cultural origins of Canadians: Portrait of a rich heritage*. https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016016/98-200-x2016016-eng.cfm

Statistics Canada. (2023, June 28). *Immigrants' sense of belonging to Canada by province of residence*. https://www150.statcan.gc.ca/n1/pub/36-28-0001/2023006/article/00003-eng.htm

Stewart, M., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Weston, W. W., & Jordan, J. (2000). The impact of patient-centered care on outcomes. *The Journal of Family Practice*, *49*(9), 796–804.

Stewart, W. N. (2023). White/white and/or the Absence of the Modifier. *Journal of the Early Republic*, *43*(1), 101–108. https://doi.org/10.1353/jer.2023.0006

Stowe, J. D., & Cooney, T. M. (2015a). Examining Rowe and Kahn's Concept of Successful Aging: Importance of Taking a Life Course Perspective. *The Gerontologist*, *55*(1), 43–50. https://doi.org/10.1093/geront/gnu055

Stowe, J. D., & Cooney, T. M. (2015b). Examining Rowe and Kahn's Concept of Successful Aging: Importance of Taking a Life Course Perspective. *The Gerontologist*, *55*(1), 43–50. https://doi.org/10.1093/geront/gnu055

Stubbe, D. E. (2020). Practicing Cultural Competence and Cultural Humility in the Care of Diverse Patients. *Focus: Journal of Life Long Learning in Psychiatry*, *18*(1), 49–51. https://doi.org/10.1176/appi.focus.20190041

Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1995). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, *59*(4), 533–540. https://doi.org/10.1037//0022-006x.59.4.533

Sulmasy, D. P., Hughes, M. T., Thompson, R. E., Astrow, A. B., Terry, P. B., Kub, J., & Nolan, M. T. (2007). How would terminally ill patients have others make decisions for them in the event of decisional incapacity? A longitudinal study. *Journal of the American Geriatrics Society*, *55*(12), 1981–1988. https://doi.org/10.1111/j.1532-5415.2007.01473.x

Swihart, D. L., Yarrarapu, S. N. S., & Martin, R. L. (2023). Cultural Religious Competence in Clinical Practice. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK493216/

Taylor, L. S., & Lurie, N. (2004). The Role of Culturally Competent Communication in Reducing Ethnic and Racial Healthcare Disparities. *The American Journal of Managed Care*, *10*(1 SP). https://www.ajmc.com/view/sep04-1875psp001-sp00

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125. https://doi.org/10.1353/hpu.2010.0233

Thambinathan, V., & Kinsella, E. A. (2021). Decolonizing Methodologies in Qualitative Research: Creating Spaces for Transformative Praxis. *International Journal of Qualitative Methods*, *20*, 16094069211014766. https://doi.org/10.1177/16094069211014766

Thind, A., Hoq, L., Diamant, A., & Maly, R. C. (2010). Satisfaction with Care among Low-Income Women with Breast Cancer. *Journal of Women's Health*, *19*(1), 77–86. https://doi.org/10.1089/jwh.2009.1410

Todic´, J., Cook, S. C., Spitzer-Shohat, S., Williams, J. S., Battle, B. A., Jackson, J., & Chin, M. H. (2022). Critical Theory, Culture Change, and Achieving Health Equity in Health Care Settings. *Academic Medicine*, *97*(7), 977–988. https://doi.org/10.1097/ACM.0000000000004680

Tong, C. E., Lopez, K. J., Chowdhury, D., Arya, N., Elliott, J., Sims-Gould, J., Grindrod, K., & Stolee, P. (2022). Understanding racialised older adults' experiences of the Canadian healthcare system, and codesigning solutions: Protocol for a qualitative study in nine languages. *BMJ Open*, *12*(10), e068013. https://doi.org/10.1136/bmjopen-2022-068013

Tong, C. E., McKay, H. A., Martin-Matthews, A., Mahmood, A., & Sims-Gould, J. (2020). "These Few Blocks, These Are My Village": The Physical Activity and Mobility of Foreign-Born Older Adults. *The Gerontologist*, *60*(4), 638–650. https://doi.org/10.1093/geront/gnz005

Tonkin, E. (2017). The Importance of Medical Interpreters. *American Journal of Psychiatry Residents' Journal*, *12*(8), 13–13. https://doi.org/10.1176/appi.ajp-rj.2017.120806

Torres, S. (1999). A culturally-relevant theoretical framework for the study of successful ageing. *Ageing & Society*, *19*(1), 33–51. https://doi.org/10.1017/S0144686X99007242

Torres, S. (2006). Elderly Immigrants in Sweden: 'Otherness' Under Construction. *Journal of Ethnic and Migration Studies*, *32*(8), 1341–1358. https://doi.org/10.1080/13691830600928730

Torres, S. (2015). Expanding the gerontological imagination on ethnicity: Conceptual and theoretical perspectives. *Ageing & Society*, *35*(5), 935–960. https://doi.org/10.1017/S0144686X14001330

Torres, S., & Lawrence, S. (2012). An introduction to 'the age of migration' and its consequences for the field of gerontological social work. *European Journal of Social Work*, *15*(1), 1–7. https://doi.org/10.1080/13691457.2012.661562

Trefzer, A., Jackson, J. T., McKee, K., & Dellinger, K. (2014). Introduction: The Global South and/in the Global North: Interdisciplinary Investigations. *The Global South*, *8*(2), 1–15. https://doi.org/10.2979/globalsouth.8.2.1

Treitler, V. B. (2015). Social Agency and White Supremacy in Immigration Studies. *Sociology of Race and Ethnicity*, *1*(1), 153–165. https://doi.org/10.1177/2332649214560796

Triandis, H. C. (1995). *Individualism & collectivism* (pp. xv, 259). Westview Press.

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research*, *14*, 99. https://doi.org/10.1186/1472-6963-14-99

Tuyisenge, G., & Goldenberg, S. M. (2021). COVID-19, structural racism, and migrant health in Canada. *The Lancet*, *397*(10275), 650–652. https://doi.org/10.1016/S0140-6736(21)00215-4

Vahabi, M., Lofters, A., Kumar, M., & Glazier, R. H. (2016). Breast cancer screening disparities among immigrant women by world region of origin: A population-based study in Ontario, Canada. *Cancer Medicine*, *5*(7), 1670–1686. https://doi.org/10.1002/cam4.700

Vahdat, S., Hamzehgardeshi, L., Hessam, S., & Hamzehgardeshi, Z. (2014). Patient Involvement in Health Care Decision Making: A Review. *Iranian Red Crescent Medical Journal*, *16*(1), e12454. https://doi.org/10.5812/ircmj.12454

Vang, Z. M., Sigouin, J., Flenon, A., & Gagnon, A. (2017). Are immigrants healthier than native-born Canadians? A systematic review of the healthy immigrant effect in Canada. *Ethnicity & Health*, *22*(3), 209–241. https://doi.org/10.1080/13557858.2016.1246518

Veenstra, G. (2009a). Racialized identity and health in Canada: Results from a nationally representative survey. *Social Science & Medicine*, *69*(4), 538–542. https://doi.org/10.1016/j.socscimed.2009.06.009

Veenstra, G. (2009b). Racialized identity and health in Canada: Results from a nationally representative survey. *Social Science & Medicine (1982)*, *69*(4), 538–542. https://doi.org/10.1016/j.socscimed.2009.06.009

Veenstra, G. (2011). Race, gender, class, and sexual orientation: Intersecting axes of inequality and self-rated health in Canada. *International Journal for Equity in Health*, *10*(1), 3. https://doi.org/10.1186/1475-9276-10-3

Veenstra, G., & Patterson, A. C. (2015). South Asian-White health inequalities in Canada: Intersections with gender and immigrant status. *Ethnicity & Health*, *21*(6), 639–648. https://doi.org/10.1080/13557858.2016.1179725

Veenstra, G., & Patterson, A. C. (2016). South Asian-White health inequalities in Canada: Intersections with gender and immigrant status. *Ethnicity & Health*, *21*(6), 639–648. https://doi.org/10.1080/13557858.2016.1179725

Vela, M. B., Erondu, A. I., Smith, N. A., Peek, M. E., Woodruff, J. N., & Chin, M. H. (2022). Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs. *Annual Review of Public Health*, *43*, 477–501. https://doi.org/10.1146/annurev-publhealth-052620-103528

Venkatesh, B. T., Andrews, T., Mayya, S. S., Singh, M. M., & Parsekar, S. S. (2015). Perception of stigma toward mental illness in South India. *Journal of Family Medicine and Primary Care*, *4*(3), 449–453. https://doi.org/10.4103/2249-4863.161352

Verhoeven, L. (2017). Sociolinguistics and Education. In *The Handbook of Sociolinguistics* (pp. 387–404). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781405166256.ch24

Vissandjee, B., Desmeules, M., Cao, Z., Abdool, S., & Kazanjian, A. (2004). Integrating Ethnicity and Migration As Determinants of Canadian Women's Health. *BMC Women's Health*, *4 Suppl 1*, S32. https://doi.org/10.1186/1472-6874-4-S1-S32

Vogel, L. (2019). Rise of medical AI poses new legal risks for doctors. *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *191*(42), E1173–E1174. https://doi.org/10.1503/cmaj.1095823

Voltaire, F. (1746). *Philosophical Dictionary*. Penguin UK.

von Fragstein, M., Silverman, J., Cushing, A., Quilligan, S., Salisbury, H., Wiskin, C., & UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education. (2008). UK consensus statement on the content of communication curricula in undergraduate medical education. *Medical Education*, *42*(11), 1100–1107. https://doi.org/10.1111/j.1365-2923.2008.03137.x

Wahyuni, D. (2012). *The Research Design Maze: Understanding Paradigms, Cases, Methods and Methodologies* (SSRN Scholarly Paper 2103082). https://papers.ssrn.com/abstract=2103082

Wang, Q., Davis, P. B., Gurney, M. E., & Xu, R. (2021). COVID-19 and dementia: Analyses of risk, disparity, and outcomes from electronic health records in the US. *Alzheimer's & Dementia*, *17*(8), 1297–1306. https://doi.org/10.1002/alz.12296

Ward, J. (2008). White Normativity: The Cultural Dimensions of Whiteness in a Racially Diverse LGBT Organization. *Sociological Perspectives*, *51*(3), 563–586. https://doi.org/10.1525/sop.2008.51.3.563

Warner, D. F., & Brown, T. H. (2011). Understanding how race/ethnicity and gender define age-trajectories of disability: An intersectionality approach. *Social Science & Medicine*, *72*(8), 1236–1248. https://doi.org/10.1016/j.socscimed.2011.02.034

Waters, M. C. (2001). Black Identities: West Indian Immigrant Dreams and American Realities. In *Social Stratification, Class, Race, and Gender in Sociological Perspective, Second Edition*. Routledge.

Weber, L. (1998). A Conceptual Framework for Understanding Race, Class, Gender, and Sexuality. *Psychology of Women Quarterly*, *22*(1), 13–32. https://doi.org/10.1111/j.1471-6402.1998.tb00139.x

Weingart, S. N., Zhu, J., Chiappetta, L., Stuver, S. O., Schneider, E. C., Epstein, A. M., David-Kasdan, J. A., Annas, C. L., Fowler, F. J., & Weissman, J. S. (2011). Hospitalized patients' participation and its impact on quality of care and patient safety. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*, *23*(3), 269–277. https://doi.org/10.1093/intqhc/mzr002

Westwood, S. (Ed.). (2017). *Ageing, Diversity and Equality: Social Justice Perspectives*. Taylor & Francis. https://library.oapen.org/handle/20.500.12657/27534

Whitehead, M. (1992). The concepts and principles of equity and health. *International Journal of Health Services: Planning, Administration, Evaluation*, *22*(3), 429–445. https://doi.org/10.2190/986L-LHQ6-2VTE-YRRN

Williams, D. R., & Cooper, L. A. (2019). Reducing Racial Inequities in Health: Using What We Already Know to Take Action. *International Journal of Environmental Research and Public Health*, *16*(4), 606. https://doi.org/10.3390/ijerph16040606

Wodak, R., & Benke, G. (2017). Gender as a Sociolinguistic Variable: New Perspectives on Variation Studies. In *The Handbook of Sociolinguistics* (pp. 127–150). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781405166256.ch8

Wolff, J. L., Clayman, M. L., Rabins, P., Cook, M. A., & Roter, D. L. (2015). An exploration of patient and family engagement in routine primary care visits. *Health*

Expectations: An International Journal of Public Participation in Health Care and Health Policy, *18*(2), 188–198. https://doi.org/10.1111/hex.12019

Wong, R. Y. (2018a). A New Strategic Approach to Successful Aging and Healthy Aging. *Geriatrics*, *3*(4), 86. https://doi.org/10.3390/geriatrics3040086

Wong, R. Y. (2018b). A New Strategic Approach to Successful Aging and Healthy Aging. *Geriatrics*, *3*(4). https://doi.org/10.3390/geriatrics3040086

Wood, J., Stolee, P., & Tong, C. (2023). Understanding the Patient Experience of Foreign-Born Older Adults: A Scoping Review of Older Immigrants Receiving Health Care in Canada. *Canadian Journal on Aging = La Revue Canadienne Du Vieillissement*, 1–11. https://doi.org/10.1017/S0714980823000235

World Health Organization. (2016). *Patient engagement*. World Health Organization. https://apps.who.int/iris/handle/10665/252269

World Health Organization. (2021). *Global report on ageism: Executive summary*. World Health Organization. https://apps.who.int/iris/handle/10665/340205

Wulf, C. (2011). Performativity and Dynamics of Intangible Cultural Heritage. In *Ritual, Heritage and Identity*. Routledge India.

Yancy, G. (2005). Whiteness and the Return of the Black Body. *The Journal of Speculative Philosophy*, *19*(4), 215–241.

Yates, G. (1969). Rehabilitation and the general practitioner. *The Journal of the Royal College of General Practitioners*, *17*(82), 292–298.

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research: ANR*, *26*(4), 251–256. https://doi.org/10.1016/j.apnr.2013.06.008

Yosso, T. J., & Solórzano, D. G. (2005). Conceptualizing a Critical Race Theory in Sociology. In *The Blackwell Companion to Social Inequalities* (pp. 117–146). John Wiley & Sons, Ltd. https://doi.org/10.1002/9780470996973.ch7

Yu, H. (2022). Cantonese migrant networks, white supremacy, and the political utility of apologies in Canada. *Journal of Ethnic and Migration Studies*, *48*(4), 969–988. https://doi.org/10.1080/1369183X.2021.1983957

Zghal, A., El-Masri, M., McMurphy, S., & Pfaff, K. (2021). Exploring the Impact of Health Care Provider Cultural Competence on New Immigrant Health-Related Quality of Life: A Cross-Sectional Study of Canadian Newcomers. *Journal of Transcultural Nursing*, *32*(5), 508–517. https://doi.org/10.1177/1043659620967441

Zhang, Y., Su, H., Shang, L., Li, D., Wang, R., Zhang, R., & Xu, Y. (2011). Preferences and perceived involvement in treatment decision making among Chinese patients with chronic hepatitis. *Medical Decision Making: An International Journal of the Society for Medical Decision Making*, *31*(2), 245–253. https://doi.org/10.1177/0272989X10375990

Zhao, Y., Dupre, M. E., Qiu, L., & Gu, D. (2017). Changes in perceived uselessness and risks for mortality: Evidence from a National sample of older adults in China. *BMC Public Health*, *17*(1), 561. https://doi.org/10.1186/s12889-017-4479-1

Zhou, M. (1997). Segmented Assimilation: Issues, Controversies, and Recent Research on the New Second Generation. *International Migration Review*, *31*(4), 975–1008. https://doi.org/10.1177/019791839703100408

Zuckerman, P. (2004). *The Social Theory of W.E.B. Du Bois*. SAGE Publications.

Appendices

Ethics Clearance Certificates

UNIVERSITY OF WATERLOO

Notification of Ethics Clearance to Conduct Research with Human Participants

---

Principal Investigator: Paul Stolee (School of Public Health and Health Systems)

Co-Investigator: Catherine Tong (School of Public Health and Health Systems)

Co-Investigator: Jacobi Elliott (School of Public Health and Health Systems)

File #: 40977

Title: Examining the Healthcare Experiences of Foreign-Born Older Canadians: A Pilot Study

---

The Human Research Ethics Committee is pleased to inform you this study has been reviewed and given ethics clearance.

Initial Approval Date: 06/13/19 (m/d/y)

University of Waterloo Research Ethics Committees are composed in accordance with, and carry out their functions and operate in a manner consistent with, the institution's guidelines for research with human participants, the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (TCPS, 2nd edition), International Conference on Harmonization: Good Clinical Practice (ICH-GCP), the Ontario Personal Health Information Protection Act (PHIPA), the applicable laws and regulations of the province of Ontario. Both Committees are registered with the U.S. Department of Health and Human Services under the Federal Wide Assurance, FWA00021410, and IRB registration number IRB00002419 (HREC) and IRB00007409 (CREC).

This study is to be conducted in accordance with the submitted application and the most recently approved versions of all supporting materials.

Expiry Date: 06/14/20 (m/d/y)

Multi-year research must be renewed at least once every 12 months unless a more frequent review has otherwise been specified. Studies will only be renewed if the renewal report is received and approved before the expiry date. Failure to submit renewal reports will result in the investigators being notified ethics clearance has been suspended and Research Finance being notified the ethics clearance is no longer valid.

Level of review: Delegated Review

Signed on behalf of the Human Research Ethics Committee

Joanna Eidse, Research Ethics Officer, jeidse@uwaterloo.ca, 519-888-4567, ext. 37163

This above named study is to be conducted in accordance with the submitted application and the most recently approved versions of all supporting materials.

Documents reviewed and received ethics clearance for use in the study and/or received for information:

file: FBOA Interview Guide (version 2, May 29, 2019).docx

UNIVERSITY OF WATERLOO

Notification of Ethics Clearance to Conduct Research with Human Participants

---

Principal Investigator: Paul Stolee (School of Public Health Sciences)

Co-Investigator: Catherine Tong (School of Public Health Sciences)

Co-Investigator: Jacobi Elliott (School of Public Health Sciences)

Data analyst: Alexandra Whate (School of Public Health Sciences)

Research assistant: Diya Chowdhury (School of Public Health Sciences)

Research assistant: Veronica Sacco (School of Public Health Sciences)

File #: 43297

Title: Developing strategies and resources to support patient and family engagement with racialized immigrant older adults

---

The Human Research Ethics Board is pleased to inform you this study has been reviewed and given ethics clearance.

Initial Approval Date: 07/07/21 (m/d/y)

University of Waterloo Research Ethics Boards are composed in accordance with, and carry out their functions and operate in a manner consistent with, the institution's guidelines for research with human participants, the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (TCPS, 2nd edition), International Conference on Harmonization: Good Clinical Practice (ICH-GCP), the Ontario Personal Health Information Protection Act (PHIPA), the applicable laws and regulations of the province of Ontario. Both Boards are registered with the U.S. Department of Health and Human Services under the Federal Wide Assurance, FWA00021410, and IRB registration number IRB00002419 (HREB) and IRB00007409 (CREB).

This study is to be conducted in accordance with the submitted application and the most recently approved versions of all supporting materials.

Expiry Date: 07/08/22 (m/d/y)

Multi-year research must be renewed at least once every 12 months unless a more frequent review has otherwise been specified. Studies will only be renewed if the renewal report is received and approved before the expiry date. Failure to submit renewal reports will result in the investigators being notified ethics clearance has been suspended and Research Finance being notified the ethics clearance is no longer valid.

Level of review: Delegated Review

Signed on behalf of the Human Research Ethics Board

Joanna Eidse, Research Ethics Officer, jeidse@uwaterloo.ca, 519-888-4567, ext. 37163