

# Understanding Social Inclusion from the Perspectives of Tamil Seniors and Service Providers in the Greater Toronto Area

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## **Abstract**

Understanding Tamil seniors' perspectives on social inclusion in the Greater Toronto Area is critical to inform programs and policies. The researcher engaged with 27 Tamil seniors and 13 service providers using Concept Mapping and Focus Groups. The facilitators identified by seniors in Concept Mapping sessions created a seven-cluster map: family harmony; medical system; adaptation/integration; cultural-interaction; social-interaction; financial-independence; and services for employment/settlement. The critical interpretation of the map reveals seniors' emphasis on structural (e.g. old age security) and cultural (e.g. familism) dimensions. Focus Groups participants reviewed the map and their discussion on program changes focused on: reframing service delivery; culture and long-term care homes; funding/other challenges; and oblique references to socially sensitive topics. While seniors suggested necessary changes in their families, the Tamil community, and mainstream society, they remained reluctant to impose expectations on the service providers. The findings warrant more conversations between seniors and service providers, as well as inter-sectoral approaches to improve program delivery.

*This thesis is dedicated to my mother, Sumithra Sathiyamoorthy. It is because of your countless sacrifices, unconditional love, and tenacious spirit that I am in the privileged position to pursue higher education. Your words of wisdom have prepared me to face various life challenges with faith and humility.*

*Amma, you are my source of strength and inspiration.*

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*Your existence is relative to the existence of the other.*

-Sri Amma Bhagavan

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## Chapter One

### INTRODUCTION

#### 1.1 Background

As the Canadian population continues to age, unprecedented changes pose challenges to seniors, their families, and health and social care systems (Simich, Beiser, Stewart & Mwakarimba, 2005). Canada is also home for various immigrant communities from diverse ethnic origins (Statistics Canada, 2016) who are also aging but scholarly work in this area is in its infancy (McDonald, 2011). There is a need for critical policy development and service modifications to assist immigrant seniors with successful aging and their integration into Canadian society. Evidence reveals that the settlement process is facilitated when integrative approaches at the system level accommodate the specific needs of diverse community members (Carr & Chen, 2004). To better understand such integrative approaches for under-examined elderly immigrants, the graduate student (referred as “researcher” hereafter) engaged with Sri Lankan Tamil seniors to examine factors central to their social inclusion.

The aim of the proposed exploratory research is to understand the dynamics of social inclusion among Canadian Tamil seniors. **The main research question is: What factors help Tamil seniors feel socially included in the Greater Toronto Area?** For the purpose of this research, the researcher conducted a Concept Mapping (CM) (Kane & Trochim, 2007) study with Canadian Tamil seniors followed by Focus Groups (FGs) with staff of community-based agencies serving Tamil seniors. This sequential mixed-method design facilitated interpretation of the results. The planning, completion, and interpretation of this thesis project is informed by the researcher’s interdisciplinary approach (sociology, health, and diaspora studies) and drew from

the life course theory, political economy of aging, individualist-collectivist framework, and health geography.

This research is significant at several levels. The generated knowledge will contribute to the growing field of ethno gerontology research in Canada – an important but neglected field in scholarly world. The findings will address not only scholarly gaps, but are anticipated to inform health and social care programs, and policies to support aging Tamil seniors in Canada. Further, the participatory approach of the CM method provides a platform to participants to share their perspective, and may also increase their awareness and understanding of aging. Finally, the researcher aims to advance her own scholarly understanding of seniors from the Tamil community in Canada – an area she is passionate about as a Tamil Canadian.

The thesis chapters are organized to provide a comprehensive account of the relevant body of work and the research undertaken by the researcher.

The first section of **Chapter One** provides an overview of immigration in Canada, scholarly critique of the *Multiculturalism Act*, and literature on settlement challenges and social inclusion of immigrants. The next sections present the establishment of the Sri Lankan Tamil diaspora (outside of Sri Lanka) and how it has influenced aging Tamils in Canada followed by an overview of the development of ethnic-specific senior centres. Finally, a concluding summary followed by specific objectives of the thesis research is presented.

In **Chapter Two**, the researcher examines the methodology of the research project, which is informed by the Critical Social Theory. The theoretical underpinnings are presented through life course theory, political economy of aging, cultural framework of individualism-collectivism and health geography. Next, the first phase of data collection, CM, is described with details on procedures (*Brainstorming, Sorting and Rating, Interpretation* sessions) to engage with members

of senior Tamil Canadians in the Greater Toronto Area. The partner agency, the Senior Tamils' Centre of Ontario, assisted in recruiting participants and provided in-kind support. The second phase of data collection comprised of FGs with service providers, who have worked directly with the Tamil seniors, to gain a system-level perspective on the aging immigrants' experiences. These service providers have specific knowledge on the diverse and often neglected needs of immigrant groups, which is critical to understand the meso- and macro-level barriers to social inclusion.

In **Chapter Three**, the researcher reports the results from both phases of data collection. This chapter provides descriptions on all participants that were recruited in this study based on brief survey results. The CM software, Concept Systems, generated the necessary maps for interpretation. The final *Cluster Map* included seven clusters for the 72 *Brainstormed* items using similarity index for the sorted and rated data. In the *Interpretation* session, participants discussed the statements within each cluster for *importance* in relation to social inclusion and *feasibility* to address at the program level. The FG discussions with service providers were based on the same questions posed in the *Interpretation* session. The audio-recorded data was transcribed and thematically analysed, and five themes were identified. The chapter concludes with the design challenges and ethical aspects.

In **Chapter Four**, the researcher discusses the results and implications for the social and health programing and future policy. The findings of this research are expected to contribute to scholarly understandings of the challenges faced by aging immigrant Tamils to social inclusion, and their perceptions of resilience building and place-making in their adopted country as Canada.

## **1.2 Immigration in Canada**

In 1988, Canada became the first industrialized state to implement an official multiculturalism policy (Kobayashi, 1990), officially called *The Multicultural Act* (“Act”). This Act shifted multiculturalism from a celebratory policy to one of nation building and soon became a defining feature of Canadian identity. Nonetheless, discourses of Eurocentric ideals still existed, constraining the vision of multiculturalism.

Canada, as a country with large geographic area but extreme cold conditions for its substantial parts, has faced the issue of human capital right from its inception. The industrialization and economic growth of the country has added the paradox of people living longer but a decline in birth rate (Statistics Canada, 2016). Accordingly, immigration has been a necessity to counter these concerns. Adult immigrants work on arrival and contribute in the economic engine, balancing the aging population’s dependency on Canada’s social welfare systems (Mérette, 2009; Kustec, 2012). As a result, two major waves of immigration have occurred: 1) when individuals only from ‘preferred’ (read White European) countries migrated after the World Wars, and 2) when more racialized individuals began to enter Canada in the late 1960s after the removal of preference for European origin in immigration policies. Under this new system, incoming immigrants were no longer assessed on their race, but rather on education, training, knowledge of English language, job prospects in Canada, and adaptability via the point-system (Segal et al., 2010). Further, different immigration classes were developed to identify their migration trajectory and include family, refugees, and independent immigrants via the point-system and sponsored family members via a separate application (Segal et al., 2010). Thus, the demographic profile of Canada has changed overtime.

The 2016 Census states that 7.5 million Canadians are immigrants from more than 200 countries of birth (Statistics Canada, 2016). Further, approximately 1.2 million residents are recent immigrants who migrated from 2011 to 2016. Among this group, the top ten countries of birth starting from the biggest contributor include the Philippines, India, China, Iran, Pakistan, United States, Syria, United Kingdom, France and South Korea (Statistics Canada, 2016). The dominant groups of refugees in Canada have arrived from Cambodia, Chile, Tibet, Vietnam, Uganda, Ukraine, and Sri Lanka (Tator, Henry, Mattis & Rees, 2000; Statistics Canada, 2016).

However, the resulting heterogeneous society that, in writing, has embraced differences in ethnic origins and religions remains somewhat an idealized vision rather than an actualized reality. For instance, the history of Canada is not free of discriminatory and racist practices that have specifically marginalized non-British and non-French groups. Some historic examples include the Chinese Head Tax, anti-Asian riots, internment of Japanese, Italians, and Germans, the desolation of Indigenous groups, turning away Jews and Blacks at the border. (Cho, 2002; Lee, 2007; Bolaria & Li, 1988; Iacovetta, Perin & Principe, 2000). One might argue that covert racism may have decreased overtime, but Eurocentric ideals still overtly prevail across immigration policies. Likewise, refugee policies show declining humanitarianism although Canada had once received the Nansen Refugee Award in recognition for its outstanding service to the cause of refugees (Dauvergne, 2012). A recent example is the detainment of 492 Sri Lankan Tamil individuals who arrived in 2010 via boat in British Columbia to seek refuge from war crimes but experienced harsh treatment (Medianu, Sutter & Esses, 2015).

Several scholars critique the simplistic notions of Canadian multiculturalism (Arat-Koc, 2005; Bannerji, 2000; Mackey, 2002; McLaren, 1994). These theorists argue that multiculturalism promotes conformity to mainstream Canadian culture in the public domain and

tolerates ethnic-specific cultures in the private domain (Bun, 2004). Hence, multiculturalism is a means to eventual assimilation via a one-way integration as opposed to a two-way integration. Further, to become a full member of society means not only having the same access to work and educational opportunities as other citizens, but also having a sense of belonging, acceptance, and inclusion in Canadian society (Alba & Foner, 2015). Given the Act officially promotes equal participation of all individuals and groups in Canadian society, and seeks feedback to eliminate barriers to participation, two-way integration is an opportunity for different groups to interact, learn new values, and gain new membership. However, two-way integration has been difficult for many immigrants (Goodman & Wright, 2015). Those who do not find themselves reflected in this process feel alienated from society and therefore less attached (Goodman & Wright, 2015). Thus, a non-functional multiculturalism through a shortcoming of the Act could become a means to sustain the status quo as opposed to ensuring a more equitable society through meaningful praxis of two-way integration.

Further, integration of Canadian elderly immigrants is of growing concern for family caregivers, service providers, and policy-makers. Elderly immigrants are comprised of two groups primarily: 1) long established immigrants who arrived in the independent economic class, or 2) recent cohorts who arrived in old age through sponsorship applications (i.e. family reunification or 10 year Super Visa program) (Simich, Beiser, Stewart & Mwakarimba, 2005). The immigration policy of a 10-year visitor visa employed in 2011 was skewed towards recognizing the needs of independent class immigrants specifically (Root, Gates-Gasse, Shields & Bauder, 2014). Those who arrive through the 10-year visitor visa have restrictive access to health coverage and social assistance programs; they have become dependent on their sponsors for the 10 years, thus impacting their settlement and feelings of inclusion (Simich et al., 2005).

As such, it is important to recognize that even amongst immigrants, there are nuances to each particular group in terms of arrival date and conditions upon arrival.

### **1.3 Settlement Challenges**

Settlement challenges can be discussed critically using the social ecological approach as a framework to understand the interactive effects of individual (microsystem), community (mesosystem) and societal factors (macrosystem) that affect perceptions of inclusion (Green, Richard and Potvin, 1996; Grzywacz and Fuqua, 2000). Bronfenbrenner (1994), a significant contributor to the development of this theory, suggests that human beings develop according to their environment. In the post-settlement context for immigrants, all three levels contribute a considerable amount to the lifestyle of the individuals, acculturation, and the relative success of integration.

Existing scholarly works exhibit that immigrants experience several settlement challenges. At the individual level, recent immigrants encounter challenges with acquiring the English/French language, navigating various systems, integrating into the Canadian culture and lifestyle, seeking employment, and accessing a supportive network (Gierveld, Van der Pas & Keating, 2015). For immigrants with family in Canada, existing connections tend to be supportive and protective, thus slightly reducing barriers to integration. However, changes to family dynamics, role reversals, expectations and conflicting values may become overwhelming and contribute to social isolation (Yeh, 2003). At the meso level, attachment to an ethnic community of origin facilitates access to resources and connections to their homeland (McMichael & Manderson, 2004). In maintaining social and economical ties to multiple countries via common ethnic origin, or other types of intra-group affinity, immigrants often seek opportunities to engage in transnational practices (Levitt & Waters, 2002). Access to social

support impacts their sense of belonging, connectedness and isolation (Kelaher, Potts & Manderson, 2001), and the lack thereof can result in poor integration (Keown-Bomar, 2004).

At the macro level, scholarly work also demonstrates that institutional discrimination in hiring practices, housing policies, and civic engagement all affect how well immigrants remain connected and socially engaged (Ajrouch, 2017). Economists argue immigrants may become dependent on the government with no accessible alternatives (Sen, 2000). Employment conditions, and recognition of immigrants' previous educational and employment credentials at the system level will largely affect their integration into the labour market. Some scholars have observed employment within ethnic communities as a strategy used to counter unemployment among immigrants because of the spatial concentration of immigrants in urban cities (Ley and Germain, 2000). However, the concern with such settlements is the high degree of residential segregation and risk of ethnic enclaves, which may limit opportunities for immigrants to avail their full potential and participate fully in the broader society. Indeed, city and provincial policies also play a central role in enabling conditions for full inclusion of immigrants into community life, the labour market, and Canadian society (Polese & Stren, 2000).

Researchers examining the process of acculturation argue cultures are not static and immigrants face challenges in maintaining their core cultural beliefs while modifying other norms and values to integrate into the host society. Scholars document that despite acculturation stress, core values were difficult to change in later life such as beliefs in filial responsibility (Ho et al., 2003; Jones et al., 2002). Other scholars show that acculturation is dependent on family support, length of residency, pressure to assimilate (one-way integration), and the strength of and involvement in the ethnic community. For example, studies on East Asian older immigrants (65+) in the United States have shown their adoption of Western cultural values were

exacerbated with learning a new language, social standards, and adjusting to a new place (Jones et al., 2002; Ho et al., 2003; Miyawaki, 2015). Thus, acculturation at the individual level is influenced by micro, meso, and macro factors experienced in the post-settlement context.

Another important dimension to inclusion is immigrants' mental health. The mental health of Canada's immigrants is a growing area of research given increasing involvement in social, cultural, and economic institutions (Ali, 2002). An older report by the Canadian Task Force showed that mental health services delivered to immigrants and refugees were often ineffective due to language and cultural barriers between service providers and clients (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). These include barriers at the individual-level (e.g., knowledge and communication difficulties), community-level (e.g., provider time constraints), and societal-level (e.g., mental health stigma and/or gender roles) (Woloshin, Schwartz & Welch, 1997; McKeary & Newbold, 2010; Beiser, Simich & Pandalangat, 2000). Other researchers report gaps in optimal health care delivery as a result of inadequate number of trained mental health workers, such as psychiatrists, general physicians, and interpreters (Sadavoy, Meier & Ong, 2004). Given these difficulties in addressing mental health needs, a proactive approach to focus on upstream determinants of mental health, such as social inclusion, could alleviate the burden on both communities and the system simultaneously. Although there are some scholarly work on the social inclusion (or exclusion) of older immigrants, research on older immigrants is limited (Janie, 2002).

#### **1.4 Overview of Social Inclusion (and Exclusion)**

Social exclusion reflects unequal power between individuals, and communities that systematically advantages some while disadvantaging others (Labonte, 2004; Shakir, 2005). Social exclusion was initially discussed as a consequence of poverty and deprivation in a pure

economic sense (Toye & Downing, 2006), but the discourse shifted to include barriers for integration (Guildford, 2000). Scholars argue that exclusion can manifest in multiple forms, including: institutional, cultural and material (Reis, 2004), economic (Stewart, Brown & Langer, 2008), relational (Ocean, 2005; Reis, 2004; Stewart et al., 2009), and moral (Reutter et al., 2009; Kidger, 2004). Further, social exclusion manifests in multiple contexts (Mitchell & Shillington, 2002; Popay et al., 2008), across lifespans and generations, and at multiple levels of social relations (Percy-Smith, 2000).

Guildford (2000) defines the alternative to exclusion as social inclusion, which is being accepted and being able to participate fully in family, community, and society. Exclusion refers to conditions that constrain inclusion. Thus, inclusion is framed as the solution to the problem of exclusion. Social inclusion and exclusion are inter-related dichotomous phenomena that need to be interrogated together (Mitchell & Shillington, 2002). However, Galabuzi (2004) argues that social inclusion and exclusion are not mirror opposites, where

Social exclusion is different than social inclusion because the former seeks to identify and transform the root causes of exclusion, while the latter in practice seeks to reconcile the excluded to existing societal institutions without changing them (p. 90).

While social inclusion may be the end goal, the means to this end is rectifying the processes of social exclusion (Tastsoglou & Jaya, 2011).

Canadian literature on social exclusion spans poverty, deprivation (Sen, 2000), racism, discrimination (Galabuzi, 2006), gender inequality (Reis, 2004), and oppression (Young, 1990). Groups historically excluded are poor women (Raphael, 2011; Reis, 2004), Aboriginal peoples (Frohlich, Ross, & Richmond, 2006), and ethnic minority groups in Canada (Galabuzi, 2006). As Raphael (2011) states, the enduring result of social inequalities is difference in “power and resources among individuals, and groups of people that influence the quality of their lives.” (p.

91). Discourse on social inclusion was popularized in Canada in the early 2000s during the establishment of neoliberal social policies (Harrison, 2005) and the economic re-structuring of social structures, which resulted in gross income inequalities (Guildford, 2000). Canadian scholars such as Jenson (1998), Li (2003), and Luxton (2002) in agreement with Saloojee (2003), suggest that an important factor constraining inclusion and the racialization of poor quality of life, poverty, and disability. Saloojee (2003) states that racism is an expression of social exclusion, and we need to move beyond the rhetoric of multiculturalism into full citizenship by working in an anti-racist framework. Racism interacts with other forms of exclusion, such as poverty, to create multi-dimensional disadvantages. Exclusionary processes, such as racialization, Eurocentrism, and colonization, have resulted in various structural inequalities that resist and undermine diversity, a central tenant of social inclusion.

However, Young (2000) contends that engagement with social inclusion alone is not critical, but rather a subtle acceptance of the status quo. Discourse on inclusion integrates individuals and communities who have been historically excluded without truly effecting appropriate change to improve the lives of the affected (Young, 2000). The dichotomous concepts of social inclusion and exclusion must be reframed to dismantle power and structural differences together. If critically engaged, the contribution of social inclusion can affirm a commitment to rectify historic exclusions through social mobilizations (i.e. advocacy) to reduce inequalities in power relations. The researcher was cognisant of the simplicity in engaging solely with social inclusion and ensured that the lived realities of exclusion grounded her thesis on social inclusion. To that end, this thesis suggests that notions of inclusion rely on exclusions. Questions, such as inclusion for whom, for what ends, and how, are necessary for reflection to create both inclusive policy and societies. Carr and Chen (2004) extend this analysis to pose the

following questions: “exclusion from what (land, housing, other productive assets, credit, secure jobs, productive work, income worker benefits), excluded how (market transactions, policies, social norms) and exclusion by whom (dominant players and institutions)” (p. 20). These questions facilitate discussion on identifying both the processes that exclude and co-create interventions to minimize exclusionary processes sustainably.

An important aspect for research with immigrants is to acknowledge their heterogeneity. Thus, whenever possible, a researcher should aim to examine migration trajectories, settlement challenges, and integration experiences for specific ethnic groups to inform scholarly understanding, practice, and policy. This thesis will focus on understanding Sri Lankan Tamil seniors’ experiences of social inclusion in Toronto and surrounding Greater Toronto Area (GTA) specifically.

### **1.5 Sri Lankan Tamil Diaspora**

Sri Lankan Tamils represent a diaspora who were forcibly expatriated from Sri Lanka with the majority from northern and eastern provinces (Reis, 2004; Cheran, 2007). Sri Lankan Tamils who migrated to Canada prior to the civil war in 1983 were mostly well-educated professionals and arrived as landed immigrants (Cheran, 2007). However, later arrivals did not have the same professional skills due to the disrupting impact of the war and limited access to higher levels of education due to discriminatory practices against Tamils (Guruge, Khanlou, & Gastaldo, 2010; Cheran, 2007). The post-1983 migration of Sri Lankan Tamils was a result of hate crimes and riots (i.e. burning of Jaffna library, Black July, etc.) leading up to the Civil War and during the warfare (1983-2009). Unwilling to continue enduring subjugation by the increasingly militarized Sri Lankan government (of Sinhalese majority), many Tamils migrated in diverse immigrant classes (economic, family sponsorship, private sponsorship, government

sponsored refugees, and asylum claimants). It was estimated that about one quarter of the world's population of Sri Lankan Tamils lived in the diaspora in the early 1990s with 250,000 settled in Canada (Cheran, 2007), 150,000 settled in India, 110,000 settled in the United Kingdom, 110,000 settled in the Europe, and 30,000 settled in Australia (Wayland, 2004; Canagarajah, 2008; McDowell, 1996). Sri Lankan Tamils arrived in Canada in multiple waves starting in the 1960s (Aruliah, 1994; Hyndman, 2003). In the 1991 Census, Tamil Canadians were the fastest growing ethnic population in Toronto. In 2000, Sri Lanka was recognized as the sixth largest source country of immigrants to Canada, representing about 2.57% of Canada's total immigrant population (Census, 2016). By 2007, this population was estimated at 250,000 with the majority of settlement in the GTA (Mason et al., 2008).

Many Sri Lankan Tamil Canadians arrived as refugees (while others also came later through family reunification programs) and constitute a visible minority with a culture distinct from the host society. Depending on the age of entry, Tamil immigrants had different opportunities with education, labour market participation, language acquisition, and meaningful integration in society. Further, opportunities to access Canadian pension plans and accumulate adequate savings for retirement was not possible for all Tamils who may have been un-/under-employed (Canagarajah, 2008; Arasaratnam, 2008). Further, earlier life experiences prior to settlement dictated structural (e.g. socio-economic status, social support, family arrangement), behavioural (e.g. personality traits, coping methods) and psychosocial (e.g. critical life events, stress, psychological resources) determinants of health, which shaped Tamil seniors' current personal, working, and social lives (Raphael, 2013).

Although the Sri Lankan Tamil diaspora is a recent immigrant community in Canada, they have established some social, cultural, and economic networks to strengthen the

community's access to necessary social, psychological, economic, and cultural capital. For example, there are more than two-dozen community newspapers, radio stations (i.e. Tamil FM), TV stations (i.e. Tamil Vision Incorporated), and several Tamil-specific businesses across the Canadian diaspora, which are mostly concentrated in metropolitan cities (i.e. Toronto, Montreal, and Vancouver). There are more than 300 Tamil Village Associations and Alumni Associations in Canada (Cheran, 2007). These organizations are critical in creating the Tamil Canadian identity and exemplify the transnational social field that the Tamil diaspora is built on. Further, the Tamil Canadians' established political rights in Canada allow them to engage in international advocacy and relief efforts in Sri Lanka. The active political engagement is possible because of the citizenship rights and adequate integration into the Canadian society afforded by the multiculturalism policies (Cheran, 2007; Orjuela, 2008).

Yet, Burgio (2016) argues that Tamils are never 'at home' as they remain minorities internationally and in Sri Lanka. He classified Tamils as belonging to a "diaspora that is deprived of a homeland: a stateless diaspora" (p. 111). He claims that a characteristic of a diaspora is the longing to return from exile; however, because of political obstacles and modern colonization of their home by the Sinhalese majority in Sri Lanka, return may not be possible for Tamils. Yet, he claims that Tamils are well positioned in their diasporic network to retain their sense of community and reinforce their ethnic identity. Some scholars argue that even if geographically fragmented, Tamils have adopted a 'translocal identity' (Geertz, 1973, p. 87) characterized by their strong bonds of solidarity to their political and cultural identity (Burgio, 2016). For the Tamil diaspora, connection to Sri Lanka is a 'source of identity,' while integration into the host society is a 'source of rights,' which has allowed Tamils to collectively organize to transform their political activism through newly found political rights (Ambrosini, 2008, p. 92). Long

distance nationalism (Cheran, 2007) is common among the Tamil diaspora where Tamils go to great lengths to preserve their ethnic identity but also protect their political claims to territory from which they were displaced. However, as a member of the Tamil community, it is clear that Tamil seniors' transnational activities go beyond Levitt's (2002) notion of "ways of belonging" (via the translocal Tamil identity) to also embrace "ways of being." The latter is more critical to their post-settlement experiences because it refers to the social relations and practices that seniors engage with to sustain their transnational identities, rather than simply identifying as a Sri Lankan Tamil Canadian.

Further, sensitivity to the interface of ethnicity, gender, and age is imperative to improving settlement experiences. Traditionally in Sri Lanka, Tamil family structures are patriarchal, where women historically experienced lower status compared to men. The extent to which these roles and expectations are changing or maintained in the diaspora has been increasingly researched in studies on intimate partner violence. The heterogeneity of cultural norms and values are changing (Pandian, 1987), however, other stressors may contribute to more violence in Tamil families. In fact, Guruge (2007) suggests that "the connections between factors occurring in the pre-migration period (e.g., trauma), border-crossing (e.g., detention, uncertainty, illegal travel), and post-migration contexts (e.g., gender role pressures from the diaspora community or the racism experienced in Canadian society at large)" are associated with the phenomenon of intimate partner violence in the post-migration context (p. 238). For example, male and female Sri Lankan Tamils have experienced role changes upon arrival in Canada, where the man may not always be the breadwinner. In some cases, it has been necessary for Tamil women to work outside the home, despite it being mainly low-wage and of low-status (Hyman et al., 2011).

In addition to work outside the home, women may also remain responsible for household work. For example, researchers argue that South Asian immigrant women are often portrayed as “wives” and “mothers” as a cultural norm, resulting in their family needs placed before themselves (Choudry et al., 2002; Avotri & Walters, 1999). In most cases, Tamil women may also juggle these difficult situations to maintain family harmony, but this affects their health and wellbeing. Beiser et al. (2003) reported these are common stressors among immigrants that can lead to depression. Moreover, a high level of secretiveness and stigma about gender roles among South Asian communities allows many women to continue suffering alone (Sheehan, Javier & Thanjan, 2000; Morrison, Guruge & Snarr, 1999). Further, cultural role reversals—where highly regarded seniors become dependent on their adult children for language support, financial assistance and health systems navigation—often results in intergenerational strain (Canagarajah, 2008). Thus, the crossing of traditional gender and age-based roles impacts the whole family but primarily women and seniors.

### **1.6 Aging among Sri Lankan Tamils**

In the following section, findings from studies based in Canada and other industrialized countries are examined to understand Tamil seniors’ levels of integration (defined as retaining aspects of one’s ethno-cultural identity after settling in a new ethno-cultural place), and their engagement in transnational (defined as ties between countries of origin and destination) practices to maintain their ethno-cultural identity.

Many Tamil seniors have experienced downward mobility resettling in Western countries. In addition to spatial displacement, many seniors have lost a lifetime of accumulated economic and social capital as result of the Sri Lankan Civil War (Mills, 1993; Beiser et al., 2003). Mills (1993) states that Tamils’ prefer to continue living in extended families, where

reciprocal care is exchanged and strong social connections are maintained. These factors are all protective against mental illness and poor integration into the host society (Beiser et., 2003). However, living with extended family does not always guarantee integration and interdependence (Malhotra, Chan & Ostbye, 2010) because family structures are subject to change. In a qualitative study of elder abuse in Canada among Tamil and Punjabi communities, two of the six Tamil seniors interviewed reported that their ethnic culture impacted rates of family violence (Tyyska et al., 2013). Seniors identified various forms of abuse, which include verbal insults, deprivation of basic needs, and spiritual, financial and/or physical abuse. For example, seniors had conflicting views of their daughters-in-law. Some seniors believed their daughters-in-law were jealous of their mother-son relationship and/or were interested in their pension money. Tyyska et al. (2013) concluded that post-settlement stressors such as poor employment conditions, language barriers, mistrust of service providers, lack of respect for seniors, and capitalistic notions of Western society have stressed extended families, often times resulting in family violence. Furthermore, Tamil seniors reported that their own ethnic community contributed to perpetuation of abuse in their homes due to the cultural taboo and, hence, being unable to proactively address it.

Further research on family violence within Sri Lankan Tamil community in Canada has examined the interaction of settlement and cultural scripts of gender expectations (Mason et al., 2008; Guruge et al., 2010; Gamage, 1998). In their qualitative study, Guruge et al. (2010) reported that older Tamil women in Canada were aware of the threats and control posed by their ethnic community and adult children. Often, such threats forced seniors to live with the perpetrator and engage in unpaid domestic labour because they were unable to find paid employment to support themselves. Another study (Ekanayake, Ahmad & McKenzie, 2012)

echoes this finding, as seniors felt overburdened by kin-keeping and household chores. Their increased dependency on adult children led to hopelessness, and consequently led to feeling emotionally and physically isolated in Toronto. Both research papers stressed that treatment of seniors, especially elderly women, in a patriarchal and ageist society has resulted in the belief that elderly women must continue to sacrifice their wellbeing to raise their children and grandchildren. In summary, elderly immigrants' downward social mobility (as a result of low income, lack of social networks, increased dependence on the family, lack of respect for seniors, and the burden of providing informal care to family members) positions them unfavourably for integration into the Canadian society.

A qualitative participatory research on Tamil and Chinese seniors in Toronto identified the following barriers to access mental health services: disrupted family structures, decline in self-worth, and fear of rejection in the Tamil community (Sadavoy et al., 2004). Further, when researchers looked more closely at gender, they noted that women are more at risk for depression and encounter more barriers to access to mental health services. Similarly, a large-scale quantitative study on mental health among 1600 Sri Lankan Tamil households in GTA identified that Tamil women were more likely to report higher rates of depression than men (Beiser et al., 2003). Employment and marital status were protective factors for Tamil men, but less so for women. Research confirms that more Tamil women are entering the workforce for low pay, out of necessity, while not having their household work relinquished; this takes an emotional toll on their health and wellbeing (Hyman et al., 2011). Further, cultural health beliefs such as believing the problem will resolve itself or self-ownership of the problem reduced help-seeking behaviour among Tamil adults (Beiser et al., 2003). The results from this study show a high reliance on cultural practices among Tamils in the GTA. However, it is concerning that seniors continue to

depend on familism and other obsolete cultural practices in the post- settlement context.

Unfortunately, Tamil seniors' reluctance to seek outside help and adopt western practices places them in a vulnerable position (Beiser et al., 2003; Sadavoy et al., 2004).

George (2011) explored the development of Tamil ethnic identity among Tamil seniors (age 55+) in Toronto's East End with ideas about age, culture, and social suffering (as defined by Ato Quayson, 2004). Using Quayson's (2004) concept of social suffering, George suggests Tamil seniors made sense of changing cultural practices at crossroads of suffering and celebration, while situating themselves in the disruptions of the past and present. For example, seniors identified their families as a site of struggle and support. The cultural script of extended family life was disrupted by the Sri Lankan Civil War and current living arrangements. However, in the face of such barriers, Tamil seniors continued to be bearers of culture and willing to relinquish traditional expectations to develop a positive social imaginary of their current state. As described by Beiser et al. (2003), disruptions in family dynamics are prevalent across the lifespan. Through interviews, George (2011) stressed that notions of the Tamil identity are gendered, diasporic, and contemporary. Seniors discussed problems that range from financial problems, intra-family conflicts, to feelings of neglect, disrespect, boredom, and isolation. Their migratory patterns, exacerbated by changing cultural expectations, limitations of Canadian sponsorships, and old age entitlements exposed Tamil seniors to loneliness, ambivalence, and social isolation. While these breaks in cultural practices result in personal and collective suffering among Tamil seniors, they overcame these conditions through reflecting on positive experiences. George (2011) concluded that Tamil seniors continue to contest and reproduce cultural constructs of their modern identity— a hybrid of two cultures. Other scholars have documented such hybrid identity as well (Burgio, 2016). It appears that the Tamil diaspora selectively acculturates whereby they comply with

national laws and local customs to acquire linguistics fluency for professional and economic achievements, but retain certain values of the culture of origin. It is possible that complete acculturation poses a threat to their Tamil identity, and as a result, Tamil cultural trends, such as respect for seniors, obedience, discipline, modesty, and discretion are socially reproduced to counterbalance Western scripts. However, as demonstrated in the breadth of research examined, traditional cultural scripts are contested by Tamil seniors and sometimes, Tamil seniors are disproportionately affected by changing lifestyles.

### **1.7 Evolution of Ethnic Seniors Centres**

Senior centres act as a centralized hub for seniors to receive a variety of services to assist in self-fulfilment (Pardasani & Thompson, 2012; Wick, 2012). Most senior centres are voluntary non-profits, which advocate for socialization, education, and empowerment of older adults (Fitzpatrick et al., 2005; Fitzpatrick & McCabe, 2008). For example, commonly used amenities and services include cooked meals, screening for high blood pressure, social games, and day trips (Turner, 2004). Research confirms that the common clients include predominantly seniors of female gender, age 70 or older, who live alone, of a lower income, have fewer difficulties completing daily activities, and demonstrate an interest in social interaction (Aday, Kehoe & Farney, 2006; Farone, Fitzpatrick & Tran, 2005; Miner et al., 1993; Turner, 2004). Benefits of senior centre utilization include independence throughout retirement (Aday, Kehoe & Farney, 2006; Jett, 2006); higher levels of satisfaction and better quality of life (MaloneBeach & Langeland, 2011); closer friendships, sense of security, and protection from loneliness and depression (Aday et al., 2006; Farone et al., 2005; Pardasani & Thompson, 2012). Interestingly, seniors centres have also started to offer intergenerational programming as an alternative to their exclusive environment (V. Shanthakumar, personal communication, June 22, 2017). Such multi-

purpose senior centres offer programs to seniors from various socio-economic and cultural backgrounds to ensure that social participation leads towards active aging for all.

Given the diversity of Toronto, the number of ethnic senior centres and retirement homes has grown to meet the demand for culturally and linguistically specific senior services. High-profile pioneers in ethnic senior long-term care include Yee Hong Centre for Geriatric Care and Mon Sheong Long-Term Care Centre for Chinese populations, Villa Colombo for Italians, Hellenic Home for Greeks, Suomi-Koti for Finnish, and Baycrest Centre, a renowned long-term care facility for the Jewish community. There are ethnic senior centres and respective retirement homes for the following ethnic communities also: Armenian, Lithuanian, Filipino, Polish, Portuguese, Spanish, French, Ukrainian, Tamil, East Indian, Slovenian, Russian, Caribbean, Ismaili, Japanese, and Korean. Accordingly, these ethnic senior organizations (including day program services via senior centres and long-term care) provide culturally specific activities such as cultural meals and celebration of cultural events to encourage feelings of community.

A scan of Tamil senior services in Toronto identified more than 10 organizations, which include Access Alliance (Danforth location), Harmony Hall, Human Endeavour, Markham Tamil Seniors Association, Brampton Multicultural Centre, Social Services Network, Toronto Tamil Seniors' Association, Vasantham, Woodgreen Community Services, Peel Tamil Seniors and Senior Tamils' Centre of Ontario. This is by no means an exhaustive list of all available Tamil senior services. These organizations are designed for Sri Lankan Tamil seniors, where all activities from the meals to dance classes are culturally relevant. With staff that speak Tamil, they organize local and international events. For example, the Senior Tamils' Centre of Ontario recently took a trip with their members to Iceland (V. Shanthakumar, personal communication, June 22, 2017). Although many seniors utilizing these centres are able to speak English well and

are more active in their communities, they would prefer to socialize with other seniors of the same ethnic background out of comfort (V. Shanthakumar, personal communication, June 22, 2017). Yet, as illustrated in the Iceland trip, there is a growing curiosity among Tamil seniors to learn about other cultures.

Despite the overwhelming support for ethnic-specific senior centres and long-term care, critics argue this arrangement runs counter to the goals of multiculturalism. For example, the *Toronto Star* Columnist Heather Mallick states,

I dislike the idea that anyone, even the elderly, can be made comfortable only with others of their own ethnicity, which is more than language. I'm worried that Canadian ethnic groupings now run from birth until death. This was not the multiculturalism Pierre Elliott Trudeau dreamed of. He was talking about tolerance, not avoidance (July 13, 2012).

However, regardless of whether this service supports or undermines the multicultural identity of Canada, the reality remains that the quality of care for older immigrants is suboptimal compared to Canadian-born seniors. Given the need for quality long-term care support for older immigrants, it seems that until demand ceases, such facilities will continue to exist. The multicultural aspect does not need to be lost with ethnic-specific services. For example, many Tamil senior organizations celebrate Canadian holidays such as Canada Day and Christmas (V. Shanthakumar, personal communication, June 22, 2017). Thus, having ethnic-specific programming does not need to lead to exclusivity; rather it provides seniors who require more language and cultural assistance formal support.

### **1.8 Research Objectives**

The reviewed literature shows that the experiences of seniors from Tamil Sri Lankan community are unique, but under-researched. There is limited understanding about what factors are central to social inclusion from the perspective of Tamil Sri Lankan community in Canada. Thus, this thesis research explores such factors by conducting community-engaged research with

the Tamil seniors in the GTA and service providers from community-based social services, using CM and FG methods (details in Chapter Two). The key objectives are:

**Objective 1:** To identify facilitators (and barriers) that Tamil seniors in the GTA consider central to their social inclusion.

**Objective 2:** To identify factors that Tamil seniors consider a) important, and b) feasible to change at a program level (e.g., in the next 12 months) to support social inclusion of Tamil seniors.

**Objective 3:** To understand service providers' perception of the generated results in terms of program priorities and action challenges.

The findings are anticipated to advance scholarly knowledge, and community-based programming and policies. It is clear from my literature review that documenting the relationship between social inclusion and migration is an under-researched area of immigrant health. Thus, while this research is not generalizable to other immigrant seniors or Tamil populations throughout Canada, this research prompts the need for larger, longitudinal studies.

## **Chapter Two**

### METHODOLOGY

#### **2.1 Overview**

The overarching aim of the research is to contribute to scholarly understanding about aging, immigration and social inclusion. More specifically, the researcher aims to examine the perspectives of Tamil seniors about factors central to social inclusion and how these might be addressed through community-based programs and other institutions.

Informed by the research paradigm of the Critical Social Theory, the thesis research project engaged with Tamil seniors using CM (phase 1) and service providers of community-based agencies through FG (phase 2) methods. The primary goal of CM was to examine Tamil seniors' perspectives on factors (e.g. individual, family and community levels) central to social inclusion. The primary goal of the FGs was to examine broader systemic aspects for social inclusion from the perspectives of providers in community-based agencies serving Tamil seniors. The combined results are expected to illustrate a holistic picture of Tamil seniors' inclusion from the post-migration context in a multicultural city, such as Toronto. These research aims and the interpretation of findings draw from theoretical concepts drawn from life course theory, political economy of aging, individualism-collectivism cultural frameworks, and health geography. Also presented in this chapter are the key tenets of the Critical Social Theory. The subsequent sections of the chapter describe the study setting and study methods (participant eligibility, recruitment strategies, data collection, and analyses procedures) for the CM and FG methods. The last section discusses the study limitations and ethical concerns.

## **2.2. Research Paradigm – Critical Social Theory**

The proposed research is guided by the philosophical paradigm of Critical Social Theory (CST). Kincheloe and McLaren (2011, p. 281) state “a critical social theory is concerned in particular with issues of power and justice, and the ways that the economy, matters of race, class, gender, ideologies, discourses, education, religion and other social institutions, and cultural dynamics interact to construct a social system.” In terms of ontology or belief about reality, CST scholars assume that reality is historically situated and is crystallized over time (Guba and Lincoln, 1994). In terms of epistemology, CST scholars aim to challenge power structures that maintain the status quo (Kincheloe and McLaren, 1994). CST theoretical approaches rely on dialogic methods, where observation and discussions take place to foster reflection.

Based on the ontological belief, prevailing assumptions held about Tamil seniors will be contextualized and unpacked through the proposed research. Further, the knowledge generated from this research is also expected to challenge conventional social structures that impose barriers to social inclusion, which aligns with the emancipatory aim of the CST informed epistemology. This paradigm also allows both researchers and participants to reject false consciousness of perceived truth in order to develop a shared understanding for confronting unjust social structures and evoke effective practical change at the community level (Giroux, 1988). The researcher anticipates that the undertaking of such research will invoke improved understanding of social inclusion among study participants, and potential social change.

The researcher acknowledges her social location as a university-educated, Canadian-born, Sri Lankan Tamil, young female, and native English-speaker. This self-awareness has informed the choice of topic and methodology, which is community engaged. In understanding her social location relative to the participants, she could understand and empathize with their

experiences of power, privilege and oppression. The researcher's perspectives were accounted for at the time of data collection and analysis to enhance rigor and transferability of generated knowledge. The researcher, an Interdisciplinary Studies graduate student, examined several theories and frameworks to become theoretically sensitive and inform her engagement with the community, data collection, and interpretation of findings (due to the belief that the researcher is the key instrument in qualitative research).

### **2.3 Theoretical Underpinnings**

Theory is critical to the development of research methodology. With respect to social inclusion, aging, and immigration in social research, there is no encompassing theory that engages all three issues simultaneously. Thus, this type of ethnogerontology research remains atheoretical to some extent. Social gerontologist Lynn McDonald (2011) outlines the lack of development of theory in aging and immigration research, and suggests that most research is based on the healthy immigrant effect (i.e. immigrants are healthier at time of arrival than average population because of their volunteer self-selection to migrate) or multiple jeopardy. In light of these gaps, the following theories and frameworks are utilized to inform the study context and procedures and will be especially drawn upon for the interpretation the results.

#### **A. Life Course Theory**

Glen Elder (1998) articulated the life course theory in relation to aging and stated "historical time, social location and culture affect [the aging] experience" (Hutchinson, 2010, p. 11). This theory is used to study individuals' lives in relation to structural contexts, and social environment over time, while accounting for cumulative advantages and disadvantages of evolving social locations (Dannefer, 2003). Thus, this theory claims that an individual's

developmental path is influenced by historical periods and geographic locations such as economic cycles (e.g. recession), social and cultural ideologies that shape perceptions (e.g. racism), and geopolitical events (e.g. Sri Lankan Civil War) (Mitchell, 2003). Life course theory acknowledges the accumulation, maintenance, and loss of social capital over one's life. Further, the roles of individuals are defined within the domains of family, education, work, or leisure and include the reconciliation of work and family (Raphael, 2014). Thus, in using the life course theory in aging research, a researcher seeks to understand how earlier life events characterized by age-specific social roles impact later life (Browne, Mokuau & Braun, 2009; Ferraro, Shippee & Schafer, 2009; Crosnoe & Elder, 2002).

There are three important concepts of the life course theory that are central to this research: *latency effects*, *pathway effects*, and *cumulative effects* (Hertzman & Power, 2003; Mitchell, 2003). The *latency effects* describe how earlier life experiences impact later life outcomes, regardless of improved social standings. The *pathway effects* discuss how life experiences have sequential impacts on future life trajectories that can lead to positive or negative outcomes in later life. Lastly, the *cumulative effects* are the accumulated impact of continued exposure to multiple factors that can protect or threaten wellbeing across life course. Some scholars also argue that life course theory enhances the ability of researchers to advocate for aging immigrants as their exposure to stressors during migration and post-settlement results in disparities in later life (Durst, 2005; McDonald, 2011). Particularly, the post-settlement experience immediately after arrival is viewed to greatly impact the inclusion of immigrants in terms of employment, community building, and wellbeing (Turcotte & Schellenberg, 2007; Ng, Lai, Rudner & Orpana, 2012).

The incorporation of life course theory in the thesis project is anticipated to allow enriched understanding of the complex dimensions of aging overtime and social inclusion for Tamil seniors in Canada with a necessary consideration of context and history. At the same time, the theory might not be fully exploited given the collection of thesis data at one time only and the age of +55 years as ‘senior’ population in the thesis research; the latter was a choice made in order to respect the community’s own definition as the retirement age is 55 in Sri Lanka. Nonetheless, during the CM sessions elderly participants were requested to consider their experiences like early years after migration to Canada, marriage and family life, occupational history, and retirement or planned retirement.

### **B. Political Economy of Aging**

Older adults are increasingly recognized in research and policy as living with multiple intersecting barriers to economic security and equitable health (Walker, 1981). The prevalence of poverty in old age is well documented in Canada (Bryden, 1974), yet research on aging often focuses on individual approaches to old age, and, as a result, offers narrow functionalist solutions (Minkler and Estes, 1999; Estes, 2001). As Mills (2000) pointed out, a shift in the perspective of individualizing problems of aging from private troubles to public state-mediated issues is needed. In fact, Estes (2001) argues that the root of all private troubles, such as status loss, low income and social isolation in old age, can be linked to the poor relations between the state and seniors. Furthermore, the current focus on individualized interventions has further exacerbated the depressed social status of marginalized older adults, such as first-generation seniors (older immigrants). Repeatedly, seniors are represented as a homogenous group facing similar problems (Walker, 1981). However, asymmetric health outcomes between resettled immigrants and their Canadian born counterparts demonstrate that the foreign-born advantage in health

declines with resettlement due to poor integration in the host society (Gee et al., 2004). Structural barriers related to immigrant status, employment, language acquisition, access to appropriate social and health care, and increased isolation directly contribute to poor health of older immigrants (Vissandjée, 2001; Thurston & Vissandjée, 2005). To address these barriers, scholars argue that political and economic factors need to be unpacked further to understand the conditions and quality of life of older adults, including older immigrants (Minkler & Estes, 1999; Estes, 2001; Vissandjée et al., 2004; Kapilashrami et al., 2015).

In contrast to examining the aging problem from the conventional gerontology lens that emphasizes targeted individual interventions, an analysis based on political economy can offer new critical insights with a focus on upstream determinants. The political economy of aging proposed by Estes (2001) outlines how power compatible through existing social structures contributes to social and economic inequalities of different groups of seniors. Depressed status of the retired in later life is a result of poor economic and social status prior to retirement and limited state support (Walker, 1981). However, current social and health policies fail to acknowledge that persistent inequality in old age is a result of social structures (Minkler & Estes, 1999). Estes' analysis of the political economy of aging has confirmed that all efforts to resolve the aging problem at the individual level fail because overarching ideologies that inform inequitable social structures are not rectified (2001). These problems are socially created and then supposedly resolved by neoliberal policies (e.g. minimum state interventions and emphasis on responsibility of individuals); it is a tautological phenomenon (Mills, 2000).

Although the political economy of aging has been generally used to examine the issues of mainstream White older adults, the researcher drew on this framework for issues specifically

faced by older immigrants, such as Tamil seniors who may live with their adult children due to financial constraints and experience changes in their traditional roles as seniors.

### **C. Concept of Place**

According to health geography, the concept of place can be conducive to or a limitation for social inclusion because the attachments and connections people make to a particular place and community influence the outcome of inclusion (Gatrell & Elliott, 2014). Place has physical, social, and cultural dimensions, and immigrants negotiate various identities to build ties across diverse geographies. To understand older immigrants' inclusion or the lack thereof, there is a need to understand the structural and relational forces that act within social and physical spaces (Cloutier-Fisher & Kobayashi, 2009). Social inclusion is influenced by community characteristics such as their promotion of wellbeing, and accessibility to health and social services. In Canada, where immigration is the driving force for population growth, place making is central to co-creating an inclusive home. Thus, the influence of spatial distribution, access to health and social services, and connection to the local community are all likely to affect immigrants, but particularly older immigrants who increasingly depend on their immigrant family for support. Thus, the concept of place was drawn upon to develop probes for the CM brainstorming sessions (e.g. commute to community-based centres, family support for interpretation, and so forth) to elicit their responses on the facilitators and barriers for social inclusion of aging Tamil seniors in the GTA. This concept is also anticipated to facilitate the interpretation of results.

### **D. Collectivism and Individualism**

The framework of individualism-collectivism has been employed in sociology and social psychology to understand some of the variability across cultural groups. As people move from

one culture to another (e.g. cultures associated with the “East” and the “West” or vice a versa), they experience a shift in their cultural norms and values. Similar push and pull for the ‘cultural syndromes’ is likely to be experienced by immigrants, such as senior Tamils. Thus, the framework of individualism-collectivism could allow the researcher to interpret the findings with a cultural stance.

According to Hofstede (1980), “collectivism pertains to societies in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people’s lifetime continue to protect them in exchange for unquestioning loyalty” whereas “individualism pertains to societies in which the ties between individuals are loose; everyone is expected to look after himself or herself and his or her immediate family” (p. 51) - “we” versus “I” consciousness. Triandis (1995) has outlined four universal attributes of collectivism and individualism, which include: in relation to self; goals; cognitive focus; and relationship (1995). *Self* is interdependent in collectivist cultures and includes many of the attributes of the groups to which a person belongs. In contrast, self is independent in individualist cultures and consists of unique identifying information. In collectivist cultures, there is an alignment of personal and collective *goals* and personal-goals are subordinate to the goals of some collective; in case of misalignment between personal and collective goals conflicts often arise. In individualist cultures, the personal goals and collective goals are not aligned and individuals give priority to personal goals. In collectivist cultures, the social behavior is guided by *cognitive focus* on norms, obligations, and duties while the individualist cultures focus on attitudes, personal needs, rights and contracts to guide social behavior. Compared to individualist cultures, there is more emphasis on *relationships* in collectivist cultures even when they are disadvantageous and, thus acceptance of hierarchies is often found in collectivist societies. Further, Triandis and other scholars delineate

collectivism into horizontal- and vertical-collectivism (Triandis, 1995, 2001; Triandis & Suh, 2002). In a horizontal-collectivist culture, the majority cooperate with their in-groups, whereas in a vertical-collectivist culture, the majority accept power differentials in defined hierarchies to sacrifice self for the collective good.

Given these distinctions between two cultural syndromes, Tamil seniors may experience difficulties integrating into Canadian society where their collectivist values may be increasingly challenged. Tamil seniors' adult children and grandchildren are uniquely positioned in comparison to them because they are socialized and exposed to the conflicting expectations of the two cultural syndromes in their daily lives (Wardak, 2000). The balancing of these cultural differences does not solely take place between intergenerational family members, but also between their two selves: the Canadian self and the Sri Lankan Tamil self (Shariff, 2008). As a result, Tamil seniors can be described as "living between cultures" or "living in translation" (Giguere et al., 2010; Hall, 1992, p. 310; Wakil et al., 1981; Wardak, 2000). Tamil seniors are torn between reinforcing their traditional beliefs of being family-oriented and adopting aspects of individualism to preserve family harmony (Kalliyvayalil, 2004). Given these cultural and generational differences in managing different cultural syndromes, Tamil seniors are at crossroads of negotiating cultural and familial expectations to reflect the realities they face in Canada post-settlement (Durham, 2004; Rajiva, 2006; Shariff, 2008; Varghese & Jenkins, 2009).

In summary, the aforementioned theories, concepts and frameworks not only enhanced the contextual and cultural sensitivity in study procedures but also facilitated the interpretation of findings.

## **2.4 Study Setting**

The City of Toronto and peripheral suburban areas, known as the GTA, is home to many Tamil seniors (Mason et al., 2008). Toronto continues to be a desirable location for older immigrants due to its high density of health and social services, increased accessibility to public transportation, and better opportunities to live close to their children (due to increased economic activity and development). Given these features, it was optimal to recruit Tamil seniors in Toronto and the GTA to achieve an adequate sample size. Current research reports outward migration of immigrants from Toronto to peripheral regions (Ng, Lai, Rudner & Orpana, 2012), and accordingly recruitment of service providers and aging seniors' was expanded to the GTA.

After obtaining ethical approval for the conduct of research, several community-based organizations were contacted by the researcher to approach Tamil seniors they serve in the GTA. Research partnerships were developed with the Senior Tamils' Centre of Ontario and the Social Services Network. The Senior Tamils' Centre of Ontario was founded in 1986 with a mandate to promote the health of Tamil seniors (age 55 and above), their culture, and heritage. They offer healthy living programs including fitness and recreation activities, coordinate with other organizations to deliver healthy living seminars and workshops (i.e. falls prevention), engage with environmental groups to raise awareness about global warming, offer counselling and referrals, and celebration of Canadian and Sri Lankan Tamil holidays. Most services are delivered at local temples (i.e. Canada Kanthasamy Temple Hall and Sri Iyappan Temple) or at their main office. Social Services Network, established in 2002, delivers culturally and linguistically appropriate services to the diverse South Asian community through partnerships with other service providers. They offer intergenerational family programs, information and referral programs, and senior-specific recreational and adult day programs for the South Asian

community. Services are delivered in the community at places of worship, community centres, or at their main office.

## **2.5 Concept Mapping**

CM is a community-engaged approach with three phases: (i) *Brainstorming* for idea generation in response to a focal question (e.g. what facilitators do Tamil seniors residing in GTA consider central to social inclusion); (ii) *Sorting* of the finalized list of generated ideas and *Rating* around dimensions of interest (e.g. ‘importance’ and ‘feasibility’ to change in this study), and (iii) *Interpretation* of the visual maps (including concept maps) produced by the CM software through analyses of the data gathered in previous two phases (Trochim, 1989). This approach integrates both qualitative and quantitative data to organize perspectives from various participants into a common framework to inform future planning (Kane & Trochim, 2007). The qualitative data is generated through *Brainstorming* and *Interpretation* while quantitative is generated through *Sorting and Rating* activities.

This participatory research aligns well with the CST paradigm because it enables participants develop and finalize the concept maps (Burke et al., 2005). Feminist and constructivist perspectives insist that populations of interest should be included throughout the research process and recognized as experts of their lives (Browne, 1998; Lincoln & Guba, 1985). These goals are met in the CM design as it is semi-structured and allows inclusion of perspectives in all phases up to *Interpretation*.

### **A. Participants and Recruitment**

Participants in CM study are understood as cultural experts (Stringer, 2013) and, hence the sampling is *purposive*. In this study, the aim was to recruit 20-30 elderly Tamil men and

women who arrived as immigrants or asylum migrants. The inclusion criteria for this study were: to be age 55 or older, be a self-identified Sri Lankan Tamil senior, and have the ability to read and understand English. The researcher applied the last criterion during in-person contact with the interested potential participants. The study flyer was posted and shared with the clients accessing the partnering organizations. Interested participants were asked to call the researcher via the phone number listed on the flyer to obtain further details. In return for their in-kind support, the researcher allowed community partners to benefit from the collected data with participant consent to potentially inform their future programming. Letters of information and consent forms were provided prior to starting the *Brainstorming* session (see Appendix A). An additional audio-recording consent form was provided during the *Interpretation* session (see Appendix B).

## **B. Data Collection Procedures**

The *Brainstorming* and *Interpretation* sessions are often organized as group sessions while *Sorting and Rating* could be offered as a group or one-to-one sessions. In this research, all three activities were group based and delivered in-person. The researcher sought support of five volunteers to assist in the logistical aspects of the groups and note taking. Each session was capped at 10 participants to ensure the amount of data was manageable and a wide variety of opinions were represented (Kane & Trochim, 2007; Trochim, 1989). In addition, given the complexity of the concept maps, only participants with English literacy and strong communication skills were selected to participate in the *Interpretation* session.

The participants were first invited to the *Brainstorming* sessions [two for women (n=18) and one for men (n=9) with 8-10 participants in each] to generate items on the facilitators and barriers of social inclusion. Each *Brainstorming* session started with participants filling out their

informed written consent form and a brief survey (details provided below). Then, participants were invited to answer the focal research question (Objective 1): What facilitators do Tamil seniors, residing in Greater Toronto Area, consider central to social inclusion? As the facilitator, the researcher steered the conversation and all statements were noted on a flip chart for participants to minimize the number of duplicate statements. The volunteers took detailed notes at each *Brainstorming* session to enhance rigor and quality. In total, 204 statements were generated through three *Brainstorming* sessions.

In the brief survey (see Appendix C), participants were asked about socio-demographic characteristics (age, gender, birth country, marital status, work status, education, financial means, family in Canada, English proficiency, and social support), immigration background (year of arrival in Canada, immigrant class category on arrival, current immigrant class category, health (self-rated health, Patient Health Questionnaire-9 depression scale), and access to health care (access to doctor, culture of doctor, barriers to medical care). The self-rated health was a 5-point scale (1 = poor, 2 = fair, 3 = good, 4 very good, 5 = excellent) and has been used worldwide since 1950s (Phillips, Streib & Suchman, 1957). The PHQ9-2 had two questions on interest or pleasure in doing things and feeling down or low over last 2 weeks with a 4-point scale for each (0 = not at all, 1 = several days, 2 = more than half days, 4 = nearly every day); a total score with range of 0-6 was calculated based on existing guidelines (Kroenke, Spitzer & Williams, 2001). The total score for social support was derived (range 0 – 6) by summing responses (no = 0, not sure = 1; yes = 2) across three items that asked about having people to seek advice, accommodation in emergency, and money in case of need. The aim of gathering this information was to describe the sample for future applicability of the findings.

Next, the participants were invited again to the *Sorting & Rating* sessions [two for women (n=13) and one for men (n=9)]. Before these sessions, the researcher consolidated the 204 original statements in consultation with advisor, Dr. Farah Ahmad. This was achieved by removing duplicates and irrelevant statements along with merging similar ones to reduce the number of statements used in the *Sorting* and *Rating* activity. The final list had 72 statements. For the *Sorting* activity, these statements were placed on cue cards. Participants were asked to sort them and make piles of statements (also referred to items) based on “what makes sense to you” and label each pile in accordance with its content. Some guidelines were provided for sorting, which included: each statement can only be sorted once, participants were encouraged to sort statements into 10-13 piles to ensure there were no piles with only one statement, and to avoid one pile of 72 statements (Kane & Trochim, 2007). In the *Rating* portion of this session, participants were asked to rate each item for "importance" (Objective 2-A) and "feasibility" (Objective 2-B) independently. Participants rated each item on a scale of 1-5 for the following two dimensions:

Table 1: CM Rating Dimensions

<p><i>Importance</i> for seniors’ social inclusion:</p> <p>1 = Very Unimportant;  2 = Somewhat Unimportant;  3 = Not Sure;  4 = Somewhat Important;  5 = Very Important</p>	<p><i>Feasibility</i> at a program level to address within the next 12 months:</p> <p>1 = Not Feasible;  2 = Somewhat less Feasible;  3 = Not Sure;  4 = Somewhat More Feasible;  5 = Very Feasible</p>
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One *Interpretation* session was organized, attended by 7 women and 1 man, to interpret the visual maps. These maps were produced before this session by entering the sorted and rated data into the CM software (Concept Systems), which was used to employ multidimensional scaling and hierarchical cluster analysis. The researcher, in consultation with thesis committee,

examined various cluster solutions and the seven-cluster solution was deemed to generate concepts with item content in a meaningful manner and the stress value (see below) was also acceptable. The generated visual maps (e.g. *Point Map*, *Cluster Map*, *Cluster Rating Map*, *Pattern Match Map*) were shared with participants for refinement and discussion. Participants also received print copies of the complete statement list, a list of the statements for seven clusters, and the seven-cluster CM maps generated by the software. To assist with recall, participants were asked to review the list of brainstormed statements, which they had sorted and rated in the previous session. Next, participants reviewed the subsets of statements grouped in seven-cluster CM solution and the top 10 labels given during sorting activity. The facilitator encouraged the group to reach a consensus on cluster labels to aid the discussion. In this process, participants had the option to move one or two statements that did not belong in existing clusters. In this process, participants identified three statements to be moved. However, after reviewing the resulting map (with three points moved in real-time), participants agreed that leaving some of these poorly fitted statements in their original position preserved the integrity of the overall clusters.

After labels and statements were confirmed for each cluster, participants previewed the two *Cluster Rating Maps* for importance and feasibility. The researcher facilitated the discussion and prompted participants to discuss how these maps represented their perceptions of social inclusion in Toronto as well as the potential implications for community program planning. Participants held the power to decide how the concept maps should be used to organize program priorities that locally affect them, examine where additional resources are needed on a community level, and make recommendations for future program initiatives to improve social inclusion for Tamil seniors. This process led to a general discussion of the sensibility of the maps

and their implications for future programming. Through guided questions and the spontaneous exchange of strategies to address social inclusion, the resulting data informed broadly seniors' perspective and questions to be used in the subsequent FG discussions with service providers.

### **C. Analyses**

The data collected from the survey (n=21) was analysed using Statistical Package for Social Sciences (Corporation IBM, 2013). The survey dataset was cleaned and screened by conducting descriptive statistics to prepare data for analysis. A summary of the tabulated survey results was prepared with a mean or proportion. The rating scores for importance and feasibility gathered via CM's rating activity were also entered into SPSS to conduct gender-based analysis.

The statements generated, sorted, and rated by participants were represented graphically via concept maps. Results from the sorting portion were combined across the three sessions to create a similarity matrix (see Results chapter) using the software designed for this purpose (Concept Systems Incorporated) (Kane & Trochim, 2007). This matrix was constructed for each participant and was aggregated into a single total matrix. The sort data matrix has sorters as rows and statements as columns, which estimates the similarity among statements across all participants. Next, multidimensional scaling of the similarity matrix creates coordinates for each statement, which locates each statement as a separate point on a map. The first map called the *Point Map* displays all statements as points and the space between these points is determined by their similarity/difference determined by participants in the sorting activity. Statements that were sorted more frequently together by all 21 participants were represented closer than those that were sorted less often together (Kane & Trochim, 2007). In multidimensional scaling, a diagnostic statistic 'stress value' was used to determine the goodness of fit of the map. A low stress value implies good overall fit between the input matrix data and its representation on the

map. According to Trochim and Kane (2007), the ideal values fall within the range of 0.21 and 0.37.

In the next visual representation, *Cluster Map*, hierarchical cluster analysis partitions organized individual statements (points) into clusters, which represented a common theme among the included statements. The *Cluster Map* illustrates how participants' opinions are organized and related to each other. To decide on the final Cluster Map, a divisive method was used to begin with one single-cluster solution and successively divide until an appropriate number of meaningful clusters was decided upon by the thesis committee who took into account the meaningful content of clusters and the stress values for various cluster solutions; the seven-cluster solution had an acceptable stress value of 0.33. This final map was used in the *Interpretation* session. In the *Cluster Rating Maps*, statements were graphed on values plots based on importance and feasibility to change a program level. To do this, the rating information of all statements was aggregated to assess the statements on two scales. Average ratings were computed for each statement and for each cluster. The visual representations of these statements facilitated consensus building in the *Interpretation* session to determine the group's thoughts on the importance and feasibility of the items generated (Trochim, 1989).

#### **D. Quality and Rigor**

The researcher prepared for the CM methodology by attending a facilitator-training workshop in Ithaca, New York. Along with the hands-on skills gained, this training allowed for the refinement of the focal question to ensure participants' comprehension for rigor and quality of data. One of the advisors (Dr. Ahmad) also guided the conduction of first few sessions to ensure rigor and quality. The volunteers were also trained prior to their contributions in the fieldwork. While long intervals between each session could potentially prompt feelings of

forgetfulness, the four-month data collection timeline provided ample time to produce high-quality concept maps. To enhance participant recall, confidence, and full participation, the researcher spent time at the beginning of each session to reorient participants and explain the CM process. In the consolidation of statements from 204 to 72 items, the researcher paid close attention to the raw data to capture the meanings while collapsing similar statements.

### **E. Challenges**

During the CM sessions, the researcher was afforded insider status because she shared the same cultural and ethnic background as the participants. In addition, she spoke the language fluently, which helped her build a good rapport with the participants before the sessions started. According to Ganga and Scott (2006), a degree of social proximity enhances the researcher's awareness of social divisions within the researcher-participant relationship, which can be addressed. However, because she pursued unilingual research, she was unable to recruit with Tamil seniors who could not read in English. This reinforced her outsider within status, where the senior participants felt inclined to understand her position in relation to theirs. Due to this outsider within status, the researcher engaged in reflexive thinking to understand the researcher-participant dynamic and to improve the relationship between inquiry and theory (England, 1994). Many questions about researcher's family background, whether she have visited back home, how come she had not learned how to write in Tamil, and her connection to this research were posed to make sense of her role. Lastly, this research was conducted in an intergenerational context, where seniors had perceptions about how the younger generation viewed them and the growing generational gap between age cohorts in Canada compared to Sri Lanka.

## **2.6 Focus Groups**

Service providers bring valuable expert opinions and professional skills to research studies, and thus, were involved in this research. Service providers have specific knowledge about the information desired by the researcher, which is to understand the macro- and meso-level factors that reinforce exclusion for Tamil seniors. It is possible that seniors may not be aware of macro-level structural barriers or were unable to discuss them during CM sessions due to time limits. Consequently, service providers were approached through focus groups to contextualize social, political, and economic environments of older immigrant communities.

This method aligns with the CST paradigm because during group discussions, the researcher can gauge interpersonal communication, which may not be accessible in interviews and surveys. For example, the researcher can analyze the use of humour, consensus, and dissent to examine the variety of narratives and identify shared knowledge. Further, it stimulates group thinking and thereby has a synergistic effect on participants (Morse, 1994; Padgett, 2016). For example, less inhibited participants can provide mutual support and facilitate empowerment of shyer participants to discuss more complex topics. Due to the dynamic participant-to-participant interaction, the group explored nuanced solutions to problems associated with social inclusion as a group rather than as individuals, contributing to the richness of the results (Kitzinger, 1995).

### **A. Participants and Recruitment**

The researcher held two FGs with 13 service providers (i.e. executive director, board members, program leads, social workers, etc.) at two partner organizations (the Senior Tamils' Centre of Ontario and Social Services Network). To ensure diverse representation of opinions, service providers were recruited from two different senior organizations of varying positions to avoid biased results. FGs were conducted from November 2017 to December 2017. The FGs

discussion guide was determined based on the developments during the *Interpretation* session. Letters of information and consent forms were provided to the potential participants prior to the FG sessions (see Appendix D).

## **B. Data Collection Procedures**

The goal of these FGs was to triangulate the data collected via CM sessions with participants from the Senior Tamils' Centre of Ontario. Each FG participant completed a brief survey (see Appendix E). The main objective was to interpret the resulting maps (Morse, 1994) and to understand whether service providers agreed with seniors' ratings of feasibility on various items. The second objective was to determine what strategies could be developed to address statements deemed most feasible by senior participants. By addressing these two objectives, the FG data set broadened the understanding of challenges to social inclusion for older Tamils in Canada. Service providers were asked the following open-ended questions:

1. What could be done by agencies in the community to change facilitators and barriers for social inclusion in the bottom three clusters: medical system and senior care, services for employment and settlement, and financial independence?
2. Why are the top four clusters (adaptation and integration, cultural interaction and feeling of security, social interaction, and family harmony) less feasible to change in the community?
3. Would any of these strategies (facilitators and barriers) vary for new and established seniors?

Both FG discussions were audio-recorded and transcribed verbatim.

## **C. Analyses**

Service providers shared their perspectives of what they believed were facilitators and barriers for the social inclusion of Tamil seniors in the GTA. In this discussion, the researcher began to understand the challenges service providers faced at an agency level. The triangulation

of data from the FGs and the *Interpretation* session from the CM methodology allowed the researcher to present a rich, detailed description of the various factors that inform social inclusion as well as add recommendations to study conclusions.

Data analysis used an inductive approach employing thematic analysis techniques as described by Clarke and Braun (2014). The purpose of the analysis was to expose service providers' beliefs of whether senior-identified barriers and facilitators were feasible to address at a program level. The first step involved reading each transcript thoroughly line by line to gain an understanding of the data. In a method of open coding, initial ideas and phrases were coded and condensed into analyzable units. Next, the researcher compared the codes from each transcript to identify recurring ideas that helped illustrate common facilitators and barriers. Then, codes were grouped into broader categories, which resulted in identifying salient themes affecting social inclusion as explored by the service providers. Thematic analysis was used to focus attention on context and commonalities between the two discussions, which was guided by the open-ended research questions. The results section showcases each theme with direct quotations to provide the reader access to the thoughts of the service providers.

#### **D. Quality and Rigor**

To enhance reliability of coding, both transcripts were coded independently. Further, all codes, subthemes, and categories were repeatedly examined, and the results were discussed with thesis advisor, Dr. Ahmad, who is experienced in qualitative studies. It is clear from the literature review that the relationship between social inclusion and migration is an under-researched area of immigrant health. Thus, while the FG results are not generalizable to other immigrant seniors or Tamil populations throughout Canada, this research prompts the need for larger studies including longitudinal designs.

## **E. Challenges**

The involvement of various groups of service providers resulted in nuanced power relations between the members of each group. For instance, FGs included frontline staff as well as Executive Directors, which would impact the information being provided by either participant. The potential for this to influence the research is acknowledged. In facilitating the FG discussions with service providers, limited time persisted as an issue. Additional time would have likely drawn out more insightful feedback, and this too is acknowledged as a challenge of this research.

## **2.7 Ethical Considerations**

A study protocol was submitted to the Human Participant Research Committee at York University to obtain research ethics approval and the researcher has successfully completed the Tri-Council Agencies Tutorial. Four amendments were made with respect to data collection methods, all of which were approved before moving the research to completion. Participation in the study was completely voluntary. The participants' benefits and their protections were outlined in their respective consent forms. Strict consideration and care was taken to protect participants' confidentiality and privacy. A strict protocol was followed to ensure that no participant could be identified during the study and with subsequent knowledge mobilization. The data were analyzed at the aggregate level. Future publications and presentations based on the study findings will not identify the names of participants. The data will be kept a maximum of five years after publication of major reports or articles and then destroyed.

Given that the research involves Tamil-speaking participants, in addition to English, the researcher spoke in Tamil when appropriate to facilitate the CM process. The researcher is proficient in Tamil to complete the proposed research; however, only Tamil seniors with English

fluency were recruited to participate. While this is a limitation, the researcher did not have the necessary resources for translation and interpretation to conduct data collection in only Tamil.

The decision to focus on a specific immigrant group rather than comparing multiple immigrant groups is due to many challenges, which include: limited time span, limited funds, lack of language expertise, and limited capacity (Adamson and Donovan, 2002). Given these challenges, the researcher decided to focus on one ethnocultural group that is under-represented in research especially in the post-migration context, namely Sri Lankan Tamil seniors. The researcher acknowledges her privilege of “researching” the experiences of vulnerable ethnic minority seniors in regards to their social inclusion. However, providing equal access to participate in research is important as research often serves as currency for government funding to support new programming (Fryer et al., 2012). In fact, Fryer et al. suggest: “(t)he lack of linguistically diverse participant samples acutely limits the relevancy and application of new health knowledge to contemporary multicultural communities” (2012, p. 23). To counteract the routine exclusion of older immigrants in research, Tamil seniors contributed to the research as experts on their experience of social inclusion. Their narratives and lived experiences were treated as the primary method for data collection. To supplement seniors’ narratives, FGs with service providers were necessary to contextualize current limitations in immigration and public policy, health service utilization, and access to social benefits.

Given the exploratory nature of the study, transferability of the findings needs caution. Nonetheless, the data collected by the community-engaged methods of CM and FGs meet the aim of giving voice to the perspectives of an under-researched community of Tamil seniors residing in the GTA. The insights gained are expected to inform further research and program development for the specified community.

## Chapter Three

### RESULTS

This chapter reports results from both phases of data collection (CM and FGs) and the descriptions of participants.

#### **3.1 Concept Mapping**

Sri Lankan Tamil seniors residing in the GTA, who are above the age of 55, were invited to participate in all three phases of the CM sessions at the Senior Tamils' Centre of Ontario. The data was collected from June 2017 to September 2017 for *Brainstorming*, *Sorting and Rating* and *Interpretation* phases. The number of participants varied across three phases (*Brainstorming* n = 27; *Sorting and Rating* n = 21; *Interpretation* n = 7) due to participants' schedules and the time frame of four months over which the data was collected. Further, based on the CM methodological guidelines, the *Interpretation* sessions were conducted with participants who expressed abilities to share their thoughts without hesitation and comprehend the visual maps generated by the CM software.

#### **A. Description of Participant Sample**

The total sample was comprised of 27 participants (9 males and 18 females) with the average age of 71 years. Most of the participants were born in Sri Lanka (92.6%). The majority arrived as economic class immigrants (48.1%), and others through sponsorship (25.9%), refugee (22.2%), and visitor (3.7%) visa programs. At the time of study, they had lived 26 years on average in Canada, majority were Canadian citizens (85.2%), most of them were married (70.4%), and almost all had children (92.6%). A large number (81.4%) had college or university

education, reported good/excellent English language skills (85%), and most of them were retired (see Table 2 for more details).

In terms of health, a majority of the participants rated their health as good/very good/excellent (74.1%). At the time of the study, all participants had access to a doctor, with equal representation of both female (48.1%) and male (51.9%) genders who mostly (63%) did not share the same ethnic culture as the participants. Most participants did not experience barriers to medical care (85.2%). However, some participants had barriers (14.8%), which included transportation (75%), knowledge of care services, and family reaction to seeking professional care (25%).

### **B. Brainstorming Activity**

Twenty-seven participants in total attended one of three *Brainstorming* sessions (two groups for females and one group for males). In the first session, there were 10 females, in the second, there were 9 males, and in the third session, there were 8 females. Each session lasted for about 90 minutes. The *Brainstorming* sessions resulted in 204 statements in response to the focal prompt “what factors help you and other Tamil seniors in the Greater Toronto Area feel included?” After reviewing the initial statements and upon consultation with Dr. Ahmad, the researcher removed redundant statements, clarified and condensed complex statements, and added statements when important concepts from literature review were missing. A final list of the 72 statements was prepared prior to the *Sorting and Rating* session (see Appendix F).

Table 2: CM Participants' Socio-demographic Characteristics (N= 27)

<b>Variable</b>	<b>Number</b>	<b>Mean or Proportion</b>
<b><i>Age, mean (SD)</i></b>	27	71.04 (4.8)
<b><i>Gender, %</i></b>		
Male	9	33.3
Female	18	66.6
<b><i>Birth Country, %</i></b>		
Sri Lanka	25	92.6
Malaysia	2	7.4
<b><i>Years lived in Canada, mean (SD)</i></b>	27	26 (8.9)
<b><i>Immigration status on arrival, %</i></b>		
Independent Economic Class	1	3.7
Sponsored Family Class	19	70.3
Refugee	6	22.2
Visitor's Visa	1	3.7
<b><i>Canadian citizen status now, %</i></b>		
Citizen	23	85.2
Permanent Resident	4	14.8
<b><i>Arrived with, %</i></b>		
Partner & Children	10	37.0
Alone	4	14.8
Children or Partner	13	48.1
<b><i>Current intimate relationship, %</i></b>		
Married	19	70.4
Widowed	6	22.2
Separated or divorced	2	7.4
<b><i>Education, %</i></b>		
Up to high school	13	48.1
College	11	40.7
Bachelors	3	11.1
<b><i>English proficiency (scale 1-5), mean (SD)</i></b>	27	3.3 (0.8)
<b><i>**Working status, %</i></b>		
Housework	8	29.6
Volunteer	4	14.8
Paid work	1	3.7
Retired	19	70.4
<b><i>*Difficulty in Making Financial Decisions, %</i></b>		
Often	3	11.1%
Sometimes	11	40.7%
Never	12	44.4%
<b><i>* Social Support (scale 0-6), Mean (SD)</i></b>	27	5.1 (1.1)

Note: \* 1 missing; \*\* respondents selected more than one response

Table 3: Health Related Characteristics of CM Participants (N= 27)

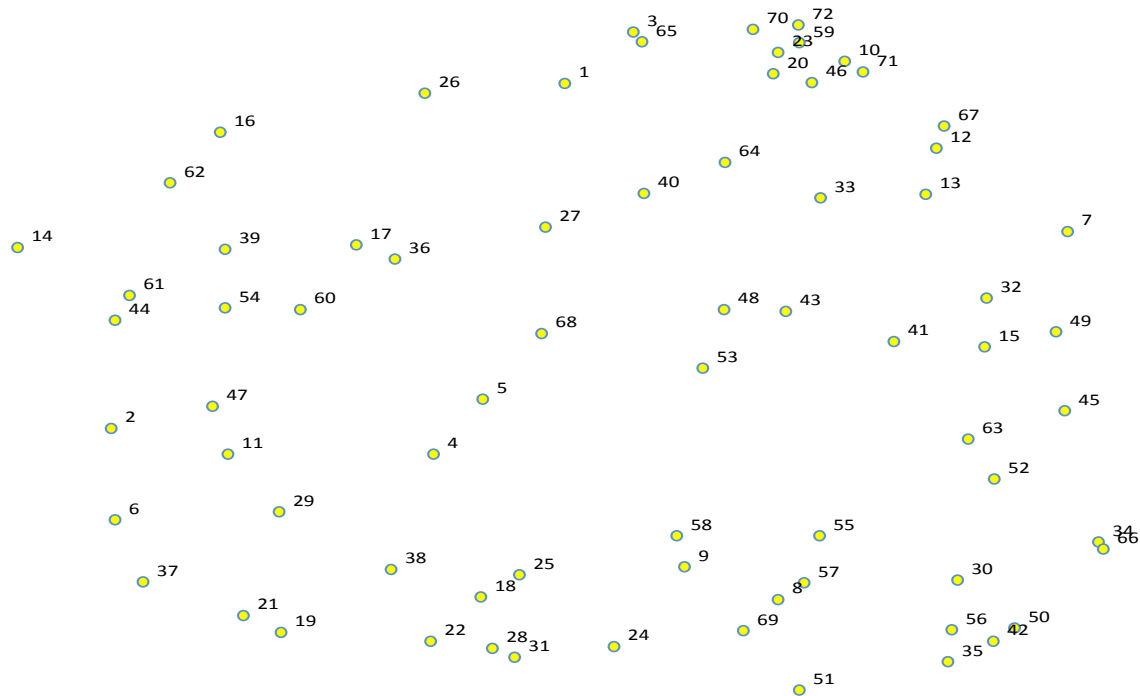
<b>Variable</b>	<b>Number</b>	<b>Mean or Proportion</b>
<b><i>Self-rated Health, %</i></b>		
Poor	1	3.7
Fair	6	22.2
Good	14	51.9
Very Good	5	18.5
Excellent	1	3.7
<b><i>Access to Doctor, %</i></b>		
Yes	27	100
<b><i>Family doctor (gender), %</i></b>		
Female	13	48.1
Male	14	51.9
<b><i>Family doctor (from same culture), %</i></b>		
Yes	10	37
No	17	63
<b><i>Barriers to Medical Care, %</i></b>		
Yes	4	14.8
No	23	85.2
<b><i>If Yes to Barriers (n=4)</i></b>		
Transportation	3	75
Knowledge of Care Services/Family Reaction	1	25
<b><i>PHQ-2 (scale 0-6), %</i></b>		
Scored < 1	20	70.07
Scored 1-2	7	25.93
Scored > 2	0	0.0

### **C. Sorting Activity**

The final list of 72 statements was sorted and rated by each participant as outlined in the previous chapter. Twenty-one participants completed the sorting and rating activities in one of three sessions. There were 7 females in the first session, 8 males in the second, and 6 females in the third. Participants took between 90 minutes to 120 minutes to complete both tasks. For sorting, the participants were told to sort the statements into piles that were conceptually similar and suggest a label for each sorted pile. The number of piles that participants used ranged

between 10 to 13. This data was entered in to the CM software where the sorts by each participant are compiled into group similarity-matrix. The similarity matrix table is then converted into a dissimilarity matrix in order to conduct the multidimensional scaling (MDS) analyses. The CM software generated a *Point Map* based on the x-y coordinates of each statement from the three-dimensional model and is presented in Figure 1. Points closer in appearance represent statements that were more often sorted together, whereas statements that are farther away were less often sorted together, representing dissimilarity.

Figure 1: Point Map



**D. Rating Activity**

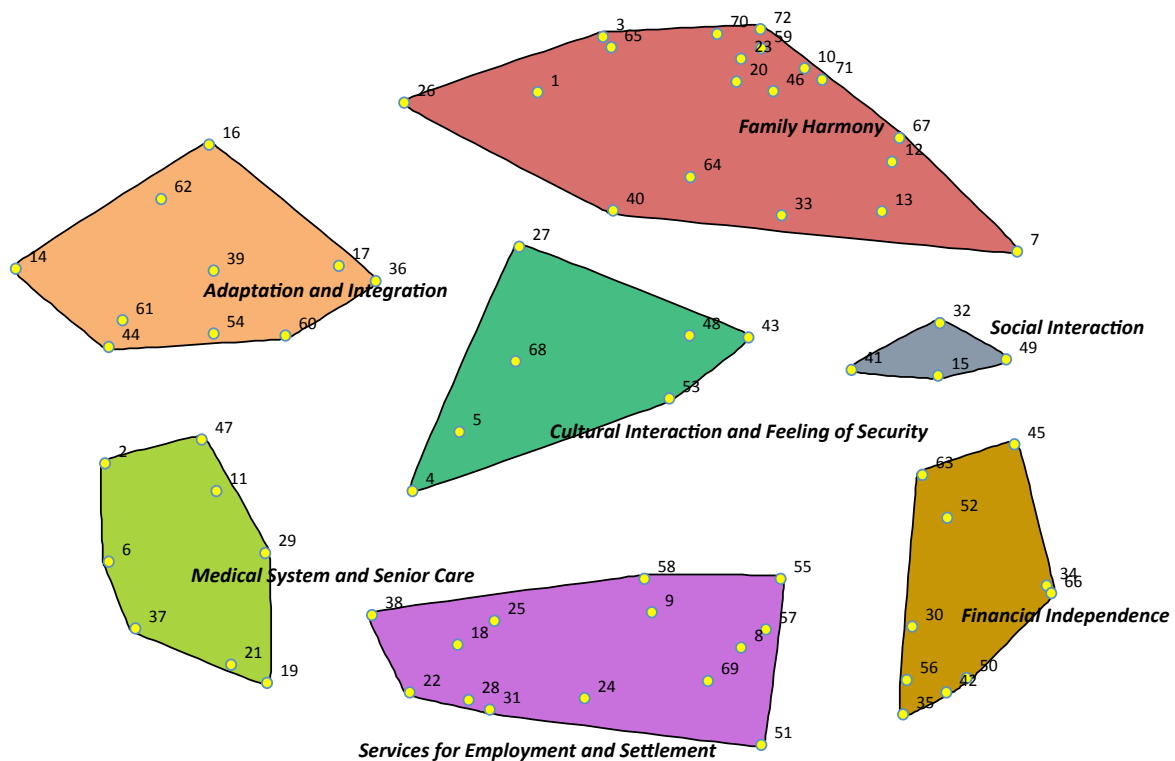
Participants also rated each item on a 5-point scale for the dimension of importance (1= very unimportant to 5 very important) and feasibility to act on at a program level in the next 12 months (1= not feasible to 5 = very feasible). This data was entered into the CM software as well. The average ratings for all 72 statements on both dimensions are listed in Appendix G. The

mean scores for importance of the clusters ranged from 3.82 (SD 0.48) to 4.33 (SD 0.24). The mean scores for feasibility ranged from 3.67 (SD 0.16) to 3.99 (SD 0.30), which represent less feasibility to change some factors on a program level.

### **E. 7-Cluster Solution Map and Interpretation Activity**

The *Cluster Map* with seven clusters was discussed with seven participants in the *Interpretation* session, which lasted approximately 90 minutes (details are as described in the earlier chapter). They provided final labels for each cluster (Figure 2) and opted not to move any statements across the clusters.

Figure 2: Cluster Map (7 Clusters)\*



\*Note: Clusters labels were established with participants during the interpretation session.

The seven clusters are discussed below in terms of content, anchoring or bridging aspects, and the ratings. The CM software provides anchoring and bridging values (mirror opposites), which ranges from 0 to 1, for each statement. In remaining sections, these values are aggregated and discussed at a cluster level. Clusters with lower bridging values are considered “anchors” and are good indicators of the meaning of that part of the map they are located in. Statements with higher bridging values are considered “bridges” and loosely integrated to one part of the map. The CM software was also used to create *Cluster Rating Maps* for the dimensions of importance and feasibility (see Appendix H and I). The mean scores for the importance and feasibility were examined for gender differences using *Student t-test*; no statistically significant differences were found, possibly due to small sample size (see Figure 3 and 4).

Figure 3: Cluster Rating for Importance by Gender

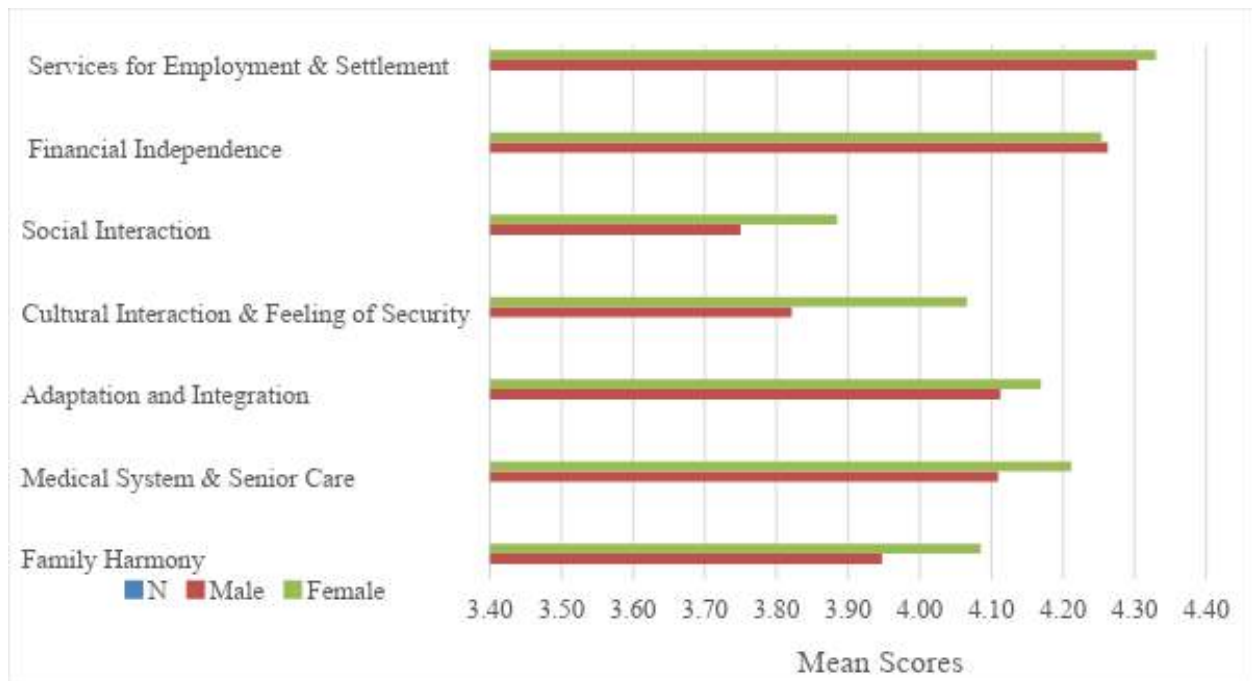
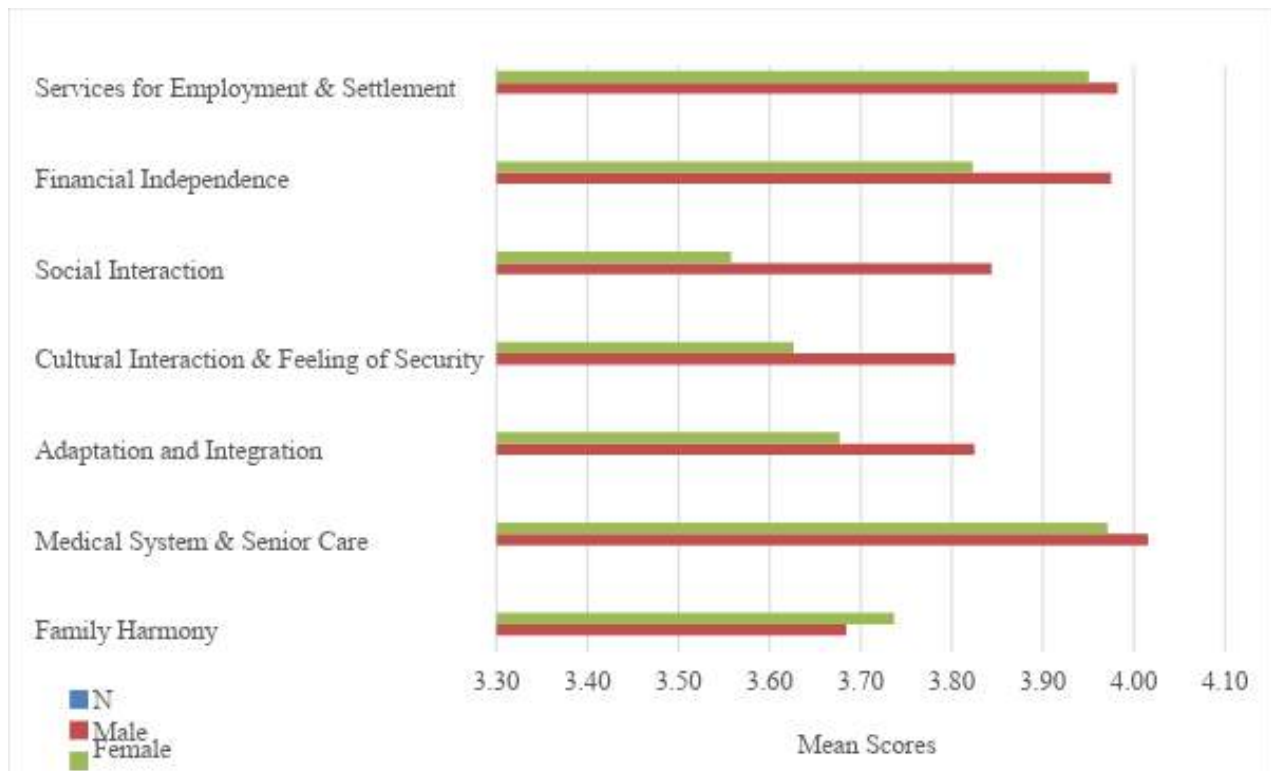


Figure 4: Cluster Rating for Feasibility by Gender



Cluster 1: Family Harmony

This cluster entailed 19 statements and was labelled Family Harmony by the participants. It includes eight barrier statements and eleven facilitator statements for the social inclusion. The representative statements in this cluster include: Having more family events and creating a support system for seniors (Statement #23); Reducing communication/generational barriers with grandchildren (Statement #20); and Developing a tolerance for children’s put-downs and negative attitudes (Statement #65). The *bridging value* (statistical indicator of sorting similarity in for statements in this cluster) for this cluster is 0.29. The lower value shows that many participants sorted these statements alike. Thus, this is an anchoring cluster and is a well-defined central idea. Based on the rating activity, the mean value for the dimension of importance and feasibility to change at program level were 4.05 (SD 0.39) and 3.72 (SD 0.25), respectively.

### Cluster 2: *Medical System and Senior Care*

This cluster entailed 8 statements and was labelled *Medical System and Senior Care* by the participants. Among these statements, one was a barrier and seven facilitators to social inclusion. The representative statements in this cluster include: Having an increased life expectancy in Canada due to medical care and no war (Statement #6); and Keeping yourself busy and healthy through activities (e.g. yoga, biking, etc.) and self-care (Statement #2). The bridging value for this cluster is 0.58. Thus, this cluster is a loosely defined idea and is neither an anchoring or bridging cluster. Based on the rating activity, the mean value for the dimension of importance and feasibility to change at program level were 4.17 (SD 0.46) and 3.99 (SD 0.30), respectively.

### Cluster 3: *Adaptation and Integration*

This cluster entailed 10 statements, three barriers and seven facilitators, and was labelled *Adaptation and Integration* by the participants. The representative statements in this cluster include: Meeting friends in public places to share, listen, and relieve stress (Statement #17); and Moving on with a positive mind frame after difficulties (e.g. war, widowed, separated from spouse; Statement #54). The bridging value for this cluster is 0.67. Thus, this is a bridging cluster that is linked to other parts of the map though not strongly defined within itself. Based on the rating activity, the mean value for the dimension of importance and feasibility to change at program level were 4.14 (SD 0.23) and 3.73 (SD 0.15), respectively.

### Cluster 4: *Cultural Interaction and Feeling of Security*

This cluster entailed 7 statements; one barrier and six facilitators to social inclusion. Participants labelled this cluster *Cultural Interaction and Feeling of Security*. The representative statements in this cluster include: Volunteering here in Canada (e.g. Walkathons; Statement #4);

and Staying in Little Jaffna (GTA) because of the increased Tamil-specific supports and services (Statement #48). According to the sorting activity, the bridging value for this cluster is 0.40.

Thus, this is an anchoring cluster that is a well-defined central idea. Based on the rating activity, the mean value for the dimension of importance and feasibility to change at program level were 3.99 (SD 0.23) and 3.69 (SD 0.33), respectively.

#### Cluster 5: *Social Interaction*

Participants labelled this cluster *Social Interaction*, which entailed 4 statements, among them there was one barrier and three facilitators to social inclusion. The representative statements in this cluster include: Having friendly and non-judgemental conversations with non-Tamil Canadians (Statement #15); and Memberships in associations via schools and villages in Sri Lanka to maintain ties (Statement #32). According to the sorting activity, the bridging value for this cluster is 0.54. Thus, this cluster is loosely defined idea and is neither an anchoring or bridging cluster. Based on the rating activity, the mean value for the dimension of importance and feasibility to change at program level were 3.82 (SD 0.48) and 3.67 (SD 0.16), respectively.

#### Cluster 6: *Financial Independence*

This cluster entailed 10 statements and labelled *Financial Independence* during the *Interpretation* session. Among these statements, one barrier and nine facilitators to social inclusion were identified. The representative statements in this cluster include: Learning to manage finances within one's budget (Statement #50); and Having Old Age Security and Canada Pension Plan (Statement #56). The bridging value for this cluster is 0.43. Thus, this is an anchoring cluster that is a well-defined central idea. Based on the rating activity, the mean value for the dimension of importance and feasibility to change at program level were 4.22 (SD 0.29) and 3.88 (SD 0.31), respectively.

### Cluster 7: Services for Employment and Settlement

This cluster entailed 14 statements and all were facilitators to social inclusion, participants labelled it *Services for Employment and Settlement*. The representative statements in this cluster include: Having knowledge about government services and available opportunities (Statement #18); Developing life skills (e.g. banking, tax return, credit card fraud; Statement #58); and Overcoming hesitation to ask for information and seek professional advice (Statement #38). The bridging value for this cluster is 0.37. Thus, this is an anchoring cluster that is a well-defined central idea. Based on the rating, the mean value for the dimension of importance and feasibility to change at program level were 4.33 (SD 0.24) and 3.96 (SD 0.33), respectively.

After reviewing the *Cluster Point Map* and *Cluster Rating Maps* for importance and feasibility to change at a program level, participants were invited to discuss possible actions that community-based agencies can take for Cluster 2, 6 and 7; explanations for low feasibility rating of Clusters 1, 3, 4 and 5; and possible difference when reaching established versus recent senior Tamil immigrants. In response to the first question, participants identified several statements that were critical to their social inclusion.

In the *Medical System and Social Care* (Cluster 1), one participant identified that the possibility of going to a senior home (Statement #11) is important to be addressed at an agency level. Many participants discussed the long wait-list for senior homes and how they can wait for many years before they provided with a place. One recommendation was to assist seniors in registering for long-term care well in advance to ensure that they will be able to circumvent the long waiting period. Another participant agreed that reducing the waiting time would be helpful. The participants envisioned community agencies acting as liaisons between seniors and long-term care providers to remove communication barriers. Further, one participant stated that if all

informative sessions were held under one roof, such as in a senior centre, it would limit the amount of transportation required and be more accessible. This kind of service was described as critical because seniors would not need to travel to different senior homes to register themselves but could do so at the comfort of their senior centre. Similarly, another participant insisted that having access to welfare housing should be addressed at the program level. Participants stated the waiting list for welfare housing is too long for anyone, but particularly for vulnerable seniors.

Another participant mentioned that having better access to transportation to reduce loneliness (Statement #45) should be addressed at the program level. One participant insisted that local transportation should be in one place for ease of convenience. Other participants quickly disagreed with the previous comment stating that the government cannot provide more support for transport because “they have already given so much.” Another participant argued “we have to learn to adjust [with] what we have already and try to make the most of it... if we ask for more, we won’t get nothing.” Participants discussed the convenience of WheelTrans because it picks up clients from their home and takes them to the destination of their choice. Further, WheelTrans allows appointments to be booked with four hours’ notice, which participants agreed was much better than the previous condition where a 24-hour notice was required. Participants were satisfied with the new system, which allowed them to cancel appointments four hours prior to the appointment with no penalty and suited their daily demands. However, the former participant argued that WheelTrans only offers four subsidized rides per month and a late cancellation would also count as a trip. This participant said four subsidized trips are not enough for seniors, especially if they are to be socially engaged in their community. Another participant stated that whether seniors’ carpool together or take the bus is a private concern and is not agency-related,

so this cannot be addressed at the program level. As discussed above, there were several conflicting views on whether public transportation could be addressed at a program level.

Developing life skills such as banking, filing tax return, and preventing credit card fraud (Statement #57) were deemed important and feasible to be addressed, but not at a program level. One participant reported that when they go to the bank, often bank officers speak their language, thus, communication barriers have been removed. Another participant recounted how at Woodside Mall, there are a lot of Chinese seniors in the area, and accordingly, there are many Chinese-speaking tellers. Another participant reported that there are several banks with bilingual tellers. Participants agreed that banks already teach seniors about banking and tax returns, thus, agencies do not need to provide this service, nor do seniors depend on agencies for such support.

All participants agreed that having English language skills or learning English (Statement #37) and having knowledge about government services and available opportunities (Statement #18) are important to address at a program level. Seniors discussed that “ESL programs are really good [especially] for new[comer] seniors.” Participants recommended that senior centres could help seniors navigate existing programs and services by acting as liaisons with other agencies. Agencies can offer language support and act as knowledge brokers to provide formal support to seniors, both established and recent immigrants.

In response to the second question, participants discussed changes needed at a cluster level. The first cluster to be discussed is the *Family Harmony* (Cluster 1). Many of the participants discussed that this is individual-based, “work that must be done within families,” but if agencies were to help they should work with individuals to identify problematic areas. One participant reasoned that “back home” (in Sri Lanka) elders were consulted whenever young family members had problems. But in Canada, seniors are not aware of available solutions and

feel a cultural role reversal. Seniors do not feel valued in the traditional sense. Participants mentioned the work of other agencies that are not senior specific, such as the Children's Aid Society and other counselling services that exist to support families when issues arise (i.e. child abuse). However, another participant added workshops could be facilitated through senior centres to educate seniors about elder abuse and how to manage such issues. Also, seniors can be educated on how to manage intergenerational gaps and how to adjust to changing family dynamics. Seniors need access to support groups with peers who are also experiencing similar situations to become aware of solutions. Another participant claimed that senior centres already facilitate connections to counselling services so they are connected when support becomes necessary. Thus, it seems that participants varied in their experiences and perceptions though there was an overall interest in taking a proactive approach towards Family Harmony.

The next cluster labelled *Adaptation and Integration* (Cluster 3) was discussed as less feasible to change at a program level. Participants collectively agreed that agencies are not able to assist seniors with adaptation and integration concerns. Instead, the Tamil community as a whole should address this. One participant insisted that statements about promoting Tamil language, cultural and religious values amongst youth (Statement #62) and setting up more Tamil cultural facilities, such as temples (Statement #61) is a community endeavour that will take years and even generations to do. However, another participant agreed that education could teach seniors how to make new connections in the community and adapt to Canadian lifestyle.

The last cluster discussed was *Social Interaction* (Cluster 5) and perceived as less feasible to change at a program level. One participant argued this is an individual problem. She explained how "seniors, themselves need to be motivated to speak to other [non-Tamil Canadians]...say hi to neighbours, and overcome the language barriers by attending ESL

programs run by local agencies.” Another participant agreed, stating “yes, seniors should come to this agency, come to STC and we will teach them how to interact and move along with people.” When prompted by the facilitator about how senior centres can facilitate meeting non-Tamil Canadians, many participants responded that community centres exist for this purpose. Another participant argued that community centres already have several senior programs where you can be of any culture, and the only requirement is that the individual be above the age of 55. This participant listed the various opportunities that exist in community centres. She explained, “You can meet other seniors and exercise with them, but you need to be willing to do that.” She stressed that agencies can encourage seniors to come out, even other seniors can encourage their isolated peers to join them at senior centres or community centres, but only if the senior in question is interested and willing to do so, can anything be done to facilitate their inclusion. Reconciling the notion of Tamil elders interacting with non-Tamils with the rest of this cluster is critical to fully embrace the ideals of multiculturalism.

In response to the last question, many participants stated that the strategies discussed do not need to be specific for recent or established seniors, rather, they can be offered together. In fact, established seniors have better awareness of available programs because “[they] know the system [now].” However, recent seniors who arrived in Canada within the last five years may struggle with the language and culture. But all participants agreed that recent older immigrants are better positioned compared to established seniors who arrived in the 1970s or 1980s. One participant remarked that there are more services available now. Another participant mentioned that there are also more Tamil seniors who can also help them connect with various networks. All participants discussed the extensive network of Tamil services available now. From Tamil-speaking service providers to Tamil agencies such as the Tamil Eelam Society of Canada, one

participant suggested that “you can go to one agency for help with elder abuse or another family problem and they will connect you to other specific Tamil-serving agencies.” She explained, “there is much more connection now [and] we do not feel isolated.”

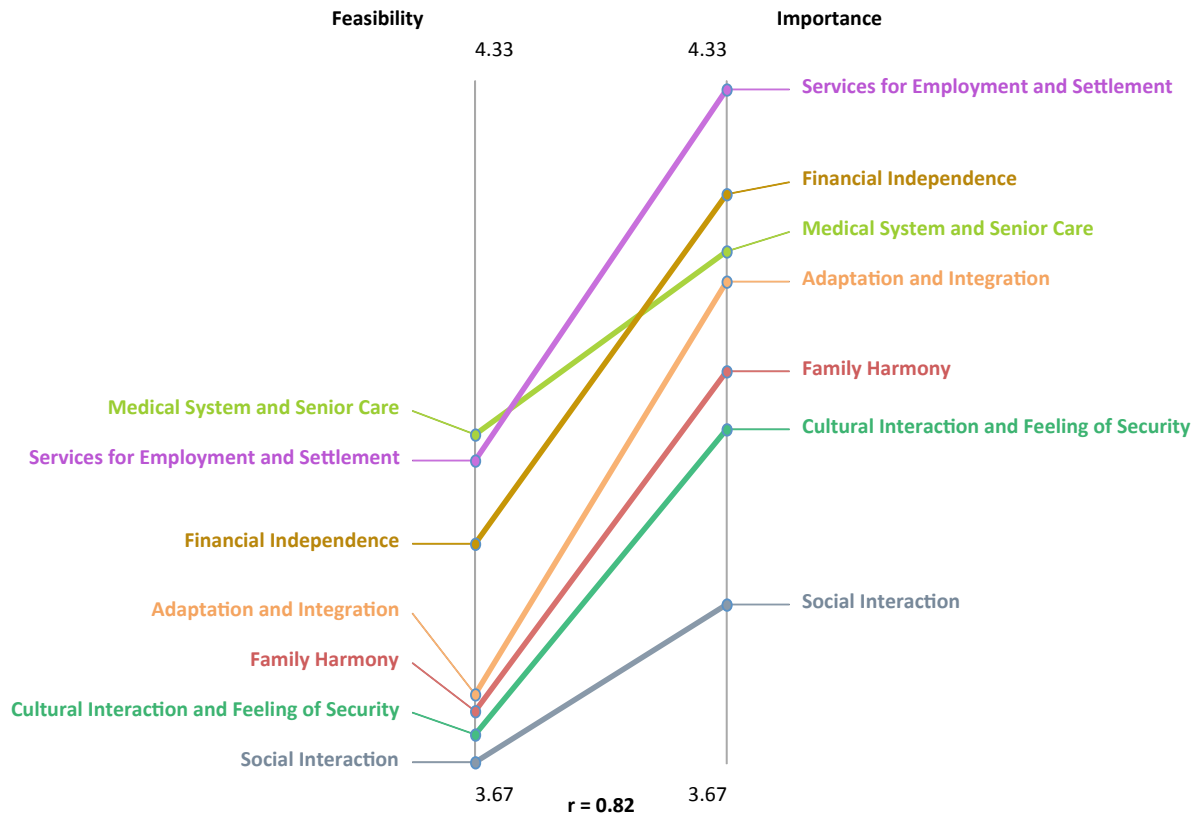
The purpose of the *Interpretation* session was to confirm the labels of each cluster, to finalize the cluster solution, and if necessary, move one or two statements to better suit the labels, and close with a discussion based on questions posed above. The ability of participants to understand which cluster was most feasible to change at a program level enabled them to brainstorm actions that agencies can take to address some of the barriers seniors face for social inclusion. Given the fruitful discussion provided by the participants, it was important to review these recommendations with service providers both from the partner agency (Seniors Tamils’ Centre of Ontario) and another agency (Social Services Network) to corroborate the findings.

#### **F. Pattern Match Map**

The Concept System software was used to examine data in many ways. The *Pattern Match* is a map that compares the cluster-level rating scores for the measured dimensions. Figure 5 shows the mean scores of importance and feasibility for each cluster relative to other clusters. This map was not discussed with Tamil seniors because of the limited time and its complexity. However, this map was used in the FGs with service providers. Some key findings are notable. For example, the cluster labelled *Services for Employment and Settlement* was rated as most important for seniors’ inclusion and the second most feasible to change at a program level. Another interesting finding was that the cluster labelled *Social Interaction* was rated least important and least feasible to change. This visualization ranks each cluster based on the cluster

rating scores to understand how to address the different clusters at a program level. The Pearson product-moment correlation was 0.82 for the dimension of importance and feasibility.

Figure 5: Pattern Match

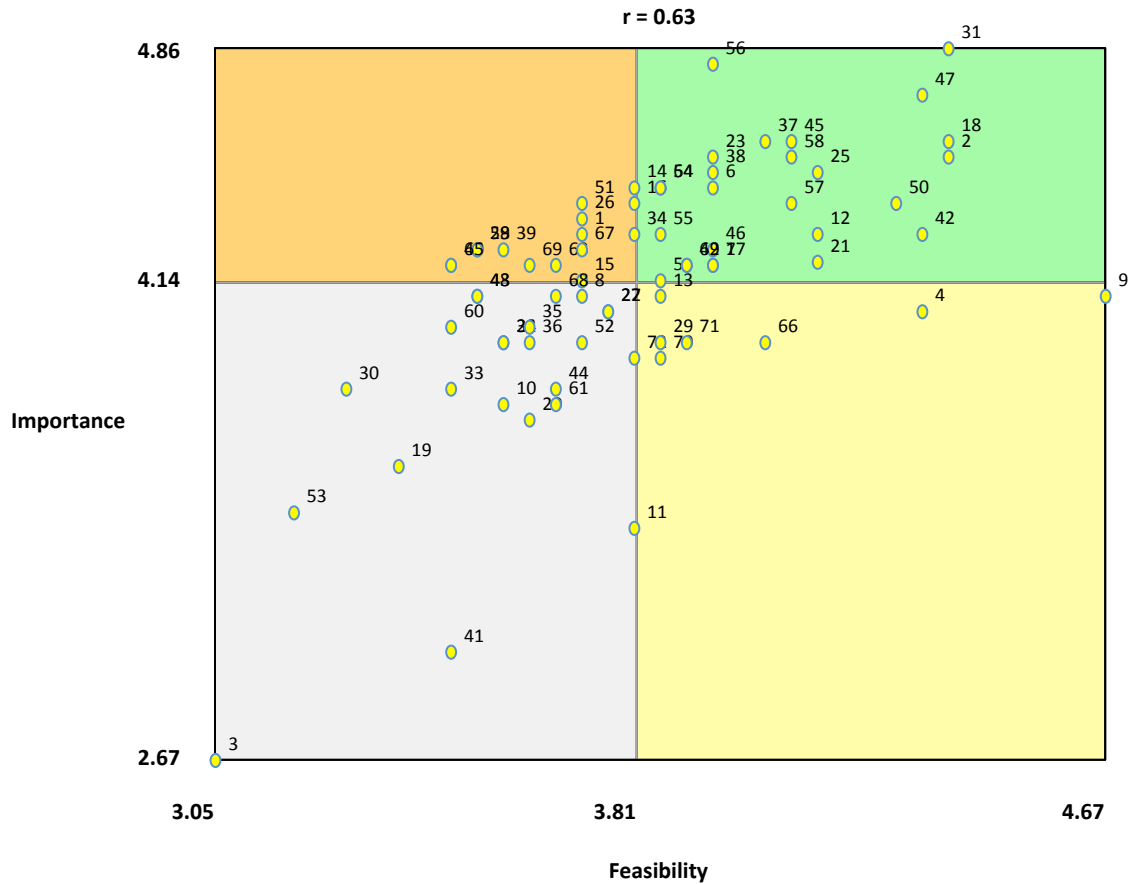


### G. Go-Zone Map

Another map produced by the CM software is *Go-Zone* map, which displays position of the rated statements for the measured dimensions in four quadrants (high-high, high-low, low-high, low-low). Figure 6 was generated for the 72 statements using their average ratings for feasibility and importance dimensions. The most important and most feasible statements are represented in the top right quadrant whereas less important and feasible items are in the lower left quadrant. Statements in the lower right quadrant represent items that are very feasible to change but not very important. Statements in the upper left quadrant represent items that are very

important but less feasible to change at a program level. This *Go-Zone* map were not presented to the Tamil seniors or to service providers because of limited time, and the general difficulties associated with explaining *Go-Zones*. However, this map illustrated to researchers the most actionable items for change and facilitated interpretation of the results (see next chapter).

Figure 6: Go Zone Map (All Statements)



### **3.2 Focus Groups**

The second phase of the mixed-method sequential design study comprised of FGs

#### **A. Description of Participant Sample**

Two FG discussions were organized with service providers working with Tamil seniors.

The first group had 8 participants (1 male; 7 females) and the second group had 5 participants

(all females). A total of thirteen service providers were recruited based on their affiliations with organizations that served Tamil seniors in the GTA. All participants were from one of two organizations identified in Chapter Two and served a designated service catchment area. Most participants were born in Sri Lanka (69.2%). At the time of the study, they lived 31.46 years on average in Canada. In total, participants reported nine spoken languages with English (100%) and Tamil (76.9%) as the most common. A large number had a university or college education (92.2%). All participants were service providers directly working with immigrant seniors through programs developed at their organization. Eight service providers specified working with Tamil seniors specifically and the remaining five worked with several aging immigrant communities. For more demographic details of the participants see Table 4.

## **B. Thematic Analysis**

The perspectives of service providers collected during the FG discussions were transcribed verbatim. These transcriptions and fieldnotes were analysed for dominant and unique themes using constant comparison technique across and within the group discussions (Morgan, 1996). Five major themes were identified in relation to social inclusion: (1) reframing service delivery to meet Tamil seniors' needs; (2) advancement of long-term care homes to become culturally appropriate; (3) sustainable funding and required partnerships; (4) factors with feasibility challenges; and (5) oblique references to socially sensitive topics. The last theme was identified by paying attention to indirect comments made by participants.

Table 4: Demographics of FG Participants (N=13)

<b>Variable</b>	<b>Number</b>	<b>Mean or Proportion</b>
<b><i>Gender, %</i></b>		
Female	12	87.5
Male	1	12.5
<b><i>Birth country, %</i></b>		
Sri Lanka	9	69.2
Malaysia or India	2	15.2
Kenya or Tanzania	2	15.2
<b><i>Years lived in Canada, mean</i></b>	13	31.46
<b><i>*Languages spoken, %</i></b>		
English	13	100
Tamil	10	76.9
Sinhala	3	23.1
Hindi	2	15.4
French	1	7.6
Malay or Punjabi or Gujarati, or Swahili	4	30.4
<b><i>Education, %</i></b>		
University	5	38.4
College	7	53.8
High school	1	7.6
<b><i>Last employer, %</i></b>		
Senior centre	6	46.2
Not-for-profit	2	15.4
Ministry or university	2	15.2
With bank	1	7.6
Editor	1	7.6
Retired	1	7.6
<b><i>Years worked for recent employer, mean</i></b>	13	15.5
<b><i>**Years worked with elderly population, mean</i></b>	12	9.3
<b><i>**Years worked with immigrant population, mean</i></b>	12	13.2

Notes: \* responded provided more than one response; \*\*1 missing

## Theme 1: Reframing Service Delivery to Meet Tamil Seniors' Needs

All participants heavily discussed the need to reframe existing services to meet the needs of the Tamil seniors. The subthemes included effective services, incorporating cultural and age-friendly insights, barriers to effective service delivery, and innovative ideas.

*Effective Services:* Across both groups, participants viewed effective services as meeting the intertwined dual goal of access to services and empowerment to participate in community activities. For example, they discussed access to various community classes and programs (e.g. recreational Zumba, English as Second Language (ESL), financial budgeting, education on clean air, and a ladies' wing) to support Tamil seniors lead a healthy life. As noted by one service provider:

[We can support] increased life, you know expectancy [because it] is also based on the health and wellness program that they access, right?... that's the easiest one to kind of address. (FG2, P1)

Empowerment at senior centres takes multiple forms. For example, teaching seniors about skills for entrepreneurial ventures was discussed in response to later-life employment as an alternative for seniors seeking extra income. One participant stated “we teach [seniors] how to make these jewellery things right? And now it's like they can sell this ... so, it's like a business, you know?” (FG1, P1). Seniors' empowerment continued to be discussed at several times in reference to CM statements, such as teaching seniors how to negotiate with their adult children to stay at home and encouraging senior women to gain independence from spouse and/or adult children. They shared experiences when Tamil seniors, especially women, encountered resistance to attend programs or information sessions (e.g. financial management). Participants agreed that despite community pushback, it is important to continue programs on socially sensitive issues to improve problematic family dynamics. One participant suggested that:

Like when we say that we build confidence and give them resources and a lot of [seniors] have no clue [at first] because [finances are] managed by their children... most of the things are managed by their caregivers, their children, right? So, when they come here they get to know lot of things and then sometimes they get into trouble for having more information, right? You have seen that all the time. Yeah. (FG2, P1)

***Incorporating cultural and age-friendly insights:*** The participants felt because they were already offering culturally specific programs, they could address the needs of Tamil seniors more appropriately. For example, educating seniors about community issues, namely elder and child abuse, was a major concern. Some service providers described it as the predictor of intergenerational strain in families. One participant explained:

Like telling the grandfather, ‘So, please stop hitting your teenage [grand]-daughter’... Even if it doesn’t go that far, even at the school there’s a duty to report... and [Children's Aid Society] will then invade their lives so even if, you know, children aren’t taken away, it’s still a kind of an upheaval. And it’s shocking to them because they’re not at all [aware].... they’re like ‘What? I just slapped [her]’. (FG2, P1)

Participants also recognized the gender disparity in those who attend their workshops. Both agencies have some targeted strategies to recruit isolated senior women (e.g. offer programs at temples) to encourage their participation. One participant said:

We have a- a ladies’ wing. Sometimes we invite the men also but most of the time it’s ladies. [But if you look at a] senior Tamil women and [Senior Tamils’ Centre of Ontario] women ...they are more independent than a non-STC member. You can see a big difference. (FG1, P1)

There was also discussion about seniors’ eagerness to learn more about technology and it has been now added as a program to meet this need. One service provider reported:

Well we’re certainly starting a program-based art project, like a computer course so that they can ... get online and uh explore that world but I’ve also heard from quite a few seniors who have grandchildren, who are helping them with their smartphones or iPods. (FG1, P2)

***Barriers to Effective Service Delivery:*** Despite taking pride in existing services, service providers overwhelmingly acknowledged challenges for developing and continuing effective

services. These discussions focused on funding, ethnic-specificity, and coordination. The lack of funding to support programs and subsidize transportation was discussed dominantly. In the words of a participant:

We do provide, you know, like subsidized transportation based on the funding we receive [but] .... not 100 percent [able to] meet their challenges but just to some extent we do. (FG2, P1).

One participant raised the concern that ethnic-specific centres run the risk of having seniors only socializing with other members of their own culture. Overwhelmingly, across both FGs, service providers made suggestions to build multicultural community supports. Seniors involved in this research have resided in Canada for a large portion of their lives, and therefore are predominately acculturated or have chosen not to do so. However, for the subset that has yet to acculturate due to barriers beyond their control, a lack of government support serves as a barrier to effective service delivery. To counter existing barriers, one participant stated “[m]aybe we can do a project, like involving, teaching them [about] different cultures maybe [that] is something we could do. Apply for a grant [to] teach them, I think. (FG1, P1)

With an interest to increase the integration of Tamil seniors in mainstream society, participants emphasized the possibility of coordinating opportunities for Tamil seniors to meet Canadian war veterans to collectively share past war experiences. However, there was mixed responses among service providers, which include:

When we bring together people who share traumas...War veterans [and Sri Lankan Tamils] and who else can better understand them than people who share [similar] experiences.... and I think it’s amazing. (FG2, P2)

You know that it has come to a stage that people don’t want to [be] reminded. They want to take it off their mind ...the hardship and the traumatic experience in Sri Lanka... They want to remember the pleasant part of it. (FG1, P2)

***Ideas for Innovative Services:*** In all FGs, participants discussed the need to meet current gaps in service delivery. For example, service providers acknowledged language barriers to accessing

government services related to welfare housing, health care services, and other social programs.

In light of this concern, one participant suggested that other bilingual seniors could offer interpretation services on a volunteer basis. This participant stated:

[We] can provide more [volunteer] interpreters but we have to pay some allowance or something.... at least transportation for these things. There are more [seniors who are] more educated.... [have] more knowledge... [are] bilingual...who can support [other] seniors. (FG1, P1)

However, other participants flagged the issue of capacity building and the difficulty of teaching seniors the importance of volunteering. Some service providers claimed that in later-life, volunteering becomes less common as most seniors start to focus on their own families and themselves. Thus, there was little consensus on whether agencies can expect other seniors to volunteer as interpreters because many were becoming more family-oriented.

Seniors' preference to be around family in later life was a widely accepted belief across both FGs. For example, service providers further discussed that they are aware of seniors' interests in intergenerational programming as it leads to improved family harmony and facilitates their involvement in future generations' lives.

For the grandparents and grandchildren, the parents are the common enemy... I think the grandchildren have more patience, too then their parents.... (FG1, P3)  
.... that's why I always tell them, let's start a youth wing. (FG1, P1)

In addition to being more involved in their families, service providers emphasized seniors' interests in increasing the visibility of their programs at senior centres. They felt that seniors utilizing their programs were proud of their advancements (i.e. becoming more "New School" as one senior put it) and wanted to showcase their evolution to their families. Accordingly, a service provider stated:

For this year's Christmas program, we have [been] told even the family members can be invited because we want to show them what these seniors can do and they're also capable of doing certain things which [their own family members] cannot do. They can dance, they can act, they can sing. So we want to

show [their adult children this] because sometimes they might not know what their parents are doing. (FG1, P1)

## **Theme 2: Advancement of Long-Term Care Homes to Become Culturally Appropriate**

Across both FGs, participants moderately discussed the need to recommend culturally appropriate care for Tamil seniors at long-term care homes. The subthemes included call to improve advocacy efforts, and community education on long-term care homes.

***Call to Improve Advocacy Efforts:*** Across both FGs, service providers agreed that multicultural long-term care homes could lead to better integration of ethnic minority seniors into mainstream society. One service provider commented, “there are morals like, you keep your identity as a community but at the same time learn to live with other communities under one roof.” (FG1, P4)

Some service providers mentioned that the government is also aware of this concern.

Consequently, service providers discussed the possibility of future collaboration to improve long-term care living standards for Tamil seniors. In fact, one service provider discussed:

Recently we have been hearing from [the] government ministry that they’re trying to promote ‘community-based’... senior homes. For example, ... they [plan to] take a building for that matter, [where] a twenty percent [will consist] of a certain community. They will design it in such a way to have [culturally-appropriate] kind of a food, related activities and even, to bring people to go and interact with them. Meaning that we can play a part by going and showing or meeting them and then create program specifically for the community, you know? (FG1, P3)

There was an interest expressed by some of participants in becoming advisory board members of long-term care homes to address cultural barriers, which impact residents’ wellbeing. One participant argued the importance of “educating [long-term care staff] on what’s important to the seniors and that’s a way of improving the lives of seniors who are already in the nursing home.”

(FG1, P4)

***Community Education on Long-Term Care Homes*** – The participants in both groups recognized an increasing demand for long-term care homes but felt unable to help their clients in securing adequate economic support from their families and the government to make long-term care decisions. They identified various factors impacting the decision such as cost of care, long wait lists, bed availability, not being in close-proximity to the rest of the family, and whether the care is culturally appropriate. One participant stated:

Going to a senior home, sometimes the language barrier is there and also having a[n] environment where the food and everything is more social... [needs to made] to [seniors'] own way of life. (FG1, P4)

Participants discussed some cases where seniors were not ready to move but felt forced to go because their adult children were not available to provide adequate care. They discussed the importance of educating seniors and caregivers about various long-term care options.

### **Theme 3- Sustainable Funding and Required Partnerships**

Across both FGs, several comments were made about improving relationships in the Tamil community and cross-sectoral collaboration with Tamil organizations. Participants recognized limitations in existing funding structures and were ready to foster new partnerships to secure stable funding. The subthemes included unsustainable government grants, partnerships and networks, and restraints in community outreach.

***Unsustainable Government Grants:*** Participants in both groups expressed frustration with government grants because they were operating with scaled budgets due to increased cutbacks. They shared changes in their programs as a consequence of limited financial resources, such as reduction in refreshments, subsidized transportation, and the number of social and recreational programs. These programs were deemed essential by participants to ensure inclusive spaces for

senior Tamils. They also expressed concerns that the procedural tasks (e.g. annual reports for each grant) take too much staff time, which often limit their ability to work at full capacity.

***Partnerships and Networks***—Despite funding challenges, demands for culturally sensitive care among aging clientele increased. Many service providers discussed the importance of establishing community partnerships in the Tamil community to fill the gaps in services. Funding for language-based needs was commonly referenced as an area that received low priority in the agenda of funding bodies despite it being widely accepted as a key access-barrier to health and social services. Participants discussed service efficiency, coordination, and community networks as one mechanism to better continuity of care. One participant stated:

I strongly believe after working with this organization for fourteen years [that] awareness among the community is very, very important, we cannot depend on the government for everything... and maybe, compared to the other communities we might be young but I think we are now in a position to do certain things, which I'm very sure we can do because the second and third generation are all doing [financially] very well. (FG1, P2)

***Restraints in Community Outreach:*** In one FG, service providers highlighted the challenges of outreach programs for isolated seniors and perceived it as a resource-draining task. They explained how common methods of outreach, such as information dissemination including newsletters' distribution, were difficult due to financial and communication barriers. One service provider described a cost-effective method for community outreach:

That's a big problem... we have a newsletter to communicate with [clients]. Once a year, this time, we [used to] mail everybody but, we can't afford to do it again [because there is a] financial piece. We can't even call to notify the people [of] what we are doing, when we are doing, [or even inform them] 'you can come and participate with us.' Those are the difficulties we have, it's sometime we use their friends to pass the [newsletter] like messengers... [so] still we try to reach people. (FG1, P2)

#### **Theme 4 – Factors with Feasibility Challenges**

Across both FGs, participants overwhelmingly agreed that some factors are not feasible to address at a program level due to capacity issues, limited time, and boundaries of care.

Some of the statements generated by Tamil seniors during the *Brainstorming* sessions were perceived by service providers as not feasible to address at a program level. They pointed to the limits and boundaries of their organizational mandate. Such statements were to: redress early life experiences (i.e. un-/under-employment) in later life; overcome hesitations to seek professional advice; having a two-income family; encouraging women to stay at home to raise children; living close to children; setting up more Tamil cultural facilities; promoting the Tamil language, cultural, and religious values among youth; and reducing reliance on TV.

Participants discussed how much service providers could do. Across both FGs, service providers agreed that they could educate seniors about community issues to raise awareness and to empower them to take some action on their own. Yet, the impact of such help was perceived to be limited for aspects that are deeply linked to the familial or economic context. In reference to the financial management workshops, one participant commented:

Whether they could do that is the question... Because when they go back in their house...[ they] feel guilty...[they] don't want to burn bridges with family to become independent... you know, the structure, the values, and the class system with the education and all that. [But] there are, seniors who would make the decision independently and would not worry about all these barriers. (FG2, P1)

#### **Theme 5 – Oblique References to Socially Sensitive Topics**

Although not explicitly stated, many service providers appeared to operate from a culturally competent approach with an equity aim to improve access to health and social services. For example, service providers discussed the importance of building trusting

relationships with their clients, families, and hired staff to reflect the cultural backgrounds of their clientele. Participants somewhat discussed Tamil seniors' perceptions of the government and nature of available social services, and how it is informed by their experiences of being uprooted from their homeland due to unstable political circumstances. Some participants made comments on seniors' difficulty in developing trust with mainstream providers due to communication difficulties, especially around socially sensitive topics. The subthemes included mental health stigma, experiences of discrimination, and cultural notions of privacy and services.

***Mental Health Stigma:*** Service providers acknowledged the presence of mental health stigma in the Tamil community but claimed it is often not the focus of their programs. One participant suggested that even before a senior can seek services from community-based organizations, there are larger barriers from a community standpoint including fear of seeking outside help, lack of trust in front-line workers, language or cultural barriers, and being unaware of the available mental health services. One participant who felt skilled in connecting seniors to culturally sensitive mental health supports insisted for more work to be done by community-based organizations.

***Experiences of Discrimination:*** Service providers agreed that experiences of discrimination coupled with ageism create unsafe spaces contributing to further social exclusion. One service provider explained that addressing past negative experiences of migration and settlement is difficult now. However, she acknowledged that this might lead some seniors to misperceive the wider community as an unsafe; which may continue to negatively affect their integration.

***Cultural Notions of Privacy and Services:*** Across both FGs, service providers agreed that statements in the *Family Harmony* cluster could be addressed at the community-based organization level. However, they cited the cultural notion of privacy as the reason for why

family issues were not discussed in their existing services. They commented that seniors often desire to resolve familial issues in the privacy of their household. One participant explained that in traditional family structures, seniors are often seen as elders advising their children. However, in the post-migration context, seniors' past experiences might be perceived as less relevant.

## **Chapter Four**

### **DISCUSSION**

#### **4.1 Overview**

The thesis project used CM and FG in a sequential, embedded mixed-methods design, collecting two sets of data that involved four phases of fieldwork to investigate three research objectives surrounding social inclusion of senior Tamils in the GTA, as described in Chapter One. The collected data gained depth and breadth by engaging with aging Tamil immigrants through seven CM sessions, and holding two FG discussions with service providers. Overall, this exploratory research identified intertwined multi-level contextual factors to effectively improve Tamil seniors' experiences of social inclusion in the GTA. Both Tamil seniors and service providers viewed all seven clusters as important, but major differences emerged between the groups' perceptions of the feasibility of acting on some items at a program level in the next 12 months. Tamil seniors perceived some clusters presenting greater challenges for feasibility relative to its importance. In the following sections, the findings are discussed in relation to relevant literature followed by implications at practice, policy, and research levels. Among the reviewed theoretical frameworks, the most influential for interpretation of findings were the political economy of aging and the cultural framework of individualism-collectivism; the other frameworks (i.e. the life course theory and health geography) informed some of the findings and insights. The chapter concludes with the study limitations followed by self-reflections and the overall conclusions.

#### **4.2 Factors Central to Social Inclusion**

The main goal of this study (Objective #1) was to identify various factors that facilitated (or inhibited) Tamil seniors' social inclusion in the GTA. In the *Brainstorming* sessions, Tamil

seniors identified 204 statements to support their inclusion; the consolidated final list entailed 72 statements. The sorting of these statements led to seven clusters and Tamil seniors rated all of them highly for importance; the service providers also agreed on the centrality of these identified factors for social inclusion. It is notable that most statements were articulated from a strength-based perspective as facilitators; however, the following analysis will also consider the barriers identified. The most critical finding to emerge from the analysis of these statements is that facilitators and barriers to seniors' social inclusion can be delineated as structural and cultural.

According to the political economy of aging framework, *structural factors* are environmental conditions that individuals cannot control (Estes, 2001). In this study, the structural aspects are well represented in the following three clusters: *Services for Employment and Settlement, Financial Independence, and Medical System and Senior Care*. The respective cluster bridging values were 0.37, 0.43, and 0.58; thus, all clusters are well-defined ideas. Participant statements in these three clusters primarily highlight macro-level factors that need to be addressed or strengthened in order to improve access to culturally appropriate public services (e.g. senior homes), better means of transportation in the GTA, and developing practical skills to gain independence. In response to these structural barriers, service providers in FGs argued that more capacity building locally among staff at senior centres is necessary and can only be supported with targeted funding.

Scholars have previously reported some of the structural factors identified by Tamil seniors, while some of these are unique. Previously reported structural risks for social inclusion of ethnic minority seniors include limited income (Stephens et al., 2011), transportation, and accessibility difficulties (Aroian, Wu, & Tran, 2005; Suwal, 2011), inadequate available services (Gerst-Emerson et al., 2014) and the lack of culturally- and linguistically- specific support for

ethnic minority seniors (Scharlach et al., 2006). Nonetheless, some of the structural factors identified by Tamil seniors in this study are relatively unique and can inform further work in this area (see Implications section). For example, Tamil seniors rated access to government supports, such as having secure income (via Old Age Security and the Canadian Pension Plan), higher than access to community supports, such as meeting non-Tamil Canadians through programs. This result indicates that Tamil seniors place more importance on institutional supports, and this finding place emphasizes on the need for more direct support from the government.

*Cultural factors* such as language, beliefs or traditions may hinder social inclusion when these become obstacles for living in mainstream society (Wenhong & Kaichun, 2008). In this study, participants sorted statements related to cultural aspects in the following four clusters: *Adaptation and Integration*, *Social Interaction*, *Cultural Interaction and Feelings of Security*, and *Family Harmony*. The respective bridging values for these clusters are 0.76, 0.54, 0.40, and 0.29. Thus, the last three clusters are well-defined or anchoring clusters, and the first cluster is a bridging cluster that is linked well to other parts of the map. Although the *Social Interaction* cluster is loosely defined, the *Adaptation and Integration* cluster is the most conceptually distinct from other clusters and was the smallest cluster with only four statements. This finding suggests statements in this cluster, such as reducing risk of elder abuse and negotiating senior women's independence from spouses in making decisions, cannot be achieved in isolation of other statements in the remaining six clusters. The most anchored and the largest cluster of the map, labelled *Family Harmony*, is discussed subsequently in detail.

Statements in the abovementioned four clusters primarily highlight meso-level factors related to better integration in their intergenerational families, resilience and self-care, and building connection in Tamil and mainstream communities. The familism aspects identified by

Tamil seniors in this study was also discussed by the service providers in FGs, which is an important contribution to an emerging area at the intersection of social and health sciences (e.g. Sabogal et al., 1987; Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002; Knight et al., 2002). Service providers argued this is a core cultural phenomenon where Tamil seniors strongly identify with their families (i.e. family orientation) and there is an entrenched sense of loyalty, reciprocity, and solidarity among family members. Thus, when issues surface in their intergenerational families, seniors often feel ill equipped to address these concerns having been uprooted from their homelands, and often leave it unacknowledged to preserve family harmony. Past research with visible minority seniors supports other cultural barriers identified in this study including language barriers (Lai, 2001) and limited trust in service providers of different ethnic backgrounds (Sadavoy et al., 2004).

*Some of the clusters had intertwined structural, cultural and individual factors.* For example, the statement “keeping yourself busy and healthy through activities” (e.g. yoga, biking, etc.) was organized in the *Medical System and Senior Care* cluster. Although statements seeking stronger structural supports generally characterized most of clusters under the *Structural* domain discussed above, Tamil seniors also acknowledged the role of individuals in active aging. Similarly, the statement “understanding the multiple commitments of adult children” organized in the *Family Harmony* cluster suggests that Tamil seniors are aware of their children's' inability to support their needs fully. This is contrary to the gross assumptions in literature and policy that ethnic seniors prefer and respond only to family support rather than formal services (Tam & Neysmith, 2006; Tilburg, Havens & de Jong Gierveld, 2004; Aroian, Wu & Tran, 2005; Tomaka, Thompson & Palacios, 2006). The reality is that individual, cultural, and structural forces need to work in a symbiotic manner to make meaningful change at structural levels. Thus, it's not

surprising to find that family members increasingly have little time to attend to their aging parents' needs, resulting in seniors' pressing needs neglected by both family and the formal sectors supported by the government. The intertwined nature of the identified factors for social inclusion challenges the organizational responses that are often characterized by increasing individualism and fragmentation of community support (Bauman, 2000). Such simplistic interpretations overlook the cultural context within which exclusion operates. Current approaches risks concealing trajectories of inequality, especially those related to age and culture that may underpin exclusion, restrictions to participation, and poor access. Findings from this research reveal that the problem with the individualized approach is that older people may be blamed for failing to integrate into their communities. Thus, it is necessary to recognize the trajectories into social exclusion and how experiences vary across social locations in later life.

The cluster rating for importance towards social inclusion varied a little by gender, though the differences were not statistically significant and a possible reason is the small sample size. The clusters of *Services for Employment and Settlement* and *Financial Independence* were rated alike by men and women. However, rest of the clusters had a trend of higher rating by women than men, and the largest difference was noted for the cluster of *Cultural Interaction and Feeling of Security*.

### **4.3 Unpacking the Family Harmony Cluster**

After reviewing statements under the *Family Harmony* cluster, notions of collectivism evidently influence many of these facilitators and barriers identified. To varying extents, statements reflect cultural preferences for interdependency, inhibition of disruptive behaviours to family harmony, and upholding emotional connectedness. For example, statements such as “understanding the multiple commitments of adult children,” “understanding generational gaps

and giving space to grandchildren,” and “listening to adult children and adapting to the ‘New School’ style” reveal seniors’ concern to avoid being a burden on their adult children. In contrast, statements such as “developing a tolerance for children’s put-downs and negative attitudes” and “babysitting grandchildren to make yourself happy and stay busy” illustrate the potential exploitation of collectivist notions; where seniors are willing to sacrifice their personal happiness and take the risk of elder abuse in support of family harmony. This personal sacrifice reflects vertical-collectivism because seniors view themselves at the bottom of the hierarchy and feel obligated to support their family. In some cases, seniors also did not seek professional support, as they feared dishonouring their family. The preference for privacy in collectivist cultures is further exacerbated by Tamil seniors’ downward social mobility after migrating to Canada, which unfavourably positions Tamil seniors vulnerable to social exclusion. Lastly, the statement “encouraging women to stay at home to raise children” is a cultural expectation shared by most seniors to ensure women remain within the domestic sphere as obedient kin-keepers. This expectation illustrates how seniors may also impose cultural restrictions on their younger counterparts. Thus, the process of reconciling conflicting cultural expectations with current realities is an important conversation to have within intergenerational families. As demonstrated in the highlighted statements, the overall family structure and function dominates all relationships. However, as demonstrated in some contradictory statements, the clash of cultural expectations with current realities disproportionately affects Tamil seniors, and addressing these concerns is important to their social inclusion.

#### **4.4 Feasibility to Act at Program Level**

The study aim also included (Objective #2) an examination of Tamil seniors’ perspectives on feasibility to act on the identified factors for social inclusion. Although all seven

clusters were viewed central for social inclusion, Tamil seniors perceived some clusters as not sufficient in themselves to improve experiences of social inclusion. This is particularly due to concerns about feasibility to address at a program level. Not surprisingly, participants argued that statements in the following four clusters: *Social Interaction*, *Cultural Interaction and Feelings of Security*, *Adaptation and Integration*, and *Family Harmony*, were least feasible to address at a program level. For example, the mean feasibility scores for the abovementioned clusters were 3.67, 3.69, 3.73, and 3.72, respectively, out of a scale of 5 (1 being not feasible and 5 being very feasible). While, there was disagreement among service providers about the feasibility of some factors in these clusters, they agreed that most of these statements could be addressed at a program level, despite individual efforts described in these statements. Service providers emphasized that greater awareness of existing community supports and significant efforts to build trust with Tamil seniors will result in more seniors seeking community support for intergenerational and intra-familial dynamics. Service providers were aware of the overwhelming need for capacity building among staff and for funding bodies to support culturally sensitive programs. The gender based comparison for the feasibility scores provided by senior Tamil participants reveal that *Family Harmony* is the only cluster where women perceived it more feasible than men. Although this difference was not statistically different, this trend shows senior Tamil women's initiative to resolve family conflicts, which can be better supported by future programming.

Based on the political economy of aging framework, statements in the abovementioned clusters in particular, *Adaptation and Integration* and *Family Harmony*, with their structural-functional underpinning, put the onus on the individual to adjust. Accordingly, Tamil seniors rated statements in these clusters as less feasible due to the belief that these are issues to be

resolved by the individual rather than through institutional change. Similarly, service providers argued that due to reduced public funding they needed to consider private fundraising. The impact of neoliberal restructuring of government funding has greatly impacted the types of programs available and expectation of service providers about what could be funded or not-funded. These individualist strategies may be a response to the prevailing neoliberal ideology that inform social and community services and policies. In fact, Shapaizman (2010) argues that:

The neo-liberal concepts of self- sufficiency and personal responsibility have had the most influential impact on the immigrant privatization policy. The privatized Canadian immigrant policy was designed for the self-reliant immigrant (p. 20).

It is possible that Tamil seniors' want to be perceived as ideal immigrants, informed by dominant narratives of self-sufficiency and self-reliance. Similarly, given that all service providers who participated in this study were themselves also immigrants, it is possible that their own work is informed by these perceptions.

One unanticipated finding was that participants suggested that statements in the following three clusters: *Medical System and Senior Care*, *Services for Employment and Settlement*, and *Financial Independence*, were most feasible to address at a program level; the mean feasibility scores were 3.99, 3.88, and 3.96, respectively, out of a scale of 5. A possible explanation for this result might be that seniors perceive governments and associated programs could be better adapted for Tamil seniors, and more can be invested in improving existing service delivery. However, this is inconsistent with some of existing literature, which documents that older immigrants tend to have less expectations, and a lowered sense of entitlement in regards to public allowances (Angel, 2009; Morawska; 2009). Drawing from the life course theory (Elder, 1998), this finding could be unique to the study participants because a majority of them have been living in Canada for several years and, hence, possibly valued the long-term investments

over short-term focused programs for social inclusion. However, it seems Tamil seniors understand the complexity of existing publicly funded social structures because comments were made during the *Interpretation* session about the limitations to requesting more public funds. One participant stated “they have already given so much” and all participants expressed their gratitude in receiving existing services. It is also possible that it’s a reflection of their collectivist culture where individual/community level goals get somewhat lower priority over national goals – this could be interpreted as an indicator of their belonging to Canadian society but at an expense of vulnerability for the Tamil senior community.

#### **4.5 Service Priorities and Action Challenges**

The results of CM were shared with services providers in two FGs to examine their perspectives about feasibility to act at program level (Objective #3). Service providers perceived most of the factors within seven clusters actionable in terms of program priorities. For example, across both FGs, factors related to the lack of social support, raising awareness of community issues, development of life skills, and community engagement were well received. However, factors related to physical isolation, transportation barriers, facilitating two-income household, and negotiating independence from adult children and spouses were less feasible and in some cases outside the organization's boundaries of care. As articulated in the life course theory, service providers discussed the need to acknowledge distinct settlement patterns between recent and established older Tamil immigrants to strategically address barriers to social inclusion. For example, service providers explained that participation of newcomer Tamil seniors in workshops to facilitate integration into Canadian society requires isolated seniors to make the first step and connect with existing Tamil senior centres. They viewed agencies as sources of empowerment and awareness; however, the decision to make changes lies with seniors. Thus, in light of this

nuanced discussion, it remains a concern that community outreach is limited. Literature on community outreach to older immigrants overwhelmingly insists the need to build off existing networks such as religious gatherings to recruit isolated seniors (Eunkyung Kim, 2016; Lee & Chan, 2009).

In discussing recreational activities and associated self-care practices, service providers discussed the importance of these services to better the life expectancy of seniors and improve seniors' quality of life. When asked about the need for culturally specific care to address past trauma experienced during the Sri Lankan Civil War, service providers explained that not requiring seniors to self-identify with their past and/or existing trauma is critical for engagement. They viewed that recovering from trauma requires engaging in behaviours that enhance seniors' ability to cope with excessive stress. They discussed development of trauma-sensitive programs like yoga, beading classes, and ladies' wing where seniors connect with each other without being identified as victims of war or other traumas. They viewed these supports as inclusive spaces for seniors to acknowledge thoughts and feelings that arise without having the pressure to react to them. This finding advances a handful of scholarly work on Tamil diaspora with past histories of trauma. A safe community space presents Tamil seniors the opportunity for controlled self-dialogue to manage their thoughts, memories, and emotions in a healthy manner. Literature on trauma-informed therapy supports this finding because trauma cannot be treated in isolation of the individual's culture (Drozdek, Boris & Wilson, 2007). Rather, each culture has its own understanding of trauma and the appropriate methods for healing.

#### **4.6 Implications**

The findings have several implications at research, practice and policy levels. In reviewing the results, there is a need to *advance research on the impact of cultural values on*

**social inclusion**, especially among immigrant communities where cultural mechanisms to act may be lost after migration (World Health Organizations, 2002; Keefe, Andrew, Fancey & Hall, 2006). In future investigations, it would be beneficial to explore the same research question from the perspective of family caregivers and Tamil community leaders to broaden the scope of results. Further, there is a need to examine closely the relationship between social inclusion and quality of life for older immigrants.

At the practice and policy level, there is a need to **expand conversations between the government and community representatives** to strategize and seek alternative methods to reach ethnic minority seniors, rather than heavily relying on immigrant families to provide that support. The recent political climate has emphasized the need to help community-dwelling seniors age-in-place, because it is more cost-effective and what most seniors prefer (McDonald, 2011). However, inadequate support or no caregiver is the central determinant for hospitalization and institutional admission among seniors. Thus, **meaningful community support is a timely response** to the age-in-place rhetoric, allowing seniors to access emotional support and assistance with daily activities of living in the comfort of their homes - a task otherwise difficult due to illness or frailty of seniors. Such approach of building community supports is then expected to reduce dependency of seniors on informal supports (such as their immediate family and close friends) to fulfil their social needs, and could also delay admissions to long-term institutions that are not only costly but have a long way to reach optimal cultural sensitivity. However, the question remains how can community supports be more accessible for socially excluded Tamil seniors?

While agencies make concerted efforts to run programs at local temples to ensure accessibility, it is possible that some seniors may never leave their homes. In such cases, more

outreach in Tamil community spaces such as local grocery, video, and clothing stores and/or virtually through Tamil radio and television networks are necessary to raise awareness of community supports – suggestions made by the study participants. This type of outreach delivers the message to the intended clients, seniors themselves, but also raises awareness in the general Tamil community about opportunities to engage seniors. However, limited funding and low staff capacity continues to restrict outreach efforts. Thus, it is important to raise awareness in the Tamil community as suggested by service providers to fundraise funds and engage volunteers as community outreach workers. However, there was also concern that Tamil seniors should not solely depend on their families and the larger ethnic community for support. In fact, service providers discussed the financial implications for immigrant families (e.g. under 10-year parent/grandparent Super Visa) (Roots et al., 2014). They argued that immigrant families are already faced with unpredictable, precarious economic circumstances upon settlement, and the current immigration policy shift is adding to their financial burden as supportive systems are lacking. As a result, service providers considered the dire consequences faced by immigrant seniors, whose needs may not be addressed despite the good intentions of their sponsoring family members, as unfair. Similar concerns have been reported in various studies (Arojan et al., 2005; Tomaka et al., 2006; Tilburg et al., 2004). Thus, to assist older immigrants better integrate in Canadian society; more needs to be done on the policy front. The participants suggested ***changes in allocation of funds to reduce barriers for participation*** (e.g. subsidized transportation, childcare support, etc.) in community programming, and opposing anti-immigrant rhetoric with the implementation of age-friendly immigration policies.

Thus, the challenge of facilitating social inclusion of senior Tamils seems to rests on emphasizing the ***importance of an intersectional approach***, where various sources of

vulnerabilities such as race, age, gender, class are accounted for, and addressed individually and jointly. Such approach is aligned with the two-way integration efforts, which hold more promise (Goodman & Wright, 2015; Alba & Foner, 2015). To be truly inclusive also means facilitating seniors' ability to shape decisions that impact their daily lives. This study is the first step to do so. An important application of these findings could be to aid in the evaluation of current policy and programs designed to promote positive experiences for Tamil seniors.

Further, life course principles, such as *cumulative disadvantage* and *latency effects*, is critical to enacting positive programs and policies with Tamil seniors' life histories of achievements and challenges in mind. To understand Tamil seniors' current and future states of social inclusion, researchers/service providers/policy-makers should acknowledge that it is not a static outcome but rather a cumulative process that unfolds over one's life course. There is a necessity to identify and analyze the various kinds of supports available across various life stages to understand when and how Tamil seniors become vulnerable to social exclusion. Without such awareness, the stratification of inequality in later life may be misconstrued as innate differences between individuals, rather than as a product of social processes that is maintained and transmitted from one life stage to another.

#### **4.7 Study Limitations**

The study has yielded several valuable insights but transferability of findings warrants caution. The first limitation relates to the *purposive* sample, which was opted due to the exploratory nature of the study and the resource constraints of a graduate student. Tamil senior participants were recruited from a single community-based organization and service providers were recruited from two organizations. The senior participants were all residents of the GTA,

fluent in English, able bodied, and living in community-dwellings. Their perspectives may not represent views of Tamils seniors who are isolated, living in long-term care homes, have English language difficulties, and have limited engagement in the community or live outside of the GTA. Further, this research captured the experiences of mainly established Tamil seniors, whose migration and settlement experiences vastly differ from recent older immigrants. Further, the researcher could not examine difference in the importance and feasibility of the identified factors by the number-of-years lived in Canada because 24 participants (out of 27) had lived more than 15 years in Canada. Thus the concept of place could not be fully employed to interpret the findings. There were some gender-based trends but no statistically significant differences, possibly due to small sample size. The researcher recommends that future research take these points into account. In the CM sessions, participants did not openly discuss patriarchy at home and racial discrimination in society. It could be interpreted that participants were trying to be “ideal citizens,” and this phenomenon ultimately is an effect of power differentials and systemic racial discrimination entrenched in our society. In terms of the FGs, participants were staff within same agency and this might have created some power dynamics between management and front-line teams.

Thus, characteristics of participants and settings should be taken into account for the transferability of findings to larger senior Tamil communities and other settings. In terms of the CM method, the participant response/time burden is important to acknowledge. The rating of 72 statements for two dimensions (feasibility and importance) was time consuming, especially when it was preceded by the sorting activity in the same session. Some participants took the rating sheets home and were provided stamped envelopes to mail back. Upon analysis, however, the computed standard deviation scores for all rated items were within a reasonable range. In the

future, response/time burden could be reduced by separating sessions for sorting and rating activities, provided the necessary resources are available.

#### **4.8 Personal Reflection**

This section provides a reflection on the strategies used to make connections with Tamil seniors, and the complexities of managing the fieldwork process. Through writing this thesis, I, the researcher, had the opportunity to reflect on the emotional impact of fieldwork. In conducting this research, my moral perspective on Tamil seniors' inclusion in GTA were made explicit as this impacted the lens through which I analysed seniors' experiences. As Letherby (2003) explains,

All research is ideological because no one can separate themselves from the world – from their values and opinions, from books they read, from the people they have spoken to and so on (pp. 5-6).

My positioning in the research is multi-dimensional, and is also heavily influenced by my own privilege as a researcher and as a Tamil Canadian.

As a researcher informed by the CST research paradigm, I focused on “accepting the essential validity of other people’s experiences,” underpinned by a belief that my role as a researcher was to listen and to validate others where they are, rather than where I might believe they should be (Stanley & Wise, 1983, p. 8). Listening to Tamil seniors’ experiences of managing family dynamics and accepting some conditions as unchangeable was difficult to hear. On the one hand, I wanted to react as positively as possible to these individual experiences, and to avoid making judgements on the choices seniors had made throughout their lives and in their current circumstances. Whilst recognising the impacts of structural oppression, I checked my own privilege as a researcher to ensure that I did not bring my personal agenda to the research process, but rather preserved seniors’ individual integrity. Despite these difficult conversations, I

understood my commitment to allow seniors define their own experiences of social inclusion in the GTA. With this in mind, study participants (Tamil seniors and service providers) explored culturally and individually appropriate strategies to better assist Tamil seniors as they saw fit. To provide some timely support to senior participants, I provided a resource list of available senior services in the local area (see Appendix J).

#### **4.9 Conclusion**

To the best knowledge of the researcher, this mixed methods study with Tamil seniors is the first exploratory study on their perspectives about social inclusion in Toronto, Canada. This project likely has made important contributions to the field of ethnogerontology in Canada, where immigration and aging are two driving forces to a diverse population. Twenty-seven Tamil seniors and 13 service providers working with Tamil seniors were recruited to participate in understanding holistically what facilitates and inhibits social inclusion for Tamil seniors in the GTA, and what challenges are faced at a program level to meet these identified needs. From hearing Tamil seniors' perspectives, it is clear that social inclusion is an on-going process and the central factors have structural-functionalist domains. It is not just about the promotion of social inclusion. Instead, we need to know how to promote principles of inclusion, belonging, participation, recognition and legitimacy, as seniors perceive them. The problem of addressing older immigrants' social exclusion is understanding the intersecting impact of multiple dimensions of difference that synergistically reinforce their exclusion. I also hypothesized that data gathered from older Tamils may not corroborate and align exactly with service providers' experiences of working with aging immigrants due to their different system perspectives. In this respect, a critical finding is seniors' cultural notions of what is feasible to change at a program level. While Tamil seniors are critical of necessary changes to facilitate their inclusion in their

immediate families, the Tamil community, and mainstream society, they remain reluctant to impose this expectation on service providers and programs. This finding warrants the need for more conversations between service providers and their clients, Tamil seniors, to openly engage on future program prospects and how to improve program delivery.

Overall, the results suggest that the barriers faced by aging Tamils negatively impact their experiences of social inclusion. Greater awareness of their needs is likely to rectify the processes of exclusion in future programs and policy-making, such as better community outreach and funding allocations. An intersectoral approach is much more likely to address the macro and meso level factors impacting their social inclusion. Given the exploratory nature of this research conducted with a *purposive* sample of senior Tamils in GTA, a larger study with a diverse sample of seniors and longitudinal assessments is needed to further advance scholarly work on Tamil seniors' inclusion in Canada.

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***Study “Concept- Mapping of Facilitators of Social Inclusion among Tamil Elders”***

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**PURPOSE OF STUDY**

You are invited to participate in a research study on social inclusion of Sri Lankan Tamil elders in the Greater Toronto Area (GTA). You were selected as a possible participant because of your knowledge and/ past experience as an immigrant or refugee in Canada. Please read this form and ask any questions you may have before acting on this invitation to be in this study.

Your participation is completely voluntary and you have the right to discontinue at any time.

The purpose of this study is to explore the facilitators and barriers to social inclusion for Tamil elders (age 55+) in the GTA. Evidence shows the positive impact of social inclusion on mental wellbeing, but little scholarly knowledge exists on the factors that facilitate social inclusion for Tamil elders in Canada. The purpose of this study is to document such factors to inform scholarly work, practice and policy to enhance social wellbeing of elders from Tamil and other similar communities in Canada.

**STUDY PROCEDURES**

If you agree to be in this study, you will be asked to participate in two to three group sessions. The groups will meet at the community agency partnering for the study; refreshments will be served.

1. Session #1 – You will be asked to generate statements in response to a focused research question. The moderator will note the brainstormed statements on a flip chart. The session is expected to complete in 1 hour.
2. Session #2 – You will be provided with a set of cards where each card will have a brainstormed statement. You will be asked to group the cards or make piles as it ‘makes sense’ to you. Next, you will be provided with a rating sheet to rate each statement for its importance and feasibility to support processes around social inclusion. The expected completion time is 2 hours.
3. Session #3 – Some of the participants will be invited for the final discussion session. The researcher will present visual maps on the generated findings and obtain your feedback and perspectives. The expected time for this session is 1.5 hours.

## **RISKS**

There are no major risks to the participants as this is a non-invasive study. However, the topic of social inclusion might be difficult to discuss for some participants and lead to feeling emotionally stressed. Please be reminded that your participation is completely voluntary and you may decline to answer any or all questions or terminate your involvement at any time. .

## **BENEFITS**

There is no direct benefit to you for your participation in this study. Indirect benefits to participation may include gaining new information/knowledge about social inclusion and effective ways to engage with community at large. The researchers hope that the information obtained from this study would influence future programming at the community level.

## **CONFIDENTIALITY**

Confidentiality will be provided to the fullest extent possible by law. Information collected via baseline survey and during the discussions in any of the three sessions will not be linked to participant names on the consent forms. Please do not write any identifying information on your discussion material. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning a study ID (e.g. code number) to each participant that will be used on all research notes and documents
- Keeping collected data and any other identifying participant information in a locked filing cabinet in the personal possession of the researcher.
- Making sure that staff from the collaborating community agency do not participate in the concept-mapping sessions to ensure confidentiality
- Publications and presentations based on the study findings will not release personal identifiable information of the participants.

**COMPENSATION:** A \$10 gift card will be offered as a token of appreciation for your participation in each session.

## **CONTACT INFORMATION**

If you have questions about the research in general or about your role in the study, please feel free to contact myself or my Principal Supervisor, Professor Farah Ahmad. The proposal of this research has been reviewed and approved by the Human Participant Research Committee of York University. If you have questions regarding your rights as a research participant, or if problems arise which you do not feel you can discuss with the Primary Investigator or Supervisor, please contact the Manager, Office of Research Ethics, York University, 309 York Lanes, at (416) 736-5914.

## **VOLUNTARY PARTICIPATION**

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawing from this study will not affect the relationship you have, if any, with the researcher. If you withdraw from the study before data collection is completed, your data will be

returned to you or destroyed whenever possible. However, once the group sessions have started, it will be difficult to track individual contributions to data collection.

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## CONSENT

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant Name \_\_\_\_\_

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Principal Researcher's signature \_\_\_\_\_ Date \_\_\_\_\_

***Study “Concept- Mapping of Facilitators of Social Inclusion among Tamil Elders”***

---

**RESEARCHERS**

***Principal Researcher***, York University  
Thrmiga Sathiyamoorthy, Graduate Student  
Interdisciplinary Studies

***Graduate Supervisors***, York University  
- Prof. Farah Ahmad, PhD (Primary)  
- Prof. Deborah Davidson, PhD  
- Prof. Guida Man, PhD

**PURPOSE OF INTERPRETATION SESSION**

As a participant of the research study on social inclusion of Sri Lankan Tamil elders in the Greater Toronto Area (GTA), you are invited to engage in the final group discussion. Researchers will present visual maps on the generated findings and obtain your feedback and perspectives. The expected time for this session is 1.5 hours.

Please be reminded that your participation is completely voluntary and you may decline to answer any or all questions or terminate your involvement at any time. We may remind you that you provided us with your written informed consent at the start of this study. The purpose of this form today is to obtain your permission to audio record some concluding parts of the interpretation discussion.

**CONFIDENTIALITY**

This session involves the audio recording of the final discussion with the researchers. Neither your name nor any other identifying information will be associated with the audio recording or the transcript. Every effort will be made by the researcher to preserve your confidentiality, such as:

- The tapes will be transcribed by the researchers only and erased once the transcriptions are checked for accuracy
- All transcribed data will be de-linked from individual names – de-identified - once accuracy is checked and preliminary analyses are complete.
- Keeping collected data and any other participant information in a locked filing cabinet in the personal possession of the researcher. Electronic data will be secured in a password-protected laptop.
- All de-identified data will be kept until 2023 and then destroyed per ethics protocol.

**COMPENSATION**

A \$10 gift card will be offered as a token of appreciation for your participation in each session.

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## CONSENT

I understand the provided information and have had the opportunity to ask questions. I am allowing the researcher to audio record me as part of this research study. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant Name \_\_\_\_\_

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Principal Researcher's signature \_\_\_\_\_ Date \_\_\_\_\_

## Appendix C – Concept Mapping Brief Survey

### Brief Survey

This survey asks some general questions on socio-demographics and health. Please select only one response unless indicated otherwise. All information will be kept highly confidential.

#### Demographics

1. How old are you? \_\_\_\_\_ (years)
2. What country were you born in? \_\_\_\_\_
3. Please tell us about your gender.       Man       Women       Other
4. When did you arrive in Canada? \_\_\_\_\_
5. What type of immigrant status did you apply for under the Citizenship and Immigration of Canada?
  - Permanent Resident
  - Temporary Foreign Worker
  - Refugee
  - Sponsored Family Class
  - Sponsored Professional class
  - Other, please specify \_\_\_\_\_
  - Don't know
  - Refuse
6. What is your current immigrant/citizenship status in Canada?
  - Citizen
  - Permanent resident
  - Undocumented
  - Other, please specify \_\_\_\_\_
  - Don't know
  - Refuse
7. Who did you come to Canada with?
  - Partner
  - Child(ren)
  - Partner and Children
  - Immediate Relative
  - Alone
  - Other, please specify \_\_\_\_\_
  - Don't know
  - Refuse
8. What is your current intimate relationship status?
  - Married

- Common law
- Widow/Divorced/Separated
- Single, in relationship
- Single, not in relationship

9. Do you have children?  Yes  No

10. Do you have family living in Canada?  Yes  No

11. How would you describe your current highest level of education?

- Up to elementary school (grade 5)
- Up to high school (grade 10)
- College some or completed (e.g. BA, BSc or certification after high school)
- Post-graduate some or completed (e.g. MA, MSc, MD etc.)

12. How would you rate your current English language reading/speaking abilities?

- Poor
- Fair
- Good
- Very Good
- Excellent

13. What is your current working status? (you may select more than one)

- Paid work (part-time)
- Paid work (full time)
- Retired
- Volunteer
- Housework
- Student
- Other \_\_\_\_\_

14. Do you have to make hard decisions when spending your money to pay for your daily needs (e.g. healthy food, paying rent, buying clothes, buying medicine)?

- Often
- Sometimes
- Never

### **Health Status and Access to Health Services**

15. How would you rate your overall health compared to other women/men of your age?

- Poor
- Fair
- Good
- Very Good
- Excellent

16. Over the last 2 weeks, how often have you been bothered by any of the following problems/

A. Little interest or pleasure in doing things?

- Not at all

- Several days
- More than half the days
- Nearly every day

B. Feeling down, depressed, or hopeless?

- Not at all
- Several days
- More than half the days
- Nearly every day

17. A. Do you have a regular family doctor?  Yes  No

B. If no, is this because (you may select more than one):

- There are no doctors in your community
- You can't find a doctor who is taking new patients
- You are not happy with the choice of doctors in your community
- You prefer to use a walk-in clinic
- You prefer to use a health center
- You haven't needed a doctor recently
- Other, please specify \_\_\_\_\_

18. Is your family doctor?  Male  Female

19. Is your family doctor from a similar culture as yourself?  Yes  No

20. A. Is there anything that would prevent you from getting medical care, if needed?

- Yes
- No

B. If yes, then please identify a reason (you may select more than one):

- Transportation problems?
- Not knowing where to go for health care?
- A lack of services in your home community?
- A lack of choice in styles of health care in your home community?
- Poor past experiences?
- Feeling that health care providers won't be able to help you?
- Language barriers?
- Cultural barriers?
- Feeling judged or disregarded by health care providers?
- Concern about how your family or community would react to your health issues?
- Other, please specify \_\_\_\_\_

### **Social Support**

21. A. Is there someone in your life you can talk about any problem?

- Yes
- No

Not sure

B. In an emergency, do you have someone you could stay with?

Yes

No

Not sure

C. Do you have someone you could borrow a significant amount of money from if needed?

Yes

No

Not sure

***Study “Concept- Mapping of Facilitators of Social Inclusion among Tamil Elders”  
Focus Group with Service Providers***

---

**RESEARCHERS**

***Principal Researcher***, York University  
Thrmiga Sathiyamoorthy, Graduate Student  
Interdisciplinary Studies

***Graduate Supervisors***, York University  
- Prof. Farah Ahmad, PhD (Primary)  
- Prof. Deborah Davidson, PhD  
- Prof. Guida Man, PhD

**PURPOSE OF STUDY**

As a graduate student, I am conducting a study to explore the facilitators and barriers to social inclusion for Tamil elders (age 55+) in the GTA. Evidence shows the positive impact of social inclusion on mental wellbeing, but little scholarly knowledge exists on the factors that facilitate social inclusion for Tamil elders in Canada. The purpose of this Focus Group study is to document such factors from the perspectives of service providers to inform scholarly work, practice and policy to enhance social wellbeing of elders from Tamil and other similar communities in Canada.

You are invited to participate in this research study because of your knowledge and past experience of working with older adults from the Tamil community. Please read this form and ask any questions you may have before acting on this invitation. Your participation is completely voluntary and you have the right to discontinue at any time.

**STUDY PROCEDURES**

If you agree to be in this study, you will be asked to participate in one Focus Group discussion. The group of 5-7 community leaders and service providers will meet at the community agency partnering with the study; refreshments will be served.

As a key informant, you will be asked to share your perspectives of what you believe are the current facilitators and barriers for the social inclusion of Tamil elders in the Greater Toronto Area. We hope to also understand the challenges you face at an agency level to improve 1) Tamil elders’ access to necessary health and social services, and 2) their engagement in community affairs. We hope to hear your insights about isolated seniors too, who are unable to participate in agency activities, and learn about current outreach efforts in place to address this issue.

If you agree, the discussion will be audio-recorded to ensure that we do not miss important information. The expected completion time is 2 hours.

**RISKS**

There are no major risks to the participants as this is a non-invasive study. However, the topic of

social inclusion is a sensitive topic and there is some possibility of feeling emotionally stressed. Please be reminded that your participation is completely voluntary and you may decline to answer any or all questions or terminate your involvement at any time.

## **BENEFITS**

There is no direct benefit to you for your participation in this study. Indirect benefits to participation may include gaining new information/knowledge about social inclusion and effective ways to engage with community at large. The researchers hope that the information obtained from this study would influence future programming at the community level.

## **CONFIDENTIALITY**

Confidentiality will be provided to the fullest extent possible by law. This session involves the audio recording of the key informants' discussion. Neither your name nor any other identifying information will be associated with the transcribed data. Information collected from this discussion will not be linked to participant names on the consent forms. Please respect the confidentiality of your fellow participants, by not sharing their personal information or their statements with anyone outside the group discussion. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning a study ID (e.g. code number) to each participant that will be used on all transcriptions and research notes
- The audio-recording will be erased once we have transcribed it and only the written notes will be kept for analysis
- Keeping collected data and any other identifying participant information in a locked filing cabinet in the personal possession of the researcher. Electronic data will be secured in a password-protected laptop.
- Publications and presentations based on the study findings will not release personally identifiable information of the participants.

**COMPENSATION:** A \$10 gift card will be offered as a token of appreciation for your participation in each session. Should you choose to withdraw from the study at any time, you will still receive the gift card as promised.

## **CONTACT INFORMATION**

If you have questions about the research in general or about your role in the study, please feel free to contact myself or my Principal Supervisor, Professor Farah Ahmad. The proposal of this research has been reviewed and approved by the Human Participant Research Committee of York University. If you have questions regarding your rights as a research participant, or if problems arise and you do not want to discuss it with the Primary Investigator or Supervisor, please contact the Office of Research Ethics (5<sup>th</sup> Floor, Kaneff Tower) at (416) 736-5201.

## **VOLUNTARY PARTICIPATION**

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawing from this study will not affect the relationship you have, if any, with the researcher or York University. If you withdraw from the study, we will try our best to return

your data or destroy it. However, once the group sessions have started, it might be difficult to track individual contributions. All data collected will be destroyed by August 31<sup>st</sup>, 2023.

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## CONSENT

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant Name \_\_\_\_\_

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Principal Researcher's signature \_\_\_\_\_ Date \_\_\_\_\_

Appendix E – Focus Group Brief Survey

**Brief Survey**

This survey asks some general questions on socio-demographics and health. Please select only one response unless indicated otherwise. All information will be kept highly confidential.

**Key Informant: Basic Information**

1. Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Other \_\_\_\_\_
2. Title in the organization: \_\_\_\_\_
3. Number of years with organization: \_\_\_\_\_ years
4. Number of years working with elderly population: \_\_\_\_\_  
Number of years working with immigrant populations: \_\_\_\_\_

**Organization: Basic Information**

1. Type of organization: (e.g. Newcomer services, Seniors' community centre, Health clinic, Specialized agencies, etc.) \_\_\_\_\_
2. How many years has the organization been active? \_\_\_\_\_ years
3. Geographic Area Served: \_\_\_\_\_
4. Ethno-cultural group served: (e.g. Poly-cultural, mono-cultural, etc.)  
\_\_\_\_\_
5. Approximately, what percentage of the clientele are later-life (aged 65 years and over) immigrants? \_\_\_\_\_ %
6. What services are offered to older immigrants?  
\_\_\_\_\_

## Appendix F

Table 5: List of Concept Mapping Statements

#	Statement
1	Strengthening supports for 'sandwiched' seniors who take care of parents and children
2	Keeping yourself busy and healthy through activities (e.g. yoga, biking, etc.) and self-care
3	Encouraging women to stay at home to raise children
4	Volunteering here in Canada (e.g. Walkathons)
5	Living in an urban area with numerous opportunities to interact
6	Having an increased life expectancy in Canada due to medical care and no war
7	Improving understanding about expectations of husbands and wives from each other
8	Having confidence to access available opportunities and improve credentials
9	Having free access to English as a Second Language (ESL) programs
10	Listening to adult children and adapting to the "New School" style
11	Acknowledging the possibility of going to a senior home
12	Celebrating Canadian holidays with your families
13	Having more family events and creating a support system for seniors
14	Reducing the risk of elder abuse
15	Having friendly and non-judgemental conversations with non-Tamil Canadians
16	Becoming aware of the risks for elder abuse (e.g. financial or emotional)
17	Meeting friends in public places to share, listen and relieve stress
18	Having knowledge about government services and available opportunities
19	Having access to electronic transfer of doctor's prescriptions to pharmacy
20	Reducing communication/generational barriers with grandchildren
21	Strengthening access to health services and senior housing with Tamil interpreters, PSWs and etc.
22	Having a better system overtime for foreign credential evaluation
23	Understanding generational gaps and giving space to grandchildren
24	Having access to welfare housing
25	Gaining knowledge about elders' rights and child abuse (e.g. via ESL programs)
26	Overtime, recognizing gender equality for women
27	Reducing reliance on TV and encouraging other forms of social engagement
28	Arriving in Canada with a good education assisted with good employability
29	Having the option to choose to live at home or in a senior home
30	Offering some paid work to seniors
31	Having or learning English language skills
32	Memberships in associations via schools and villages in Sri Lanka to maintain ties
33	Reducing family pressure on seniors to spend time in malls
34	Learning strategies to have financial independence from children
35	Having the opportunity and financial means to visit Sri Lanka whenever you want
36	Over time, senior women's independence from spouses in making decisions

#	Statement
37	Having excellent medical coverage (compared to Sri Lanka)
38	Overcoming hesitation to ask for information and seek professional advice
39	Adapting to harsh weathers in Canada
40	Building communities for Tamil seniors near their friends and family
41	Limiting interactions to people from Tamil communities
42	Saving money for the future (e.g. senior home)
43	Feeling that all cultures are equally included
44	Overcoming settlement challenges through spiritual beliefs and will power
45	Having better access to transportation to reduce loneliness
46	Living close to children
47	Feeling safe in Canada by escaping war, sexual assault and other violence
48	Staying in Little Jaffna (GTA) because of the increased Tamil-specific supports and services
49	Witnessing the economic prosperity of Tamil Canadians, especially youth
50	Learning to manage finances within one's budget
51	Landing a decent job at the right time
52	Facilitating transport between peripheral and central regions
53	Meeting Canadian war veterans to share personal past war experiences
54	Moving on with a positive mind frame after difficulties (e.g. war, widowed, separated from spouse)
55	Learning Canadian communication norms through employment
56	Having Old Age Security and Canada Pension Plan
57	Developing life skills (e.g. banking, tax return, credit card fraud, etc.)
58	Having access to community based programs and other facilities to learn life skills (e.g. banking)
59	Understanding the multiple commitments of adult children
60	Acknowledging the resilience of Tamil senior refugees
61	Setting up more Tamil cultural facilities (e.g. temples)
62	Promoting Tamil language, cultural and religious values among youth
63	Improving workplace strategies to reduce isolation
64	Offering intergenerational programs to engage youth and seniors (e.g. Tamil cooking, computers)
65	Developing a tolerance for children's put-downs and negative attitudes
66	Having a two-income family
67	Discussing with children about independence for social interactions (e.g. meeting friends)
68	Having supportive community programs to address the hardships and traumatic experiences of Sri Lankan Tamil refugees
69	Having work opportunities to showcase unique skill sets and/or hard work
70	Overtime, senior men helping with housework including care of grandchildren
71	Babysitting grandchildren to make yourself happy and stay busy
72	Driving children to help with extracurricular

## Appendix G

Table 6: Mean Rating of Clusters and Statements: Importance & Feasibility\*

#	Statement	Importance	Feasibility
<b><i>Family Harmony</i></b>		<b>4.05</b>	<b>3.72</b>
1	Strengthening supports for 'sandwiched' seniors who take care of parents and children	4.29	3.71
3	Encouraging women to stay at home to raise children	2.67	3.05
10	Listening to adult children and adapting to the "New School" style	3.76	3.57
12	Celebrating Canadian holidays with your families	4.29	4.14
13	Having more family events and creating a support system for seniors	4.10	3.86
20	Reducing communication/generational barriers with grandchildren	3.71	3.62
23	Understanding generational gaps and giving space to grandchildren	4.52	3.95
26	Overtime, recognizing gender equality for women	4.33	3.71
33	Reducing family pressure on seniors to spend time in malls	3.81	3.48
40	Building communities for Tamil seniors near their friends and family	4.19	3.48
46	Living close to children	4.24	3.95
59	Understanding the multiple commitments of adult children	4.24	3.52
64	Offering intergenerational programs to engage youth and seniors (e.g. Tamil cooking, computers)	4.43	3.86
65	Developing a tolerance for children's put-downs and negative attitudes	4.19	3.48
67	Discussing with children about independence for social interactions (e.g. meeting friends)	4.24	3.71
70	Overtime, senior men helping with housework including care of grandchildren	3.90	3.86
71	Babysitting grandchildren to make yourself happy and stay busy	3.95	3.90
72	Driving children to help with extracurricular	3.90	3.81
7	Improving understanding about expectations of husbands and wives from each other	4.19	3.95

#	Statement	Importance	Feasibility
<b><i>Medical System and Senior Care</i></b>		<b>4.17</b>	<b>3.99</b>
2	Keeping yourself busy and healthy through activities (e.g. yoga, biking, etc.) and self-care	4.52	4.38
6	Having an increased life expectancy in Canada due to medical care and no war	4.43	3.95
11	Acknowledging the possibility of going to a senior home	3.38	3.81
19	Having access to electronic transfer of doctor's prescriptions to pharmacy	3.57	3.38
21	Strengthening access to health services and senior housing with Tamil interpreters, PSWs and etc.	4.20	4.14
29	Having the option to choose to live at home or in a senior home	3.95	3.86
37	Having excellent medical coverage (compared to Sri Lanka)	4.57	4.05
47	Feeling safe in Canada by escaping war, sexual assault and other violence	4.71	4.33
<b><i>Adaptation and Integration</i></b>		<b>4.14</b>	<b>3.73</b>
14	Reducing the risk of elder abuse	4.43	3.81
16	Becoming aware of the risks for elder abuse (e.g. financial or emotional)	4.38	3.81
17	Meeting friends in public places to share, listen and relieve stress	4.19	3.95
36	Over time, senior women's independence from spouses in making decisions	3.95	3.62
44	Overcoming settlement challenges through spiritual beliefs and will power	3.81	3.67
54	Moving on with a positive mind frame after difficulties (e.g. war, widowed, separated from spouse)	4.43	3.86
60	Acknowledging the resilience of Tamil senior refugees	4.00	3.48
61	Setting up more Tamil cultural facilities (e.g. temples)	3.76	3.67
62	Promoting Tamil language, cultural and religious values among youth	4.19	3.9
39	Adapting to harsh weathers in Canada	4.24	3.57

#	Statement	Importance	Feasibility
<b><i>Cultural Interaction and Feeling of Security</i></b>		<b>3.99</b>	<b>3.69</b>
4	Volunteering here in Canada (e.g. Walkathons)	4.05	4.33
5	Living in an urban area with numerous opportunities to interact	4.14	3.86
27	Reducing reliance on TV and encouraging other forms of social engagement	4.05	3.76
43	Feeling that all cultures are equally included	4.10	3.52
48	Staying in Little Jaffna (GTA) because of the increased Tamil-specific supports and services	4.10	3.52
53	Meeting Canadian war veterans to share personal past war experiences	3.43	3.19
68	Having supportive community programs to address the hardships and traumatic experiences of Sri Lankan Tamil refugees	4.10	3.67
<b><i>Social Interaction</i></b>		<b>3.82</b>	<b>3.67</b>
15	Having friendly and non-judgemental conversations with non-Tamil Canadians	4.14	3.71
32	Memberships in associations via schools and villages in Sri Lanka to maintain ties	3.95	3.57
41	Limiting interactions to people from Tamil communities	3.00	3.48
49	Witnessing the economic prosperity of Tamil Canadians, especially youth	4.19	3.90
<b><i>Financial Independence</i></b>		<b>4.22</b>	<b>3.88</b>
30	Offering some paid work to seniors	3.81	3.29
34	Learning strategies to have financial independence from children	4.29	3.81
35	Having the opportunity and financial means to visit Sri Lanka whenever you want	4.00	3.62
42	Saving money for the future (e.g. senior home)	4.29	4.33
56	Having Old Age Security and Canada Pension Plan	4.81	3.95
63	Improving workplace strategies to reduce isolation	4.19	3.67
66	Having a two-income family	3.95	4.05
52	Facilitating transport between peripheral and central regions	3.95	3.71
45	Having better access to transportation to reduce loneliness	4.57	4.10

#	Statement	Importance	Feasibility
<b><i>Services for Employment and Settlement</i></b>		<b>4.33</b>	<b>3.96</b>
8	Having confidence to access available opportunities and improve credentials	4.10	3.71
9	Having free access to English as a Second Language (ESL) programs	4.10	4.67
18	Having knowledge about government services and available opportunities	4.57	4.38
22	Having a better system overtime for foreign credential evaluation	4.05	3.76
24	Having access to welfare housing	3.95	3.57
25	Gaining knowledge about elders' rights and child abuse (e.g. via ESL programs)	4.48	4.14
28	Arriving in Canada with a good education assisted with good employability	4.24	3.52
31	Having or learning English language skills	4.86	4.38
38	Overcoming hesitation to ask for information and seek professional advice	4.48	3.95
51	Landing a decent job at the right time	4.38	3.71
55	Learning Canadian communication norms through employment	4.29	3.86
57	Developing life skills (e.g. banking, tax return, credit card fraud, etc.)	4.38	4.10
58	Having access to community based programs and other facilities to learn life skills (e.g. banking)	4.52	4.10
69	Having work opportunities to showcase unique skill sets and/or hard work	4.19	3.62

**\*Rating Scales**

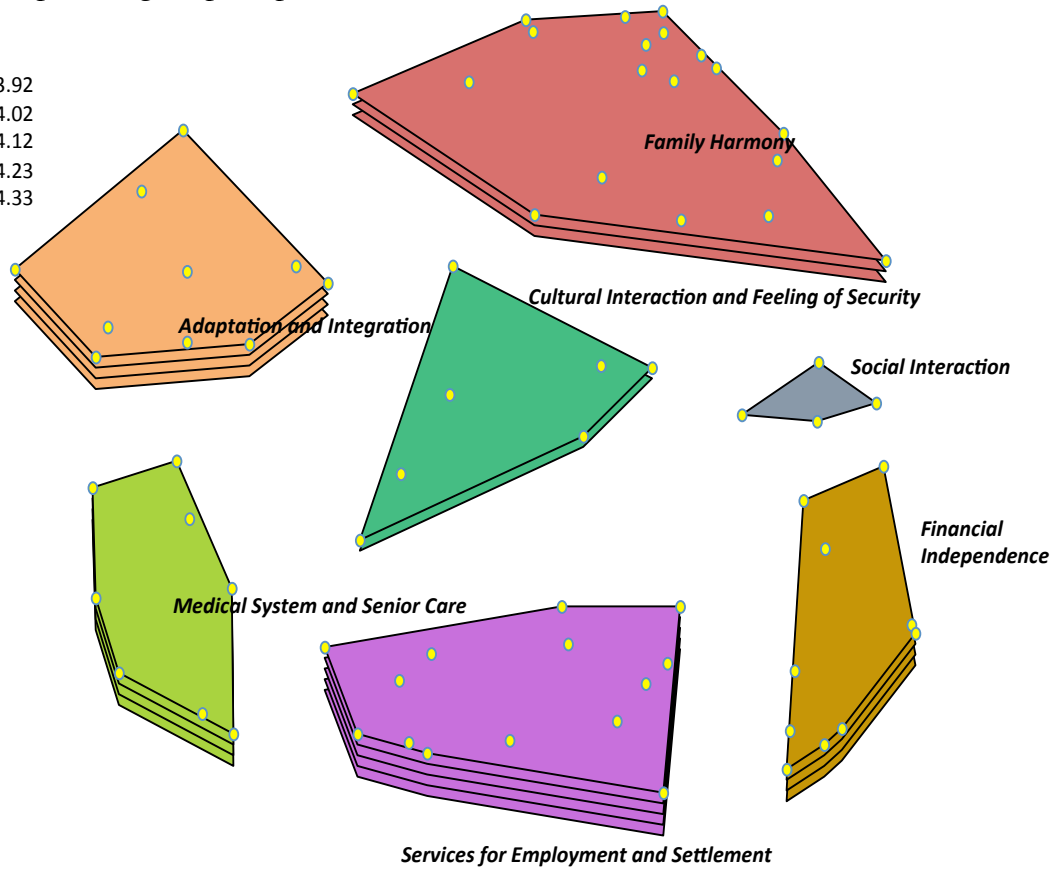
- Importance: 1= Very Unimportant; 2 = Somewhat Unimportant; 3 = Not Sure; 4 = Somewhat Important; 5 = Very Important
- Feasibility: 1= Not Feasible; 2 = Somewhat less Feasible; 3 = Not Sure; 4 = Somewhat More Feasible; 5= Very Feasible

## Appendix H

Figure 7: Concept Rating Map (Importance)

Cluster Legend

Layer	Value
1	3.82 to 3.92
2	3.92 to 4.02
3	4.02 to 4.12
4	4.12 to 4.23
5	4.23 to 4.33



Rating Scales

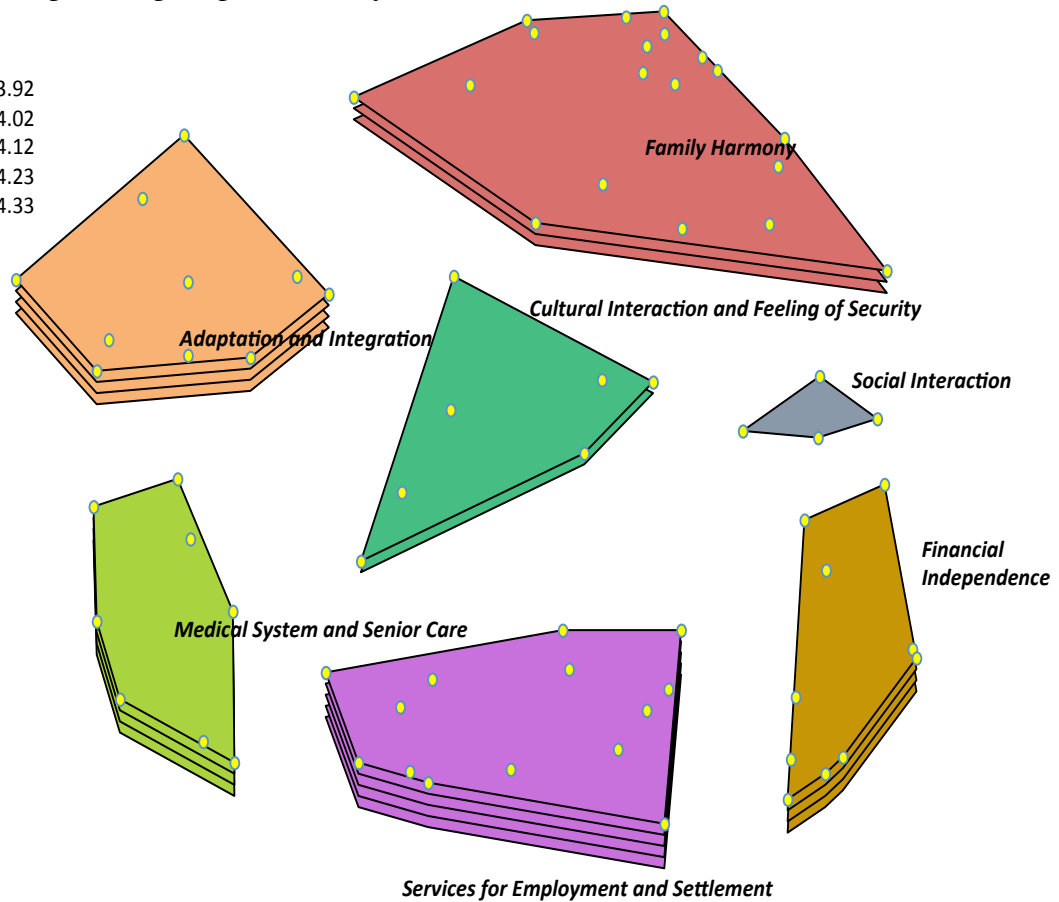
- Importance: 1= Very Unimportant; 2 = Somewhat Unimportant; 3 = Not Sure; 4 = Somewhat Important; 5 = Very Important
- Feasibility: 1= Not Feasible; 2 = Somewhat less Feasible; 3 = Not Sure; 4 = Somewhat More Feasible; 5= Very Feasible

## Appendix I

Figure 8: Concept Rating Map (Feasibility)

### Cluster Legend

Layer	Value
1	3.82 to 3.92
2	3.92 to 4.02
3	4.02 to 4.12
4	4.12 to 4.23
5	4.23 to 4.33



### Rating Scales

- Importance: 1= Very Unimportant; 2 = Somewhat Unimportant; 3 = Not Sure; 4 = Somewhat Important; 5 = Very Important
- Feasibility: 1= Not Feasible; 2 = Somewhat less Feasible; 3 = Not Sure; 4 = Somewhat More Feasible; 5= Very Feasible

Appendix J – Resource List

**Resources to Support Tamil Seniors**

***TTC-Lakeshore Wheel-Trans***

(416) 393 – 4222 (English only)

***Wheelchair Rentals - Shoppers Home Health***

(416) 431- 4621 (English only)

***Wheelchair Rentals - Able Home Health***

(416) 789 – 2542 (English only)

***Housing Help Centre*** (English only)

(416) 285 - 8070 (Toronto)

1-887-467- 9675 (York Region)

***Housing Help - St. Paul's L'Amoreaux Centre***

(416) 493 – 3333 (Tamil & English)

***Housing Help - Agincourt Community Services Association***

(416) 321 – 6912 (English only)

***Adult Day Program - CareFirst Seniors***

(416) 502 – 2323 (English only)

***Adult Day Program - St. Paul's L'Amoreaux Centre***

(416) 493 – 3333 (Tamil & English)

***Senior Services - Scarborough Centre for Health Community***

(416) 847 – 4129 (Tamil & English)

***Senior Services - Community Matters Toronto***

(416) 944 – 9697 (Tamil & English)

***Senior Services - Centre for Immigrant and Community Services***

(416) 588 – 6288 (English only)

***Central East Community Care Access Centre***

(416) 750 – 2444 (English only)

\*For assistance with long-term care and in-home supports

**For more information on senior services, call 211 Toronto at 416-392-4605 (English only).**