Cultural Considerations in the Delivery of Homecare Services:
"Beyond 2 kitchens and a disability/ più di due cucine e disabilità".

by

(Hedy) Anna Walsh

A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
Factor-Inwentash Faculty of Social Work
University of Toronto

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Abstract

This study explored the experiences, interpretations and cultural beliefs of older Italian immigrants who were receiving culturally specific formal homecare services through an assisted living facility in Ontario, to examine how their identity and life history influenced their experiences of receiving care.

The current study builds on the existing body of knowledge about Canada's older Italian immigrants, in particular their caregiving traditions and current need for formal care. This research study employed phenomenology to explore the subjective experiences of Canadian Italian older immigrants who were receiving formal homecare services to capture the personal meanings and interpretations of their immigration experiences, as they related to their need for formal homecare services.

Interviews were conducted with 25 older Italian immigrants over the age of 75 that were receiving culturally specific homecare services. The participants shared their immigration stories, fears, work history, healthcare challenges and descriptions of arrival, family, losses, and life in Canada. The Life Course Framework was selected to guide this research study, to represent the process of aging and human development that
continuously occurs across the life span. The Social Identity Theory was also used to provide additional guidance in understanding the social, cultural and historical influences of their life histories, as they related to their living arrangements in an assisted-living facility in Ontario and need for caregiving services.

Three major themes emerged: 1. the importance of communication and relationship building in the provision of care and the barriers in accessing health care services, 2. retaining identity and control, and 3. facing an uncertain future. These themes reveal the importance of language, cultural practices and residential location. At the micro level, these findings demonstrate the importance individuals assign to their immigration history and cultural traditions. At a macro level, the findings reveal the need to provide cost-effective care that enhances the physical and mental well-being of individuals.

These findings also reflect the importance assigned to the home environment and the need for workers to develop relationships with clients that are reflective of their cultural needs. Social workers have the ability to appreciate the historical context of Canada's immigrants; to develop policies in support of their cultural practices, traditions and acculturative interests, and the ability to appreciate the aging process and the associated need for formal services. As Canada's multicultural population continues to grow, social workers will be increasingly challenged to deliver culturally competent healthcare services. The findings are intended to offer additional guidance into the meaning of culture and its importance in furtherance of these goals.
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I carry in my heart, the undying spirits of my late grandparents, Shloime and Chaya Diament whose stories of survival encouraged me to go forward. I am also guided in life by the spirits of my father's late parents Chaya and Shaul Waks, and family who perished in the Holocaust. Special thanks go out as well to the memory of my husband's grandparents Augustina and Salvatore Curreri whose second kitchen inspired this study.

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Chapter 1: Introduction

Introduction

The purpose of this chapter is to provide background on the problem addressed by this study, provide a rationale for pursuing this research and outline the objectives of the study. Also included is a summary of the current limitations in the literature and brief summary of the benefits of this research to the field of social work.

Canada’s changing ethnic and racially diverse populations have specific cultural preferences for health care services (Brotman, 2003; Lai, 2004; Webster, Curry, & MacGraw, 2004; Willgerodt & Killien, 2004). Current homecare delivery models, however, are tailored to suit the needs of majority populations (Kemp & Denton, 2003) rather than cultural considerations of immigrant populations such as social support, religiosity, knowledge of diverse populations, language, socioeconomic class, gender, sexual orientation and cultural beliefs (Schim et al., 2005; Maharaj, 2007; Torres-Gil & Treas, 2009). Accounting for such cultural considerations is positively associated with better health care outcomes (Benjamin, Matthias, & Franke, 2000; Geron, 2002; Maharaj, 2007; Olsan, Shore, & Coleman, 2009; Torres-Gil & Treas, 2009). Consequently, immigrant groups often report limited access and utilization of services (Brotman, 2004; Coyte, 2000; Lee, 2004).

As a result of the paucity of information currently available on Canada's Italian older immigrants and their personal experiences in receiving formal homecare services, social workers who are involved in the assessment and referral of homecare services have little information to guide them in the provision of their services. This chapter acknowledges the importance of social workers in their role as advocates to represent this population and direct policy interventions for their receipt of responsive homecare services. This chapter also includes a brief description of
the Life Course Framework that guides this study, along with the Social Identity Theory, which highlights the importance of identity and the changes that occur throughout the life course and affect the need for care.

This chapter concludes with an outline of the organization of the dissertation and a brief summary of each chapter.

**Background**

The world’s changing demographic profile of longer life expectancy together with lower fertility rates in developed countries (Wisensale, 2006) has resulted in an increase in the adult population 65 and older (Grundy, 2006). In addition to a multitude of immigration challenges, alterations associated with declining fertility rates, increased divorce rates and women’s greater participation in the paid workforce (Wodarski & Williams-Hayes, 2002) have resulted in fewer available family members to attend to the needs of older relatives. Furthermore, advances in treatment, medication and enhanced technology in the home, along with ongoing budget cuts to health care services and an emphasis on community care, have resulted in a greater need for formal homecare services (Romanow, 2002).

Older adults are a diverse group with a great range of family and social contacts. Whereas some older individuals may have accumulated a lifetime of reciprocal social contacts, there are many vulnerable individuals—the very old, and those with low incomes, poor social ties and a reduced capacity to be independent (Grundy, 2006).

Many older adults over the age of 80 live in the community and depend upon assistance from family members and friends for their activities of daily living, such as bathing, dressing, eating, and for assistance with their instrumental activities of daily living, such as shopping, banking and transportation. Women are predominantly the providers of caregiving assistance for
activities of daily living, whereas men are more likely to assist with instrumental activities such as yard work and financial management. Alterations in prior caregiving practices (Wodarski & Williams-Hayes, 2002) as a result of women’s involvement in the paid workforce and declining fertility rates, have resulted in a greater demand for formal homecare services (Wisensale, 2006). Concerns about caregiving, provision of healthcare, pension funds, retirement policies and social welfare assistance have dominated global concerns with respect to the availability of resources and intergenerational support systems to care for older adults (Joubert & Bradshaw, 2006). Much less considered however, is the importance of cultural factors in the provision of homecare services.

Canada is one of many countries with a growing population of individuals over the age of 65. Moreover, according to recent Canadian census data, the foreign-born population is older than the native-born one, representing 18% of those 65 or older, compared to 11% of the Canadian-born (Zeng & Hart, 2002). The 2011 Canadian Census reported that Canada’s population of 33,476,688 people reflected a 5.9% increase since 2006, which was greatly attributed to net international migration. Twenty-five million people or 80% of the population were residing in urban areas, with nearly 47% living in capital cities. Furthermore, the 2006 census reported that nearly 4% of the entire population, or 1.6 million people, were over the age of 85 and 93% of all older adults were living independently in their homes and relying on some type of social support (Statistics Canada, 2006). According to the Canadian 2011 Census of Population, there were approximately 5 million (4,945,000) older adults age 65 and over in Canada of whom, 92.1% resided in private households or dwellings, while 7.9% lived in residences for senior citizens or health care and related facilities (Statistics Canada, 2011). Older women age 65 and older were nearly twice as likely (31.5%) to live alone, compared to men
(16%). This is in part related to the lower life expectancy of men whereas, due to the trend for women to reside with men older than themselves, there is greater likelihood of becoming widowed. Among older adults aged 85 and over, 36.6% of women lived alone in 2011 compared to 21.8% of men. Among older adults aged 90 years and over, 56.5% lived in private households, 28.7% lived alone, 15.7% lived with others and 12.2% lived as a couple. The remaining 43.5% resided in senior or nursing homes (Statistics Canada, 2011).

Canada is home to 1,445,335 Italian immigrants, representing 4.57% of the population with the highest concentration of 60% of Canada's Italian immigrants, or 867,201, living in Ontario (7.2% of Ontario's population), and 466,155 in the Greater Toronto area alone, followed by 303,520 or 21% of the Italian population living in Québec, or 299,655 (4% of Québec's population) and 260,345 in the greater Montréal area (Statistics Canada, 2006). This population includes individuals that immigrated as young adults and individuals who immigrated to Canada at a much later stage. Italian immigrants are Canada’s fifth largest ethnic group, after those that are of British, Irish, French and German origin (Statistics Canada, 2006). In Toronto, 71,725 individuals of a total population of 2,589,085 (2.77%) reported Italian as their primary language (Statistics Canada, 2011). In Ontario, 251,330 individuals of the total population of 12,722,060 (1.98%) reported Italian as their primary language (Statistics Canada, 2011).

Canada prides itself on its ability to offer a health care program that can deliver care on the basis of need, rather than on the ability to pay (Morrow, Armstrong, Galvin, Grinvalds, & Hankivsky, 2004). However, recent measures to contain health-care costs have led to hospital restructuring, the elimination of many medical services that were once covered by the Ontario's Health Insurance Plan (OHIP) and replacement of them with homecare services. Homecare
services provide assistance to individuals in their home, as an alternative to hospital or long-term care, in order to maximize their ability to live independently in the community.

Canada does not have a national homecare program and the provision of services falls outside of the *Canada Health Act*, resulting in no equality or transferability between the provision of care across the 13 provinces and territories. Delivered by individual provinces, territorial and some municipal governments, homecare programs vary in how they are funded and administered (Health Canada, 2011). In addition to offering home health care services following hospital discharge, homecare programs provide assistance to older adults to maximize their level of independence in their own home (Béland et al., 2006; Rotermann, 2006; Romanow, 2002; Whiteside, 2011) and have been deemed by the provincial and federal governments as more cost-efficient than institutional care (Morrow et al., 2004).

Budgetary cuts to Ontario's healthcare program have led to the introduction of the "Aging in Place" policy, encouraging older adults to remain in their home and receive homecare services. Embedded in this conceptualization is the government’s mandate for market reform to reduce healthcare expenditures (Jirwe, Gerrish, & Emami, 2006) as homecare costs are perceived to be lower than hospital or institutional care (Anderson, Tang, & Blue, 2007; Coyte 2000; Cohen et al., 2006; Edwards & Mawani, 2006; Knight, Haslam, & Haslam, 2010; Legault, 2011; Motiwala, Flood, Coyte, & Laporte, 2005; Moyser, Kaida, & Park, 2009; Whiteside, 2011). As a result, many former medical services have been shifted from hospitals and other institutions to the home setting, requiring homecare providers to respond to complex medical and safety needs of older adults in the home (Stacey, 2005).

Homecare programs have been designed to offer relief to family members who are caring for their older relatives. Although homecare programs vary in design and delivery across
provinces, they typically include an array of professional services such as nursing care, social work, occupational therapy, physical therapy, speech therapy, dietitian services, respite care and personal support services to assist with dressing, feeding, bathing and personal care. The provincial and federal governments’ cost saving initiative of providing homecare services as an alternative to institutionalized care complements the preference held by most older adults, to remain in their home.

Social determinants of health such as social, environmental and economic factors have been shown to affect the health of individuals (Adler & Ostrove, 2006; Brunner & Marmot, 2006; Marmot, Allen, Bell, & Goldblatt, 2011). Older adults are particularly vulnerable to economic challenges, especially as they relate to housing, community services and caregiving support. As a result, healthcare providers are challenged to develop culturally competent care, to improve health and social outcomes (Brotman, 2003; Warburton, Bartlett, & Rao, 2009). Most recently, there has been a growing awareness of the effect of the social environment on chronic illnesses and the importance of the environment in the prevention of further adverse effects associated with chronic conditions and the promotion of optimal health outcomes (Backman et al., 2011).

Canada's ongoing increase in immigration has led to an awareness of the importance of language, socioeconomic class, gender, sexual orientation and cultural beliefs in the provision of care (Schim et al., 2005; Maharaj, 2007; Torres-Gil & Treas, 2009) and the importance of culturally competent care (Schim, Doorenbos, & Borse, 2005). This has resulted in a need for more knowledge about Canada's diverse populations (Maharaj, 2007) and their particular experiences in the receipt of services, in order to better understand their homecare needs (Geron, 2002; Olsan, Shore, & Coleman, 2009).
Problem

Many immigrant groups in Canada experience barriers in the procurement of much-needed health care services (Baker et al., 2010; Birch, Eyles & Newbold, 2006; Kirmayer et al., 2007; Lasser, Himmelstein & Woolhandler, 2006; Neufeld, Harrison, Hughes, Spitzer, & Stewart, 2001; Schoen, Osborn, How, Doty & Peugh, 2009). Many are hesitant to receive care due to a perceived lack of knowledge among health care providers about their cultural values and beliefs (Lai, 2004). Canada’s homecare programs are based on the traditional biomedical model which aims to reduce disability and provide medical care, with less emphasis on the underlying cultural factors (Smart & Smart, 2006). As a result, individual perceptions or the cultural factors related to homecare need are rarely considered (Porter, 2000).

In addition to language barriers, most homecare programs have been criticized for their provision of care for the dominant culture with a corresponding lack of understanding of ethnic and cultural differences (Nichols et al., 2004), often resulting in inappropriate and inefficient care for older immigrants (Canadian Heritage, 2009). Cultural considerations in the provision of healthcare services are important for older adults in shaping attitudes and preferences for care (Dempsey, 2003) and lead to safer medical practices, higher patient compliance rates, lower health inequities among immigrant population groups and more cost-efficient care (Anderson et al., 2007; Lee & Yoon, 2011).

There is acknowledgment in the literature of recent economic and demographic factors that have contributed to changes in caregiving practices (Wodarski & Williams-Hayes, 2002) that have resulted in a greater demand for homecare services. Ongoing changes in demographics associated with changes in migration/job patterns, employment patterns (Stone & Salsberg, 2001) as well as recent health care reforms to limit health care spending have resulted in fiscal
pressures to reduce health care expenditures (Chappell & Hollander, 2001). As a result, social workers are increasingly challenged to offer cost effective homecare strategies that adequately reflect specific utilization patterns (Kadushin, 2004). Moreover, they are challenged to accommodate Canada’s diverse cultural populations in the delivery of health care services, and to reflect complex differences in language, beliefs, traditions and values that will impact upon health care outcomes and medical compliance rates (Schim, Doorenbos, & Borse, 2005).

Although many studies have considered the home environment within an aging framework, measures of everyday adaptive responses have not been extended to include diverse racial and ethnic groups (Gitlin, 2003). Both the Canadian Charter of Rights and Freedoms and the Canadian Multiculturalism Act endorse the need to consider culture in the provision of decision-making processes (Schim et al., 2005). Knowledge of acculturative processes however, and their impact on immigrant family caregiving practices, remain limited. This information is especially lacking among the Ontario Italian older immigrant population, despite their long-standing immigration history and presence in Canada and their strong adherence to their cultural norms, values and language. This gap in research (Kobayashi, 2000) poses a problem for social workers who play a vital role in the organization and delivery of homecare services.

There is an appreciable body of literature about other immigrant groups such as older Chinese (Lai, 2004), Haitian, French-Canadians (Guberman & Maheu, 2003), Algerian, Vietnamese, Lebanese, Sri Lankan (Leduc & Proulx, 2004), Japanese, (Verkuyten, 2005) Taiwanese, Indian, Pakistani Canadian immigrants (Neufeld, Harrison, Hughes, Spitzer and Stewart, 2001; Keefe, Rosenthal, & Béland, 2000) as well as African, Latino, White Western European (Sciegaj, Capitman, & Kyriacou, 2004; Dilworth-Anderson et al., 2005) and Filipino Americans (Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002) and their utilization of homecare
services. However, very little information is available about Ontario's older Italian immigrant population, despite previous studies that have outlined the need to consider the effects of globalization and immigration for all population groups (Wisensale, 2006). Despite the similarities among immigrant populations, there are immigrant experiences unique to the Italian immigrant population, reflective of their residence and location of origin (Mercer, 1995).

The Italian "home" and its symbolic importance in receiving services (Gitlin, 2003) has been a neglected area of research. Despite its importance as the site where services are received (Martin-Matthews, 2007), sufficient information pertaining to the symbolic utilization and meaning of space (Gitlin, 2003) is lacking (Aronson, 2004). Home ownership in Canada was emphasized (Bellamy, 1993; Constant, Roberts, & Zimmerman, 2009) relying heavily on family support for financial assistance by forming multiple family households (Delvoie, 2000). The home was an important indicator of financial success and achievement (Constant, Roberts, & Zimmermann, 2009) and incorporated women's sense of identity in the role of housewife, mother and homemaker (Leith, 2006). The inclusion of two kitchens, unique to this population (Pascali, 2006) relates to the cultural practice of "fare la bella figura" to project a positive image to others (Groebe, 1998). Whereas the basement kitchen was reserved for cooking, the upstairs kitchen was immaculate, reflecting the need for strict order and cleanliness (Pascali, 2006).

Although the particular way the significance of home is symbolized among Italian immigrants is through the second kitchen, other ethno-cultural groups have comparable places or spaces that are symbolically very important. Research on older adults has prioritized the inquiry of institutional facilities, rather than the home environment (Béland et al., 2006; Gitlin, 2003; Johri, Beland & Bergman, 2003; Kodner, 2006; Stone, 2001; Tourigny, Durand, Bonin, Hébert & Rochette, 2004). Current studies of the home environment center more on environmental
barriers, rather than its importance as the place where social relations and practices are expressed (Gitlin, 2003; Aronson, 2004). Boundaries between the public provision of homecare services and the privacy of individual home environments need to be well understood (Martin-Matthews, 2007). Canada's cost-saving strategies of hospital restructuring, reliance on less institutional care and greater emphasis on community-based care (Williams, 2006), as well as the preference of older adults to "age in place", requires an understanding of the symbolic importance of the home in receiving care (Leith, 2006).

Critical to consider is how older adults who belong to the many differing ethno-cultural groups that today define Canadian society negotiate their home spaces and the associated cultural and symbolic significance of their home environments (Kuo, & Torres-gil, 2001). The meanings attached to personal space emerging from this study can be useful in understanding other population groups. Research in this area has the potential to contribute to the development of strategies that have the capacity for enabling older adults in a multicultural society to successfully "age in place" and maximize their quality of life (Gitlin, 2003). Framed within this context, homecare policies should consider the uniqueness of the home in which private and intimate spheres of individual space will affect an older person's experience in their receipt of homecare services (Martin-Matthews, 2007). These important cultural factors need to be well understood, in order to inform future policies in the provision of culturally competent care (Gitlin, 2003).

Moreover, despite caregiving traditions that have been steadily altered in Italy (Marcellini, Giul, Gagliardi, and Papa, 2005) many Canadian Italian immigrants retain a historicized view of former filial norms of older relatives living with family members (Capussotti, 2009). The effects of these memories, as they affect their current caregiving
expectations (Santarelli & Cottone, 2009) remain unknown and thus highlight the need to acquire accurate and realistic predictions about their caregiving needs in the development of effective social policies and services (Matsuoka, 1999).

Recent interest among older Canadian Italian immigrants in institutional living follows its acceptance over the last two decades in Italy (Wister, Pereira & Lazarowich, 1996) which facilitated access to prospective participants receiving services through an assisted living facility in Ontario. Access to a cultural group where trust could be readily acquired was also deemed to be essential. Despite not being Italian, the researcher's familiarity with the Italian language, as well as her physical appearance and first name, which are often interpreted to be Italian, appeared advantageous in gaining access to this cultural group as a non-outsider (Feldman, Radermacher, Browning, Bird & Thomas, 2008).

The researcher's familiarity with the Italian language was deemed important in allowing interviews to be conducted in the participants’ native language, which fostered the true essence of their experiences to emerge (Creswell, 2007) and promoted reliable translation and interpretation of material by an interpreter (Temple, 2002). Conducting interviews in Italian relates to research that has shown that autobiographical memories of older adults are more easily retrieved in their native language (Aragno & Schlachet, 1996; Larsen, Schrauf, Fromholt, & Rubin, 2002; Marian & Fausey, 2006; Marian & Neisser, 2000; Schrauf, 2000) even when knowledge of English or French is present, as a result of the potential to revert back to one's first language (Troper, 2000).

Their inability to converse in English relates to their lack of English knowledge upon their arrival and the predominantly Italian residential and work environments. These conditions encouraged them to converse in Italian and thus to integrate into Canadian society without
assimilating (Murdie & Teixeira, 2003). Canada's policy on multiculturalism favored the survival and distinctness of other languages and cultures, which supported their desire to retain their language and cultural practices (Laroche, Kim & Tomiuk, 1998). Unlike current immigrants with access to ESL classes, few had linguistic resources at that time and thus remained linguistically isolated and unable to speak English or French (Nawyn, Gjokaj, Agbényiga & Grace, 2012).

Furthermore, healthcare providers are often misinformed about older Italian immigrants and their actual cultural preferences for care, particularly resulting from the media's frequent portrayal of them as members of a patrilineal society where women are submissive to men. In addition, ageist beliefs of older women as weak, dependent and uneducated have also contributed to these misconceptions (Bonar, 1996).

Whereas most homecare programs rely exclusively on the biomedical model (Allan, Stajduhar & Reid, 2005; Callahan & Pincus, 2005; Naylor, 2011; Spalding, Kenny, Conrad, McKeever & Macfarlane, 2007), there are some culturally specific homecare programs in Ontario that cater to its older immigrants. However, sufficient knowledge about the value and success of these programs remain critically absent. Noticeably absent are narratives to describe the experiences of the older Italian immigrant population, in receiving these culturally specific services (Olsan, Shore, & Coleman, 2009; Henderson, Kendall, & See, 2011). As a result of all these factors, the Italian population was selected for the purpose of this study.

In the climate of health care reform, issues related to the home environment are critical to any understanding of the need for formal homecare services. Ongoing government commitment to extend Medicare coverage to support services in the home that were traditionally offered in hospitals, doctors’ offices, clinics, or long-term care facilities (Romanow, 2002) has highlighted the need to consider the home environment from different perspectives (Gitlin, 2003).
Ontario's Italian older immigrant population continues to increase in size, social workers will become increasingly more challenged to understand the social and cultural dimensions of health (Gantert et al., 2008), the experience of receiving care (Brotman and Kraniou, 1999) and the importance assigned to the "home" where services are being provided (Gitlin, 2003).

Ontario's homecare program was initially designed to suit the needs of its majority populations (Kemp & Denton, 2003), based on studies that focused on the economic, medical and cost benefits associated with homecare use (Aronson, 2004). This tendency to focus on population risk factors rather than on individual emotions has resulted in a poor understanding of the individual experiences in receiving homecare services (Porter, 2000). For example, because research has tended to obtain the views of family members rather than of older adults themselves, there is limited understanding of the role of informal support and its effects on the use of services (Kristensson, Hallberg & Ekwall, 2010; Nolin, Wilburn, Wilburn, & Weaver, 2006; Penning, 1995; Tio-Londrigan & Gallagher, 2004).

Social workers play an important role in the health, economic and social integration of Canada's immigrants. Expanding the currently limited entitlement to government funded homecare support will require their support in the development of strategies with the aim of assisting individuals and their families to ensure that they are provided with adequate access to health, social and economic resources (Padilla, 1997). Cultural interpretations among healthcare providers are not only informed by their personal interpretation of meanings and values, but are also affected by the government's emphasis upon cost containment of healthcare services with the promotion of early discharges from hospital and more reliance on sources of private and informal care. For example, cultural values that encourage family members to assist their loved ones in hospital are considered a negative quality by hospital personnel as behavior, which will
result in the delay of the discharge process, thus perpetuating the cultural divide between family and healthcare providers. As a result, interpretations of culture must be also understood as they relate to Canada's restructuring of healthcare services, where the political objective of cost containment prioritizes more self-sufficiency and early discharges, with corresponding less reliance on the public healthcare system (Anderson et al., 2007). This information can only be derived, with the benefit of more knowledge about Canada's immigrant populations and the importance of cultural considerations in the provision of homecare services.

**Study Objectives**

This qualitative phenomenological study was developed to address the gaps in the research about Ontario's older Italian immigrants, particularly related to their experiences of receiving formal care, by exploring participants’ subjective experiences with services in an assisted living facility in Ontario. Aims of this study were to: (1) add to the existing body of knowledge on Ontario's older Italian immigrants and their need for homecare services; (2) enhance the knowledge of social workers and other healthcare providers about Ontario's Italian older immigrants; and (3) better understand the effects of immigration on former caregiving traditions and the need for more specialized formal homecare services (Keefe, Knight, Martin-Matthews & Légaré, 2011; Stone, 2004).

**Study Questions and Objectives:**

The central guiding objective of this study was to explore the meaning and experience of receiving publicly funded homecare services and the cultural factors that affect the nature of support required (Kobayashi, 2000). The following questions guided the exploration of these issues:

1. What have been the experiences for older Italian immigrants who have been receiving
homecare services in an ethnic and culturally supportive environment? (a) How does their Italian cultural heritage influence the use of formal homecare services? (b) How does the environment affect the experience of receiving homecare services?

2. What kind of homecare services are currently received and are these services meeting their current needs?

3. What are the perceptions of the strengths and weaknesses of the services that they are receiving?

4. What homecare services do they consider to be most effective?

**Culture**

Previous research has revealed that culture affects caregiving experiences and influences the interactions between homecare providers and recipients of care (Dilworth-Anderson, Williams & Gibson, 2002). Culture has been defined as a process in which attitudes, beliefs and traditions are transmitted from generation to generation. Cultural beliefs guide the behavior and patterns of life that become essential to consider when providing competent cultural assistance to clients from diverse backgrounds (Yan & Wong, 2005). Cultural norms are preserved and linked to specific practices, beliefs, language, traditions and religious practices, where individuals’ common perspectives and their relationships to their environment and to others are interpreted and expressed (Capitman, 2002; Greenfield, Keller, Fuligni, & Maynard, 2003; Guberman & Maheu, 2002; Lai, 2004; William, 2006). Health and illness practices are embedded in cultural norms (Dorazio-migliore, Migliore, & Anderson, 2005) where cultural beliefs and practices influence interest in submitting to care. As a result, immigrants from non-Western countries with different beliefs and attitudes may be fearful or skeptical about complying with care in Canada (Egede, 2006).
The incorporation of a cultural perspective requires the unbiased and objective ability to consider individuals within the context of their varied backgrounds, without preconceived generalized or irrelevant assumptions (Russell & Oxley, 1990) whereby diverse languages, religions, ethnicity and traditions are acknowledged (Yee, 2002).

Cultural identity is defined as an aspect of an individual's life and represents a facet of self-identity. Cultural sensitivity relates to the ability to appreciate the differences and similarities among various cultures, acknowledge ethnocultural values, traditions, beliefs and behaviors of other populations and to provide sensitive care (Majumdar et al., 2004) in order to offer interventions reflective of cultural needs (Schim, Doorenbos, & Borse, 2005).

Cultural competence refers to policies, behaviors and beliefs that reflect the cultural needs of individuals, acquired through education, training and opportunities to affirm and value individuals and their families (Jackson & Samuels, 2011). The delivery of competent health care services is built on the premise of an ability to respect, accept and acknowledge individual differences, while providing healthcare services reflective of diverse population groups. The provision of care relies on the ability to build on knowledge of different groups, to enable individuals to feel understood and feel respected by their care providers (Maharaj, 2007).

Cultural competency is a term used to describe the relationship between providers and recipients of care whereby issues of ethnicity, race, gender, sexual orientation, class and disability are often considered (Geron, 2002). Diversity relates to an extensive representation of individuals that often incorporates aspects of language, culture, religion, race, gender, sexual orientation, age, socioeconomic status and demographics. Ethnicity refers to the background or roots of a population with shared values, norms and beliefs (Maharaj, 2007).
Homecare and Community Care

The Canada Health Act provides two categories of health care services that include publicly funded "Insured Health Services" which provide for hospital care and physician care and "Extended Health Care Services" that include nursing homes, long-term care and residential care and homecare services. Extended health care services are not fully insured and differ in their availability and coverage across the provinces and territories (Duncan & Rueter, 2006).

"Health care services" refer to an array of services that include diagnosis, treatment, and prevention of illness and disease. Health care services are provided by physicians and allied health care providers, such as pharmacists, nurses, social workers, occupational and physical therapists, chiropractors, speech therapists, audiologists, respiratory therapists, nutritionists, kinesiologists, dentists, and other healthcare providers (Health Canada, 2011).

There is no national homecare program in Canada. Homecare and community care include medical and social care services and are defined as "extended" services, rather than as "medically necessary" services and as such are not an insured service under the Canada Health Act. As a result, there is no obligation on the part of the federal or provincial governments to guarantee the provision of homecare services (Canadian Healthcare Association, 2009) that has resulted in variations to the provision, delivery, management, organization, funding and distribution of homecare services across the country (Landry et al., 2006; Health Council of Canada, 2012).

Many Canadians with chronic conditions who are aged 50 or older have experienced great difficulty accessing care due to poor coordination of care and due to barriers such as the cost of extended health care services not covered by the Canada Health Act. These chronic conditions typically include diabetes, arthritis, chronic obstructive pulmonary disease (COPD,
mental health illnesses such as depression or anxiety, high blood pressure and cancer. Thus, while the *Canada Health Act* provides access to medically necessary hospital and physician care, it does not provide guaranteed coverage for services offered in the community, for example, accommodation and meal costs which are usually privately paid expenses by individuals in long-term care facilities. Most provinces charge user fees for non-professional homecare services such as transportation, respite care, and homemaking. Although the majority of provincial governments assign responsibility for funding and delivery to their regional health authorities, homecare service models vary across the provinces and territories and comprise public, mixed or private care (Health Council of Canada, 2012).

There is a maximum limit on the available public homecare hours and services with eligibility for care based on medical assessments to assign priority level (Thomson, Osborn, Squires, & Reed, 2011). The lack of a national homecare program in Canada has resulted in different homecare programs and different definitions and descriptions to describe homecare services within the provinces and territories (Schapiro, 2002). This has created difficulties in making regional comparisons of homecare outcomes or in determining reliable measurements of their cost-effectiveness and has resulted in the lack of a national database or an integrated information system through which information across all jurisdictions could be shared (Health Canada, 2005).

The Ontario Ministry of Health and Long-Term Care (MOHLTC) provides publicly funded homecare services through Community Care Access Centers (CCACs), which operate as independent non-profit community boards and which offer services by contracting with service providers through a formal Request For Proposal (RFP) process. Ontario's publicly funded homecare program has been regulated since 1996, when the Community Care Access Centers
Community Care Access Centers (CCACs) were first introduced to contract out all homecare services to competing homecare provider agencies (Aronson, 2006). Most recently, Local Health Integration Networks (LHINs) were introduced to offer outreach for homecare services in support of Ontario's ongoing strategy to expand homecare funding for the aged (Berkman, Gardner, Zodikoff, & Harootyan, 2005). The Ontario government introduced the Direct Funding Program in 1994 as a pilot project and in 1998 it was launched as a permanent program to permit eligible individuals to use government funding to hire their own attendants (HPRAC, 2006).

Community Care Access Centers (CCACs) provide personal support workers for clients in their homes or in long-term care facilities, to assist them with activities of daily living (ADL) and instrumental activities of daily living (IADL) (HPRAC, 2006).

**Canada's Homecare Models**

Currently, there are two publicly funded homecare models in Canada: the "Provider Model" and the "Self Managed Care Model". Whereas the "Provider Model" offers services for individuals through homecare agencies, the "Self Managed Care Model" provides government funding for individuals who are capable of managing and overseeing the hiring of their own homecare personnel (Macadam, 2004). Although eligibility for homecare services is primarily based on need, seven provinces, including British Columbia, Alberta, Saskatchewan, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland use income-based assessments for the financial payment of fees that are charged for services. While Quebec and Manitoba do not charge user fees and have no formal income assessment process, Quebec prioritizes service provision to low-income individuals or those with no options for private or informal care and Manitoba prioritizes individuals with no other options for care. Ontario, Yukon and the Northwest Territories do not have a formal income assessment process for
homecare services (Health Canada, 2011). Homecare programs are typically accessed by individuals who are living alone and have a functional disability, or are older with a modest or low income (Macadam, 2004).

Canada and the United States refer more people for publicly funded homecare services than most other countries. In fact, 17% of older people in Canada receive homecare services as do 16% in the United States, compared to 5.5% in the United Kingdom, 5% in Japan and 11.7% in Australia (Macadam, 2004). Current estimates in Canada indicate a 51% increase in the demand for formal homecare services between 2000 and 2010, reflecting the government's commitment to offer ongoing homecare support (Health Council in Canada, 2012). However, ongoing budget constraints have resulted in limited availability of publicly funded hours of homecare support, resulting in the need for additional care through informal sources of support from family and friends, or through privately paid arrangements for care. In addition, there is currently no national policy in Canada to provide informal family caregivers with financial compensation for their time (Markle-Reid et al., 2006).

**Ontario's Assisted-Living Formal Homecare Program**

There is a culturally specific homecare program available through an assisted-living facility in Ontario for older Italian immigrant residents of 60 years and older who reside independently in one of the facility's apartments. This culturally specific homecare program differs from the publicly funded homecare program that is offered through Community Care Access Centers (CCAC's) and is distinguished by services that are tailored to meet the cultural needs of its Italian residents. Applications for rental units in this assisted-living facility are submitted through the Community Care Access Centre and include in the cost of the assisted-
living rental unit, assistance for its residents with their bathing, cleaning and laundry needs. Residents are eligible for up to 14 hours per week of homecare services.

The majority of homecare workers at this assisted living facility speak Italian and receive ongoing education related to health and safety in dealing with hazardous material, dealing with clients suffering from dementia, dealing with issues of privacy and dealing with emergency procedures. Their salaries are lower than those in hospital and long-term care facilities which are unionized, resulting in difficulties in the recruitment and retention of employees.

Residents at this facility are permitted to request the same homecare worker, which the facility attempts to accommodate, as is the effort to provide workers who can communicate with residents in their language and that can relate to their cultural traditions and beliefs.

**The History of Italian Immigrants in Canada**

The Italian culture values the importance assigned to the famiglia or “family” unit that was traditionally overseen in Italy by a patriarchal father, a stay at home mother, many children and an extended family that included distant relatives. In addition, the familiari extended the family even further to include distant relatives and close acquaintances. The comparaggio of close friends comprised groups of people that were used for the annual harvesting, thrashing, winemaking and other activities. The acquisition of a home in Canada eventually linked the “family” to their traditional cultural customs and reinforced the prescribed duty of care for sponsored relatives, which eventually led to the emergence of distinct Italian neighbourhoods (Sturino, 1999). While historically, the family was the primary source of support for older adults, changes in the patterns of caregiving have resulted in these traditions (Wisensale, 2006) becoming steadily altered, both in Canada and in Italy as a result of women’s contributions to the
paid workforce and older adults who were no longer living with their children, as had been the norm before (Sturino, 1999).

Many Italian immigrants arrived in Canada at the end of the 19th century and after World War II, in response to employment opportunities in manufacturing and construction. The removal of barriers to non-European immigrants in the 1960s resulted in the influx of Italian immigrants often at the invitation of family members or friends. The new 'points system' was introduced, to facilitate the arrival of skilled immigrants in order to fill much-needed labour positions.

Between 1951 and 1961, the Italian Canadian population increased from 150,000 to 450,000. The Italian Immigrant Aid Society was launched in 1952 and COSTI (Centro Organizzativo Scuole Techniche Italiane) was created to offer new immigrants employment assistance and English instruction, as an addition to other social organizations that provided assistance to Italian immigrants (Institute on Governance, 2000).

In the 1970s, Italian immigration to Canada began to decline and immigration from parts of Asia, Latin America and Africa started to increase. By the mid-1980s, the Canadian government increased its annual target for immigrants from below 100,000, to well over 200,000, resulting in 2.25 million or 10% of the overall national population. The general shift in immigration policies has continued to favour the selection of Toronto, Vancouver, Montréal and Calgary as ideal destinations (Statistics Canada, 2011 census).

United States, Canada, and Australia have been home to more of Italy’s migrants than any other countries. Italian immigrants were denied access to citizenship in countries such as Germany and Switzerland, whereas in Latin American countries such as Argentina and France they were fully integrated into society. In the United States, Canada and Australia, Italian
immigrants were initially encouraged to assimilate. In the 1970s however, Canada introduced multicultural policies that encouraged the preservation of ethnic histories and traditions. As a result, Canada's Italian immigrant population has been challenged with the need to integrate, while striving to preserve its ethnic identity. Many Italian families arrived in Canada in the 1900's, in search of better futures, especially for their children. Unemployment rates were very high in Italy at the time and the prospects for employment were perceived to be better in Canada. Initially, many new immigrants lived with their relatives until they could afford a home, a car and appliances of their own. Economic self-sufficiency was achieved through the assistance of women, who secured employment outside of the home. Their engagement in both the home and domestic work challenged former caregiving traditions that previously favored a woman's involvement only in the home (Haddad & Lam, 1994).

**Aging and Immigration**

Although eight percent of all Canadians rely on some form of formal nursing care, personal care or support services, (Tousignant, Dubuc, Hebert, & Coulombe, 2007) the use of homecare services does not necessarily reflect individual need. Evidence has indicated that recent immigrants are less likely to utilize homecare services than long-term immigrants and that their reliance on more informal care may be either related to cultural preferences or to the availability of informal support from family members and friends (Laporte, Croxford, & Coyte, 2007).

The need for homecare services is greatly influenced by an individual's overall health care status. The literature offers ample evidence of a difference in health care status between native and foreign born individuals upon their arrival to a new country (Newbold, 2005) whereby new immigrants exhibit a healthier status than native born individuals, known as the "healthy
immigrant effect," upon arriving in Canada (Gee, Kobayashi, & Prus, 2004). This healthier status of immigrants upon their arrival to Canada however, tends to diminish over time. The loss of some positive health characteristics are likely due to the process of acculturation whereby changes in diet and activity level along with decreased use of medical services often due to cultural and linguistic barriers, resulting in immigrants being discouraged from seeking out much-needed healthcare (Anderson et al., 2007) will contribute to the deterioration of their health (Gushulak, 2007).

The healthier status effect relates to later midlife immigrants aged 45 to 64 and has been shown to last for up to 10 years upon their arrival. Although sociodemographic, socioeconomic and health behavior factors are known to influence these effects, (Gee, Kobayashi & Prus, 2004) less is known about its effects on the need for formal homecare services (Hyman, Health Canada, 2001).

The literature has highlighted the importance of recognizing illness as a social construct that differs across cultural groups (Anderson, 1986). Furthermore, there is evidence that cultural competence training of health care staff can enhance overall patient compliance rates and is associated with greatly improved health care outcomes (Stommel, Collins, & Given, 2005). In addition to reducing cultural barriers in the provision of care, such training has been linked to safer health care practices and interventions for homecare clients (Majumdar, Browne, Roberts, & Carpio, 2004).

Limitations in the Existing Research Literature

Although many studies have explored the utilization of services among a number of immigrant groups, little information is available to guide social workers in understanding Ontario's Italian older immigrants (Gantert, McWilliam, Ward-Griffin, & Allen, 2008) and their
experiences of formal homecare services (Litwin, 2004). Previous studies have cited language as a major barrier to immigrants accessing services (Neufeld et al., 2006), but the relationship between social networks, ethnicity and utilization of formal care services has often been overlooked (Litwin, 2004).

Rationing community support care (Aronson, 2006) with its focus on medical, economic and managerial efficiency (Aronson, 2004) discounts the importance of personal care, and safe healthcare practices and interventions (Majumdar, Browne, Roberts, & Carpio, 2004), shown to be important in the delivery of care (Baker & Norton, 2002; Baker et al., 2010; Ellenbecker, Samia, Cushman & Alster, 2008; Fortinsky et al., 2008; Hughes, Ellenbecker, Samia, Cushman & Alster, 2008; Lang, Edwards & Fleiszer, 2008)

Social workers are increasingly challenged to offer cost effective homecare services and strategies for older adults (Kadushin, 2004) due to changing demographics, migration/job change patterns, employment patterns (Stone & Salsberg, 2001) and reforms to limit health care spending (Chappell & Hollander, 2001). In the climate of health care reform, issues related to the home environment and individual experiences in receiving care are critical, to understand (Romanow, 2002). As a result, more information about the importance of social determinants of health and their effects, upon the need for services is required (Barozzino, 2010) to increase understanding of these important issues.

**Theoretical framework**

A Life Course Framework informed this study to understand the cultural influences of participants’ life histories (Day & Cohen, 2000) and to incorporate the social and historical changes that influenced living arrangements and need for caregiving services (Elder, 1987). Elder (1987) believed that aging was a process whereby disadvantages and advantages would
occur across the continuum of time. Elder's life course paradigm is defined through five core principles: (1) human development and aging as lifelong processes, (2) human agency, (3) historical time and place, (4) the timing of events in life, and (5) linked lives (Daaleman, Elder, & Sheps, 2007).

The Social Identity Theory provided additional guidance in understanding the cultural influences of their life histories (Day & Cohen, 2000) to incorporate the social and historical changes that influenced their living arrangements and need for caregiving services (Elder, 1987). Key aspects of their social identity were considered relative to the life course of events that shaped their individual experiences over time (Chapman, 2005).

This theory provides an additional context to frame and appreciate immigration experiences, level of acculturation, identity, membership to their own social cultural group and specific caregiving practices (Ploeg, 1999). Social Identity Theory was first introduced in 1959 in Britain by Henri Tajfel. He argued that an individual's identity is influenced by membership in his/her social group, which is affected by such issues as racism, discrimination and prejudice. His theory was further developed in the 1970’s by Tajfel and Turner to account for the role and impact of the large group on identity formulation and the emergence of an individual’s self-worth (Sloan Work and Family Research Network, 2007).

The Life Course Framework was used (Forder, 2009) to examine the participants' accounts and understand their roles during key events in their life and the significance of their experiences, in the receipt of formal homecare services. The Life Course Framework provides a context in which to explore social change, culture, historical events and changes in individual health (Ben-Shlomo and Kuhb, 2002). Events such as employment, marriage, rearing children,
the departure of children, retirement, disability, later-life migration and the loss of a spouse are life course events that affect older adults and their need for care (Walters, 2002).

Central to the discussion of older Italian immigrants, are their cultural beliefs and practices and the effects of these on their caregiving needs. A key theme relates to their interest in receiving services and their preferences for care. In this context, their cultural traditions and beliefs are examined for their sense of comfort and solace as they age (Warburton, Bartlett, & Rao, 2009).

Informed by an interest in understanding the cultural factors affecting family, generational processes, gender and caregiving are the cultural factors and the importance of cultural competence in the provision of their care. Cultural values, beliefs and practices are learned and shared throughout the life course thereby affecting caregiving patterns of care (Lai, 2004) that are linked to the individual's background, religion, family structure, language and attitudes with respect to aging (Capitman, 2002; Egede, 2006; Greenfield, Keller, Fuligni, & Maynard, 2003; Jirwe, Gerrish, & Emami, 2006; San Antonio, Robert & Rubinstein, 2004).

Key aspects of the social identity of older Italian immigrant are considered in relation to life course of events in order to better understand their strong connections to family, community and spiritual practices. Whereas the life course theory assumes that transitions are related to changes in roles, (Elder 1995; Moen 1995) proponents of Social Identity Theory regard the self as comprising many parts, including role identities (Amiot, de la Sablonnière, Terry, & Smith, 2007).

This study employed qualitative research methods using phenomenology to describe the experiences of Ontario's Italian older adults, receiving homecare services through an assisted living facility (Creswell, 2007). Phenomenology was used to guide the study, to explore
(Groenewald, 2004) older Italian immigrants receiving formal homecare services, in order to give this population a voice in exploring and describing their experiences (Brown, 2002). The participants provided rich descriptions of their life in Italy, their immigration to Canada, and their employment, spiritual, cultural, family and social history, all of which affected their current need for formal care.

Their level of affiliation with their cultural group was examined, as was their reason for needing formal homecare services, the extent of help that they were receiving from family members and community agencies and the difficulties and barriers that they were experiencing in their receipt of care (Neufeld et al., 2001).

**Conclusion**

This chapter introduced the problem and background issues related to the experiences of older Canadian Italian immigrants, as these relate to the need for formal homecare services (Tsai et al., 2004). The ability to provide adequate human resources (Alcock, Angus, Diem, Gallagher, & Medves, 2002) and provide optimal access to homecare services are largely dependent upon a thorough understanding of the cultural factors that affect the utilization of homecare services. Cultural heritage is an essential component of self identity that must be acknowledged in the life cycle of older adults (Day & Cohen, 2000). In addition to language, ease of access, knowledge about services, availability of informal and formal support, other cultural factors related to beliefs, attitudes and values affect the utilization of homecare services (Kuo & Torres-gil, 2001).

Social workers, policy makers, healthcare providers and policy leaders must incorporate the voices of immigrant populations in health-care reforms (Gilroy, 2006). Social workers are involved in the provision of homecare services for their clients (Wu & Hart, 2002) and are well
positioned to advocate, for better quality of homecare services (Gantert, McWilliam, Ward-Griffin & Allen, 2008; Ross-Sheriff & Swigonski, 2009). The ability to create responsive strategies can only be achieved with the benefit of research aimed in acquiring more knowledge about Canada's Italian immigrant population and their caregiving needs (MacLachlan, 2004).

This dissertation is divided into 7 chapters. Chapter 2 entails a review of the background literature and the empirical findings. Chapter 3 provides a review of relevant theoretical frameworks and reviews of the Life Course framework and Social Identity Theory, both of which have guided and framed this study. Chapter 4 provides a review of the research methodology. Chapter 5 provides a description and profile of the participants as well as an analysis of the research findings related to their homecare experiences, family beliefs, and personal preferences for care, followed by an analysis of the research findings in the context of the existing literature in Chapter 6, along with limitations and contributions to social work practice. Chapter 7 includes recommendations for further research, and a conclusion (Lichtman, 1991).
Chapter 2: Review of the Literature

Introduction

This chapter presents a review of the gerontological literature and a context for examining the Italian immigrant population and their experiences in the use of formal homecare services. The aim of this review was to explore their particular homecare consumption patterns, family beliefs and preferences for care (Lichtman, 1991), to increase understanding of culture and its effects upon the need for formal care (Forget, Deber, Roos, & Walld, 2005).

The literature on formal homecare use has centered primarily on the utilization of homecare services, cultural and ethnic variations in the access of care, cost effectiveness of overall health-care expenditures and adverse events related to client and caregiver safety in the home environment (Coyte & Mitchell, 2003). The review revealed some information related to caregiving practices in Italy, but a dearth of information related to Ontario's Italian older immigrant population and their experiences in receiving formal homecare services (Neufeld et al., 2001). As a result, a more general review was conducted of other immigrant and non-immigrant groups and their experiences (Day & Cohen, 2000).

This review is organized into four sections to include: 1. Provision of homecare services in Canada, 2. Homecare use in Canada by diverse ethnic groups, 3. Homecare use among older Canadian Italian immigrants and 4. Systemic issues affecting access to health and social services. Factors related to the utilization, satisfaction and experience in the use of homecare services are examined, as well as the role of informal care, cultural caregiving norms specific to individual ethnic groups and preferences of caregiving support.

1. Provision of homecare services in Canada

Research has examined the utilization of homecare services in Canada, focusing on
challenges associated with homecare use that include: 1. the utilization of homecare services, 2. satisfaction with homecare services, and 3. the need for cost-effective care (Markle-Reid et al., 2008). Much of this research has revealed that families in Canada have become increasingly challenged to meet the caregiving needs of their older relatives, as a result of changes in former caregiving practices related to women’s participation in the paid work force and older adults' preference to live on their own (Miller & Weissert, 2003).

Many studies have utilized quantitative research methods using the Anderson and Newman model to examine homecare consumption rates (Bradley et al., 2002; Goldsmith, 2002; Hammar, Rissanen & Perälä, 2008; Kuo, & Torres-gil, 2001; Lai, 2004; Markle-Reid et al., 2008; Miller & WeSSERT, 2003) as well as enabling and predisposing factors influencing an individual’s need for services, ability to access services and overall healthcare status (see figure 1). Key indicators of service need are informed by an assessment of an individual’s ability to engage in a range of activities of daily living (commonly captured in ADL scales) and related instrumental activities of daily living (IADL; Miller et al., 2003). Characteristics such as an individual’s demographic features and social and health care beliefs are considered predisposing factors in the use of services, whereas the most proximate cause is presumed to be an individual’s subjective complaints and the healthcare practitioner’s objective findings. Many studies position community and familial resources as moderating factors in the use of services (Miller et al., 2003).
Although the Andersen Newman Model was initially introduced to evaluate determinants of acute care health services, it has since been expanded for use in long-term care facilities. The model assumes the use of health care services is affected by societal factors, individual health factors and health services system factors. Although most studies have considered individual factors, very few behavioural and epidemiological factors such as the person’s perception of need in response to needing homecare services or individual differences in homecare use, have been incorporated into these studies. As a result, diverse complex cultural and linguistic factors have often not been fully considered especially as they relate to populations at risk, such as the very frail and older adults. Furthermore, the model’s overreliance in the Anderson Newman
Model on measures of ADL, omits the subjective qualities of illness and individual perceptions of need (Porter, 2000), or caregiver characteristics and their effects on the use of homecare services (Kadushin, 2004). In the many studies of the relationship between institutionalization and mortality rates, factors such as the importance of client-provider relationships have emerged. Cultural beliefs and their effects on the use of services, however, have rarely been considered (Goldsmith, 2002). Similarly, factors such as quality of life, availability of social support or functional health status have been considered less often (Markle-Reid et. al., 2008). Consequently, there is a limited understanding of the complexity of healthcare service use, especially among Canada's diverse populations (Kuo & Torres-gil, 2001).

The following two sections review the literature on 1. The utilization of homecare services in Canada and the factors affecting homecare need and consumption patterns and 2. Rapport between the provider and recipient of care and its importance in achieving effective relationships in the receipt of services.

1. Utilization of Homecare Services

Between 75 and 80 percent of homecare users in Canada are over the age of 75, experience health care problems, usually live alone, often experience financial difficulties and are at risk of experiencing depression (Markle-Reid et al., 2008). Homecare service is perceived as cost-effective, capable of decreasing health care costs, as a substitute or preventive strategy for institutional care and accounts for approximately 90 percent of long-term homecare expenditures (Markle-Reid et al., 2008). Ontario healthcare spending in 2010-2011 was estimated at $44.77 billion, of which 6% or $2.68 billion was allocated for community care (Ontario Ministry of Finance, 2012). Public homecare spending is relatively low in Canada, as it is in all Organisation for Economic Co-operation and Development (OECD) countries. Canada contributed 0.2% of its
Gross Domestic Product (GDP) to homecare funding in 2000 and 0.8% of its GDP on long-term care institutions (Peter et al., 2007).

Several medical symptoms have been associated with greater homecare use. The presence of depressive symptoms has been associated with greater formal homecare service use compared to the presence of physical symptoms alone. In addition, limitations in the performance of Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL) have been found to be highly associated with the use of more formal services (Bookwala et al., 2004). Subjective and objective perceptions of need were the most proximate causes, whereas the ability to access services, a predisposed need for health services and current healthcare status were the most distant causes, while better cause indicators of familial and community resources were a more moderate cause (Miller & Weisert, 2003). Publicly funded homecare services were utilized more frequently by women over the age of 75 who were functionally impaired and had little informal support available to them (Litwin, 2004). Homecare services were used most often by individuals suffering from advanced cases of dementia and lacking access to informal support (Gill et al., 1998). Canadian born middle or higher income individuals were more likely to utilize health care services compared to lower income Canadians or immigrants (Dunn & Dyck, 2000). Overall, individuals who were most likely to utilize home health care services were older, had a number of ADL/IADLs impairments, lived alone, and had limited access to informal support (Kadushin, 2004). The availability of health insurance and one hospitalization within the past year were also positively correlated with increased use of homecare services. However, factors such as population density did not appear to significantly impact upon homecare use. Evidence suggests that the initiation of formal contact with homecare services was often delayed until impairment increases (Kadushin, 2004).
Although epidemiological research has incorporated demographic variables, this research has not fully represented the complexity and variability of homecare use (Porter, 2000). Quantitative methods informed by statistical analyses provide only a limited understanding of the subjective quality and experience in homecare use (Porter, 2000). Sufficient information about the subjective experiences in the receipt of services best understood through qualitative research methods (Porter, 2000; Ramer, 1989) and the actual need for integrated services is lacking and is required, in order to avoid the duplication and fragmentation of current programs (Hébert, 2002).

Forbes and colleagues (2008) argue that most homecare programs in Canada were designed for short-term post-acute support and that as a result older adults with more chronic conditions were not being prioritized and further that access to services was largely affected by geographic location. Participants who resided in rural areas reported having fewer services available to them, compared to participants in urban areas. In addition, homecare services prioritized the provision of medical care rather than assistance with aspects of housekeeping, meal preparation and social needs, resulting in the need for families to arrange for informal or private support for older relatives. Moreover, many homecare workers were unable to adequately assist individuals with complex medical conditions such as dementia because they lacked the requisite knowledge (Forbes et al., 2008).

The use of homecare services reveals the importance of a cheerful manner and trustworthiness among homecare workers as attributes most contributing to clients' feelings of satisfaction with their care. Other factors deemed important included their sensitivity to client needs, good communication skills and the ability to take directions. Less important factors included working beyond scheduled times, punctuality and the willingness to engage in extra work outside of their job description (Forbes, 1996).
2. Rapport between Provider and Recipient

The importance of rapport between the provider and recipient of homecare services emerges whereby consistency is cited as an important factor in the ability to cultivate trusting relationships with providers. Difficulties identified relate to the personal aspect of the home environment, in which boundaries of professional and personal interactions are often blurred, and homecare workers often find it difficult to maintain a professional relationship with clients (Ayalon, Kaniel, & Rosenberg, 2008; Martin-Matthews, 2007).

The preference of older adults to be actively involved in their homecare program, emerges as an important aspect in building a relationship with providers, and is in contrast to prior perceptions of their need to be passive recipients of care (Gantert et al., 2008; Sciegaj, Capitman & Kyriacou, 2004). Still, most studies have focused primarily on the therapeutic qualities associated with homecare use, with less emphasis directed towards the importance of relationship building in the provision of care (Duner & Nordstrom, 2007).

The government's emphasis on "aging in place" complements the preference of most older people to remain in their homes (Leith, 2006) without feeling like a burden to their family that has led to a growing need for cost-efficient home and community care (Pande, Laditka, Laditka & Davis, 2007).

According to the Canadian 2001 census, less than 10% of older women and 5% of older men reside in long-term care facilities; the vast majority of individuals over the age of 85 were living in the community and were, dependent upon various sources of formal and informal support (Cranswick, 2003).

Research reveals that older adults value their independence and ability to remain in their own home and community (Bayer & Harper, 2000; Erickson, Krout, Ewen & Robison, 2006;
Gottlieb, Johns & Caro, 2005; Krout & Wethington, 2003; Michael, Green & Farquhar, 2006), avoid both formal and informal care or feel like a “burden” on their children (Robison & Moen, 2000). Research reveals that only about 20% of adults over the age of 65 are dependent on ongoing formal health care (Cheal, 2003) and that 90% of adults over the age of 65 reside independently in the community (Dempsey, 2003). Still, ageist attitudes influence older adults who often feel embarrassed about their need for care, corresponding to perceptions of caregiving assistance as a “burden” (Canadian Heritage, 2009).

There is acknowledgement in the literature about the benefits associated with homecare use, including the ability of older adults to remain in their home, lower rates of readmission to hospital or to a long-term care facility, integrated services, and relief for family members. Although homecare services are considered more cost-effective than nursing home or residential care (Duncan & Rueter, 2006) factors related to the increased physical and emotional stress for family caregivers are rarely considered. This effect is critical to understanding the family context, as are social and cultural factors in the receipt of care, which also influence the utilization of services (Alcock, Gallagher, Diem, Angus & Medves, 2000; Aronson & Neysmith, 2006; Benjamin, 1999; Romanow, 2002).

**Formal Homecare Assistance**

Women are more likely to use formal services than men and the use of formal homecare services increases with greater levels of functional limitations. Individuals over the age of 65 years with a chronic health care problem usually require assistance with activities such as their personal care, meal preparation, grocery shopping and housework. The willingness to receive formal care is greatly influenced by cultural norms, the family context and the availability of informal support. Individuals residing with other family members have tended to rely less on
formal homecare assistance. The availability of informal support and the willingness to utilize formal homecare services are strongly influenced by health care status, educational status, number of surviving children, gender and living arrangements (Carriere, Martel, Legare, & Morin, 2002). Men over 65 years rely more on informal support than older women in the same age group (Carriere et al., 2002). The main reason for this is that many more men 65 and older are in spousal relationships compared to women (Statistics Canada, 2011). Furthermore, homecare services are utilized more frequently by older women who are functionally impaired and lack sufficient sources of informal support (Litwin, 2004).

Although some studies have found that the use of homecare services does not necessarily reflect actual need, there is very little research on the barriers in the procurement of homecare services. Some evidence indicates that language barriers have impeded the receipt of care, resulting in inequities in accessing much-needed services (Health Canada, 2001). Whereas previous studies have revealed unequal distribution of resources across ethnic groups (Gradstein, & Schiff, 2006), there is insufficient information with respect to the underlying factors which influence the use of resources and are associated with stereotyping particular groups (Capitman, 2002). Issues related to economic, social and political factors and their effect upon the need and utilization of services are not typically considered. In sum, there are significant gaps in the literature, especially related to the migration experience and historical and economic factors that underlie the need for formal homecare services (Ahmad & Bradby, 2007).

Caregiving in Canada affect women in other respects as well. Formal homecare workers in Canada are usually immigrant women with limited options for employment due to language and educational barriers (Armstrong & Armstrong, 2005; McDaniel, 2002). Canada's global economy has favored free-trade agreements, corporate investment, competition and
individualism, but has placed little value on the provision of care, whether formal or informal or the contributions of older adults (McDaniel, 1999).

**Family and Informal Care**

Canada’s aging population has sparked recent debate about who will care for older adults, stemming from the increasing unavailability of children to care for their older parents, as a result of declining fertility rates, increased divorce rates and women's greater contribution to the paid workforce. This shift has been affected by widespread migration which has further eroded the role of the intergenerational household in which children were traditionally expected to provide care for their older parents (Laws, 1995). Section 32 of Ontario's *Family Law Act,* prescribes the requirement that adult children who received care from their parents provide support for older parents in need, if able to do so: “Every child who is not a minor has an obligation to provide support, in accordance with need, for his or her parent who has cared for or provided support for the child, to the extent that the child is capable of doing so” (R.S.O. 1990, c. F.3, s. 32).

Women throughout the world, as well as in western society, have been represented as nurturing, caring and predisposed to provide support (Neysmith & Reitsma-Street, 2009).

Although the majority of individuals over the age of 75 continue to live in the community, family plays an important role in providing some informal care (Lowenstein & Ogg, 2003) and its availability contributes to older adults’ ability to remain in their home (Chen et. al., 2008).

The family is not a homogeneous entity and interactions among family members impact on the family as a whole and on family members’ interest in providing informal care for older family members. Specific challenges and stressors such as education, marital status, financial and level of acculturation influence nuclear family functioning (de Valk & Schans, 2008; Klever,
Moreover, today's conception of the nuclear "family" has changed with less time devoted at home and more time focused on job demands (Knopf & Swick, 2008).

Findings also reveal a strong correlation between a caregiver’s spiritual beliefs and willingness to care for a loved one (CIHI, 2010; Tirrito, & Choi, 2006; Yarry, Stevens & McCallum, 2007). Religious and spiritual practices have a positive effect in lowering stress levels of caregivers (Tirrito, & Choi, 2006), and enhance rapport between caregivers and recipients (Wilkinson & Coleman, 2010; Yarry, Stevens & McCallum, 2007).

Most studies on caregiving however, have relied on samples of older women, resulting in insufficient information on older men and their preferences for care. As well, many studies have not considered within and between group differences in the provision of informal support and have used different types of measurements to assess social support. As a result, it is often difficult to determine whether reliable comparisons have been made (Dilworth-Andersen et al., 2002).

2. Homecare Use in Canada by Diverse Ethnic Groups

There are reported differences in the use of homecare services between non-immigrant and immigrant populations. Many immigrant groups often misunderstand the benefit of homecare services and are more unwilling to trust health care providers in comparison to non-immigrants (Ma & Chi, 2005).

Canadian immigrants also face disruption in terms of family and social ties after relocating, which can limit their informal support system (Neufeld, Harrison, Hughes, Spitzer, & Stewart, 2001), despite healthcare providers’ assumptions that such support exists due to ethnocultural norms (Neysmith & Chen, 2002).
Guberman and Maheu (2003) argue that it is often difficult to appreciate the extent of the caregiving challenges faced by many ethnocultural groups because they remain underrepresented in many studies and that the delivery of homecare services is based on practice models which often assume that North American older adults are a homogeneous group. In actual fact, Canada’s immigrant populations differ in their use of public homecare services. Whereas Haitian, Italian and Chinese families place greater value on the need for assistance than French-Canadian families, Chinese immigrants are more open to the use of public formal homecare services than the other groups (Lai, 2004). Predictors of homecare use among older Canadian Chinese immigrants include being older, living alone, having a post-secondary education, having immigrated from Hong Kong or Southeast Asia, having stronger Chinese health beliefs, having greater social support and being in poorer physical and mental health. Less use of homecare services was associated with greater self-rated financial adequacy (Lai, 2004). In a study conducted in Québec, differences between three ethnocultural minority groups were examined with respect to differences in caregiving practices and their need for formal services. Results revealed that whereas Italian families receive assistance primarily from their immediate family members, Haitian families receive assistance from immediate family members, as well as from extended family members and close friends. Differences in values and cultural norms influenced the provision of informal care and reliance on formal care (Guberman & Maheu, 2003).

Anderson (1986) argues that illness experiences often vary among immigrant groups and should therefore be understood as a socially constructed phenomenon, since cultural reactions generate particular types of illness experiences. She posited that subjective experiences must be evaluated in reference to healthcare beliefs and behaviors. According to Anderson, the medical profession relies on a Western medical paradigm to inform an understanding of illness, with the
presence of disease interpreted as a deviant occurrence that requires medical intervention (Anderson, 1986). In addition to functional decline, (Greenfield, 2009) language and ethnocultural affiliation, factors related to income, severity of illness, age, educational level, and gender were shown to affect the utilization of healthcare services among immigrant groups (Kuo & Torres-gil, 2001; Lai & Surood, 2010; Li, 2004; Leduc & Proulx, 2004; Litwin, 2004; Ma & Chi, 2005).

Socio-cultural factors, pre-immigration and migration experiences and length of time in Canada influence new immigrants’ interest in receiving services. Use of services is also influenced by factors such as proximity of services, availability of information through immigration orientation services and socio-cultural aspects such as language and available technical competency related to their level of care (Leduc & Proulx, 2004). Although research has examined underserved, oppressed, marginalized and disadvantaged groups of older individuals, very few studies have considered older diverse ethnic populations and the impact of informal support or available private care to account for the underutilization of services by many minority groups (Won Min, 2005). While most studies have identified facilitators and barriers in the utilization of services among younger immigrants, less information is available about older immigrants and their preferences for care (Iuliano, McWilliam, Ward-Griffin, & Allen, 2008).

**Culture**

Central to the discussion of older adults is the important role of an individual's cultural traditions and beliefs in their interest in receiving formal services. Culture has been defined as transmitted values, beliefs, norms and practices that are transmitted and shared among individuals. These values and beliefs are learned and shared throughout the lifecycle, as are the behavioral patterns and actions of individuals (Lai, 2004). Although cultural values and beliefs
are linked to an individual's background, religion, family structure, language and attitudes towards aging (Capitman, 2002; Greenfield, Keller, Fuligni, & Maynard, 2003; Jirwe, Gerrish, & Emami, 2006) the meanings that define individuals and their interest in receiving care (San Antonio, Robert, & Rubinstein, 2004) are fluid and influenced by their host country and by global values (Osland & Bird, 2000).

Cultural values, traditions, and norms reflect the historical context that defines individuals and influences patterns of caregiving to family members. Further, cultural differences influence the interpretation of the "family" and the provision of care. Whereas some immigrant groups have restricted the term "family" to represent nuclear family members, other immigrant groups have tended to include extended family members, close friends and individuals in their communities (Yarry, Stevens, & McCallum, 2007). The research has indicated that patterns of caregiving are largely influenced by factors such as cultural traditions, beliefs, the length of time in a new country, the level of education and economic factors (Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002).

**Acculturation**

Although cultural traditions of caregiving are often passed on from one generation to another (Won Min, 2005) variations may occur as a result of acculturation where cultural differences in a new country (Rohmann, Piontkowski, & Van Randenborgh, 2008; Scharlach et al., 2006) may emerge. “Acculturation” is defined as “those phenomena which will result when groups of individuals of immigrants and members of the host with different cultures will come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups” (Rohmann et al., 2008, pp. 337-338).
Research on cultural integration and settlement patterns has pointed to the importance of social and work related relationships in promoting life satisfaction and adaptation in a new country (Calabrese, Farber, & Westen, 2005; Gijsberts & Dagevos, 2007). The individual's cultural background and immigration experiences have been shown to affect aspects related to employment, social support, family structure and norms of behavior as well as need for formal homecare services (Segal & Mayadas, 2005). Furthermore, an individual's facility with the language of the host country has been shown to enhance interactions (Williams, 2006) and patterns of cultural integration (Kuran & Sandholm, 2008). Individuals who immigrate at an older age are socially and economically at a distinct disadvantage compared to younger immigrants and tend to underutilize health care services (Soskoline & Auslander, 2007).

Research on adaptation to acculturation, has shown a distinction between psychological and sociocultural adaptation. Psychological adaptation refers to internal psychological factors such as good mental health or personal satisfaction, whereas socio-cultural adaptation pertains to the ability to deal with external events, such as work, school, and family life. Individuals are affected by former cultural practices as well as cultural practices of the host country. External events include economic changes, social disruptions, and cultural changes that may also include a change in language. These cultural influences have been shown to be more difficult adjustments for older immigrants compared to younger immigrants. Certain socioeconomic factors influence the acculturation process, with higher education, higher income and support networks linked to better outcomes. Many immigrants encounter difficulties having their former education and status recognized in Canada, which can result in a decline in their employment and socioeconomic status (Berry, 1997).
Cultural Competency

The term ‘cultural competency’ was first introduced in the 1980s to highlight the importance of particular skills that reflect diverse cultural groups in the provision of care by understanding diverse cultural groups and their practices and beliefs (Fong, 2001). Culturally competent care that is sensitive and responsive to cultural beliefs, values, family norms and obligations (Guberman & Maheu, 2002) has been shown to enhance patient health and well-being (Narayan, 2001).

Nursing literature has examined cultural factors and women's role as primary caregivers (Andrews & Boyle 2002; Anderson & Kelley, 1998; Benjamin & Spacek, 2001; Bellamy, 1993; Black, 2005; Brotman, 2003; Capitman, 2003; Fuller, 2003; Leininger, 1995; Leninger, 2002; Williams, 2006). Leininger (2002) has highlighted the importance of culture, whereby language, gender, history, environment, gender and cultural values were considered essential in the delivery of care. Leininger’s "culturally congruent care" theory recognizes the need to provide culturally based homecare services in recognition of an individual's cultural background. Leininger believed that healing could not occur in the absence of culturally-based care (2002) and paved the way in promoting culturally congruent care (Leininger, 1995) for diverse cultural groups (DePalma, 2006).

As a result of immigration, ongoing changes to Canada's demographic profile have compelled healthcare providers and policy advisors to consider the importance of the immigration experience and cultural factors, as they affect immigrant populations and their need for homecare services (Segal & Mayadas, 2005). Servicing Canada's diverse cultural groups requires effective communication and care that is respectful of cultural differences, (National Advisory Council on Aging, 2005) values and beliefs (CAMH, 2006; Health Canada, 2001).
key theme relates to the retention of cultural practices, which may include a preference for using a first language, in the receipt of healthcare services. In this context, cultural traditions and beliefs are believed to offer older adults comfort and solace as they age (Warburton, Bartlett, & Rao, 2009). There is, however insufficient information currently available to guide social workers and other healthcare providers about immigration and its effects on family roles and caregiving practices, the need for formal homecare services (Kim, Laroche, & Tomiuk, 2001) and preferences for care (Brotman, 2002; Iuliano, McWilliam, Ward-Griffin, & Allen, 2008).

In addition to language barriers, cross-cultural differences have been shown to affect available caregiving and social support (Guberman & Maheu, 2002; Iliffe & Manthorpe, 2004). Ethnocultural groups typically share a common history, values system, beliefs, customs and language. The emphasis in Western society is on such attributes as independence, autonomy and individual responsibility, whereas dependency on financial and/or caregiving support is often devalued (Motenko & Greenberg, 1995). This emphasis on individualism prescribes the need for individuals to be self-sufficient and responsible for their well-being. This is in contrast to societal values such as collectivism (Dempsey, 2003; Motenko & Greenberg, 1995), which instead emphasizes family and others in the community (Pinquart, & Sörensen, 2005).

The age at which individuals immigrate to another country affects their choice of residency. Many older adults prefer to be reunited with adult children to receive caregiving assistance. Individuals, aged 55-64 are more likely to consider future retirement plans and to relocate to be closer to family, friends and cultural resources, whereas younger adults are more likely to live close to their employment, family, friends and cultural resources (Bolzman, Fibbi & Vial, 2006; Bures, 1997; Walters, 2002).
Patterns of Caregiving

Patterns of caregiving have also been informed by feminist scholarship that has considered the role of gender as it relates to the provision of care for older adults (Chapman, 2004). Alterations in patterns of caregiving have been observed in developed and developing countries such as India and China, as a result of adult children's migration to distant countries in search of economic prosperity (Davison & Hagedorn, 2012). Women have been traditionally expected to care for children and older adults (Cruikshank, 2007) and continue to still provide the brunt of informal and formal care in Canada (Neysmith & Aronson, 1997; Dyck & Dossa, 2007; Martin-Matthews, 2007; Stewart et al., 2006). Caregiving has been linked to “role strain” resulting from women’s need to balance work outside of the home, while still assuming responsibility for most of the care of children and older relatives (Reid & Hardy, 1999; Remennick, 1999; Rozario, Morrow-Howell & Hinterlong, 2004).

In addition to cultural factors and their influence in the provision of care (Abelson, Gold, Woodward, O’Connor, & Hutchison, 2004) studies have examined the role of women as primary caregivers for older relatives (Spitzer, Neufeld, Harrison, Hughes, & Stewart, 2003). In addition to disrupting social ties, immigration has been often linked to altering former caregiving practices of predominantly women providing informal care, as a result of their need to work outside of the home (Koehn, 2009; Neufeld et al., 2001; Williams, 2004).

Patterns of caregiving differ across countries and are affected by available funding. Norway, Denmark and Sweden are proactive in providing long-term care services, whereby social care is subsidized with tax dollars to provide social and health care for older adults. Germany, Japan and Israel, are also very committed to the provision of long-term care services and provide long-term care insurance programs. In contrast, countries such as the United States
and Canada are not as committed to funding social and medical care for their older populations. The United States' Medicaid and Medicare program, and Canada's *Canada Health Act*, provide limited outpatient and prescription coverage. In Canada, although acute care is prioritized, long-term care is not, resulting in older adults being dependent on private, formal or informal support from family members and friends. Canada and the United States consider the family the primary source of assistance for older adults. Greece, Italy, Ireland and Mexico also provide very little long-term care coverage and rather, emphasize family members providing care. Hong Kong, Seoul and Beijing, emphasize solidarity and reciprocity in the provision of care by family members (Tong, 2009).

Ethnic minorities were found to use more sources of informal support than formal support. These findings were interpreted to reflect cultural patterns of caregiving, in which reciprocity was an established norm in the provision of care. Ethnic minorities were shown to rarely consider sources of formal services and relied almost exclusively on family members for support. The rate of institutionalization, was found to be lower for minority groups than for non-ethnic minorities (Dilworth-Anderson, Williams, & Gibson, 2002).

Healthcare providers have been shown to often expect most ethnocultural groups to provide informal support, stemming from assumptions about close family relationships, cultural traditions revering older adults and innate caregiving skills (Dorazio-migliore et al., 2005), leading to unrealistic predictions, that underestimate older adults’ need for formal homecare services (Brotman, 2002; Wiles, 2005).

As a result, social workers and other health providers are being increasingly challenged to address older adults’ need for informal support, to ensure adequate allocation of resources across generations (Wisen sale, 2005), and develop future caregiving programs for Canada's diverse
multicultural populations (Curtis & Dixon, 2005). Although reciprocal relationships of caregiving are embedded in cultural traditions, information pertaining to family loyalty and attitudes of obligation and commitment (Melito, 2006; Tomlinson & Åstedt-Kurki, 2008) remain poorly understood. A critical area to examine is the effects of acculturation and resultant patterns of caregiving (Brotman & Kranis, 1999) on the interest to receive formal care (Dyck & Dossa, 2007).

**Living Arrangements in Canada**

Some research on living arrangements in Canada shows that a significant number of older immigrants reside with their adult children, or if residing on their own, have regular contact with family members. Thirteen percent of immigrant men aged 65 and older were living with an adult child, as were 12% of senior women (Cranswick, 2003). When coping with an illness, approximately 23% of older immigrant men and 37% of older women were more likely to live with an adult child. Recent immigrants over 65 years were more likely to live with family members than were Canadian born individuals. Cultural variations between and within groups seem to greatly influence available informal support from family members across generations (Citizenship and Immigration Canada, 2005). Asians, East Indians, and Southern Europeans for example, were often more likely to provide informal care to older relatives compared to British family members. Among the Greek, Polish, and Italian Canadian families, older parents were often living and being cared for in their children's homes. Families of Japanese, Chinese, Korean and Filipino backgrounds emphasized the importance of providing informal care (Verkuyten, 2005).

The source of assistance often varied among ethnic groups. For instance, whereas, Italian, Mexican, Jewish and Polish older adults were more likely to receive help from family members,
Afro-American older people were more likely to receive assistance from both friends and family members. Native Canadian families were found to provide high levels of emotional, functional, and financial support to their older relatives (Van Dijk, 2004). The decision to cohabitate was more often influenced by the older person’s health, the caregiver’s feelings of reciprocity or sense of duty and family traditions that resulted in the caregiver becoming the primary source of informal support. Other factors may also affect these patterns. For instance, older immigrants who arrived in Canada before the end of midlife, were shown to be more acculturated, with a higher English language ability, higher educational status, were more likely able to drive and more likely to live independently. This is in contrast to older immigrants who arrived to Canada after midlife, who were found to have a lower English-language ability, lower financial status and educational level and were more likely as a result, to have to rely on living with family members in an extended family living arrangement for support (Ng, Northcott & Abu-Laban, 2007). However, the availability of formal homecare services seems not to affect the decision or timing to cohabitate (Firbank, & Johnson-Lafleur, 2007).

**Informal Support among Ethnic Groups**

Some research has revealed that immigrant families will often provide informal support for older relatives as a result of long waiting lists for publicly funded homecare services (Bonsang, 2009; Hasson, & Arnetz, 2008; McGarry & Arthur, 2001; Orbell, 1996; Ward-Griffin & Marshall, 2003). In addition, older immigrants reported that homecare agencies often offered less formal homecare hours after learning that informal support was available from family members (Brotman, 2002).

Second and third generation immigrants have been shown to display a greater interest in receiving more formal care and exhibit different patterns of caregiving practices than first-
generation immigrants (Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002). Furthermore, immigrants have been found to often misunderstand the benefit of homecare services and as a result unwilling to trust their health care providers (Ma & Chi, 2005). In contrast, Canadian born middle or higher income individuals have been shown to be more likely to trust and utilize health care services, compared to lower income Canadians or immigrants (Dunn & Dyck, 2000). Consistent homecare services from the same homecare provider were shown to result in a greater ability to trust virtual strangers in the home. Older immigrant families in Canada are still assumed to have close family ties (Zontini, 2006). Their interest in relying on informal support, however, may be due to cultural and linguistic barriers that limit their access to alternate forms of care (Veenhoven, 1997; Warburton, Bartlett, Rao, 2009). Other factors that may underlie the need for informal care remain unknown (Porter et al., 2005).

3. Italian Canadians

Caregiving in Italy

The review reveals a dearth of research on older Canadian Italian immigrants and their experiences in the receipt of formal homecare services. Canadian immigrants have been shown to retain historical recollections of older relatives being cared for by family members, (Santarelli & Cottone, 2009) despite recent social changes that have altered traditional caregiving practices, (Da Roit, 2007) stemming from women's participation in the paid workforce. In the past, families in Italy had cohabitated with their older relatives and thereby oversaw their care, an arrangement that is no longer the norm. While former caregiving practices have been altered, family members still continue to reside close to one another and share caregiving responsibilities in order to provide care for their older relatives (Reynolds & Zontini, 2006).
Strong family values continue to persist but the prior practice of providing full-time informal support has been supplemented by paid female migrant caregivers (Haddad & Lam, 1994). There are well over 700,000 personal-care workers employed in Italy, with an estimated 93 per cent that are foreigners (Bettio, Simonazzi & Villa, 2006; Carriere & Pelletier, 1995; Da Roit, 2007). Despite these alterations, gender differences in the receipt and provision of care still persists with the bulk of personal caregiving support being provided by women (Chappell & Funk, 2011; Lyon, 2006; Wisensale, 2006).

Although 20% of Italy’s population is over 60 years, only two percent are ever admitted to long-term care facilities (Kreidie, 1998) and despite the increasing need for homecare services, most individuals receive assistance from family members (Bergman, Leduc, & Beland, 2006). In contrast, eight percent of Canadians rely on some type of formal nursing care, personal care or support services, through publicly funded homecare programs (Tousignant, Dubuc, Hebert, & Coulombe, 2007). Although intergenerational solidarity is still emphasized, in Italy there is some reliance on paid caregiving support by the select few who can afford it (Da Roit, 2007).

**Caregiving in North America**

Italian immigrants in the United States have been known to mistrust "outsiders" and rely more on caregiving from family members (Cacciola, 1982; Migliore, 1989; Rozendal, 1987), with women more likely to be the providers of informal care (Wiles, 2005). Italian immigrants in North America have retained their language and have transmitted their traditions and beliefs to successive generations. Italian expressions of pain described as culturally having a high degree of emotion, have sometimes been misinterpreted by medical personnel as hypochondriac
behavior. Older Italian immigrants in the United States were found to believe that illness can result from evil spirits "mal ochio" or the evil eye (Migliore, 1989).

In Canada, home ownership, perceived as financial security, especially in their latter years (Bellamy, 1993) linked the “family” to traditional cultural customs (Sturino, 1999). Historically, the family was the primary source of support for older adults but these traditions have since been altered in Canada (Wisenale, 2006) as a result of changes in the role of women, declining birth rates, increasing divorce rates and by the adoption of Canadian values that have challenged previous caregiving practices (Sturino, 1999). Upon arrival to Canada, they were unable to speak English or French and those women not in the labour force never acquired much of either official language. The retention of their language and cultural traditions was encouraged by their greater concentration in Italian neighbourhoods and labour markets (Harrison, 2000).

Despite available information about other population groups (Mercer, 1995), sufficient information unique to Canadian Italian immigrant experiences is lacking (Rozendal, 1987). This dearth of information has resulted in a poor understanding of their use of services (Saldov, 1991) and inaccurate predictions of their homecare needs (Brotman, 2003).


This section considers systemic issues affecting access to health and social services for immigrants and older adults, as well as sources of private and public funding and policy reform.

Systemic Issues Related to Immigrants

Lower socioeconomic status among many racial and ethnic minorities has been linked to their poor access to health care, compared to other populations. Associated health disparities in the form of differences in the incidence, mortality and prevalence of illnesses have been documented among individuals. We know that overall health status is affected by a person’s
unequal access to health care, housing and education (Tucker, Ferdinand, Mirsu-Paun, & Herman, 2007). Studies have shown that many immigrant populations experience limited access to and make limited use of health and social services (Bonura, Fender, Roesler, & Pacquiao, 2001; Brotman, 2004; Coyte, 2000; Lee, 2004). Poor access to care is due to communication, cultural and structural barriers such as a mixed public-private healthcare system. Communication barriers may include a lack of language skills; cultural barriers may reflect differences in the meaning of illness or differences in practices and beliefs between individuals and their healthcare providers. Structural barriers are often tied to limited financial ability to afford services. For instance, many older immigrants experience financial difficulties, resulting in an inability to finance private care to supplement their limited entitlement to public homecare services.

The overall rationing of healthcare services has played a role in the feminization of poverty in Canada, with income levels among women being less than that of men's (Forget et al., 2005), especially among older Canadian immigrant women, (Fook, 2002) a finding which has led to recommendations aimed at reducing rates of poverty by decreasing existing inequalities and improving overall health outcomes (Brown, 2002). Poverty in Canada is higher for older women and even higher for older disabled women, resulting in a greater risk for dependency and isolation than for men (Zahidi, 2012).

Globally, 19% of women aged 60 or over reside on their own, compared to 8% of men. Concerns have been raised about the limited availability of publicly funded community care and the associated increased reliance on private care that will disproportionately affect older women, who are more likely to require homecare services (Cohen et al., 2006; Wiles, 2005). Aside from impoverished living conditions, poverty is psychologically difficult, destroying individual self-worth and creating uncertainties for survival. Poverty has been linked to poorer healthcare
outcomes and reduced access to health and legal services, thus making individuals more vulnerable to exploitation, violence and coercion (Sampson, 2007). Evidence points to a correlation between lower socioeconomic status and increased rates of illness and death. Equally apparent is the observation that health status is worse as income gaps increase (Landry et al., 2006).

In the past decade, disparities in the Canadian population have increased an emphasis on international trade and investment (Epps & Flood, 2002) within a global market economy that have resulted in increased income inequalities and shrinking of the middle class, in what some authors refer to as the "disappearing middle class" (Foster & Wolfson, 2010; Lazonick, 2010; Wolfson, 1997). Not only is unemployment increasing, but many jobs are contract and short term, paying minimum wage and without benefits. The result has been an increase in households in which multiple family members must work to make ends meet. These conditions are prevalent among recent immigrants and even among established ethno-cultural groups in most metropolitan areas across Canada. One result has been a number of policies at both Federal and Provincial levels aimed at reducing healthcare expenditures. Not surprisingly, the rationing of health care services has particularly affected racial and ethnic minorities (Simms, 2003), who tend to occupy lower socioeconomic levels than non-minorities (Egede, 2006), experience poorer healthcare outcomes (Newbold & Danforth, 2003; Public Health Agency of Canada, 2001) than those in higher income brackets (Dorazio-migliore et al., 2005; Weissert, Chernew, & Hirth, 2003) and suffer greater morbidity and mortality from chronic diseases compared to non-minorities (Egede, 2006).
Systemic Issues Related to Older Adults

In addition to the importance of rapport and cultural considerations, the literature has also examined the effects of ageist attitudes that have been shown to affect the experience for older adults in receiving healthcare services. Ageism is defined as the process of systematic stereotyping and discrimination against older adults based on their age and (Butler, 1969) has been cited as an underlying cause of their mistreatment and abuse (Health Canada, 2005). Ageism has been described as any attitude, action, or institutional body that subordinates a person or group because of age (Jensen & Oakley, 1983). It has been depicted in language, media, humour, among healthcare providers, in the workplace, in the legal forum and in society as a form of social prejudice (Busse, 1968; Nelson, 2004).

Ageist beliefs contribute to societal fears of older adults becoming a drain on the economy as a result of their need for caregiving and financial support (Chappell, 2001). Such beliefs can influence the behaviour and attitudes of healthcare providers (Kausler, 1987; Lebowitz, 1987). Gender considerations are also relevant, with women often viewed as unhealthier than men, although on average, women outlive men. With society’s emphasis on revering youthful images, old or people with disabilities are typically devalued (McKenna, 1998).

There is great variation in the treatment of older adults, whereby differences in the amount of available family support has been observed across ethnic groups (Keefe, Rosenthal & Béland, 2000; Verkuyten, 2005). For example, populations in East Asian countries display extreme reverence and respect towards older adults, whereas abandonment and deprivation of older adults is more prevalent in North America. Western society’s emphasis on financial productivity is often in sharp contrast to Asian societies’ (Keefe et al., 2000) lifetime devotion and contribution to older adults’ families and communities (Verkuyten, 2005). As a result, in
North America old age is often depicted as a negative life stage, discounting the many positive associated aspects (Austin, 1985).

Policy studies have often framed the discussion of aging, based on future economic and labor predictions, portraying older adults as a growing problem in need of increased healthcare expenditures and caregiving support (Crampton, 2011; Remennick, 1999). Recent healthcare reforms aimed at reducing healthcare budgets have framed individual choice in managing or preventing illnesses without considering social or environmental factors (Steering Committee of Women and Health Protection, 2009).

Despite agreement of changes needed to be made to reduce the disparities in healthcare services, (Deber, 2003) services across the country continue to differ dramatically in terms of service models and funding structures (Lang et al., 2008). There is support to retain Canada's system of universal coverage (Deber, 2003; Deber & Gamble, 2007), but its emphasis on the delivery of acute care services continues to be a disadvantage for older adults with chronic care conditions (Simms, 2003). Recommendations have been made in support of strengthening Canada's homecare program, through a national program (Deber, 2003) and through recognition of the importance of the role of social, political and economic factors in improving overall health status (Public Health Agency of Canada, 2001). Nevertheless, concerns have been raised about Canada's ability to sustain its current healthcare program (Deber & Gamble, 2007), while providing cost-effective care for older adults from diverse cultural groups (Brotman, 2003).

Public/Private Funding

The cost of delivering care is a dominant issue within the literature with respect to delivering optimal services that are cost effective and responsive to the needs of all Canadians (Brody, Johnson, & Ried, 1997) while promoting client centered care (Benjamin, 1999; Chappell
& Hollander, 2001; Deber, 2003; Deber & Gamble, 2007; Romanow, 2002). Budget cuts have been aimed at encouraging Canadians to become more cost-conscious and more responsible about their health seeking behavior, resulting in the delisting of many previous public health care services (Forget et al., 2005). These reforms have resulted in early hospital discharges and more policy emphasis on community based care. Unfortunately the dollars needed to implement community based care have not materialized. The predictable result has been greater pressure on families to provide care for older relatives (Baranek, Williams, & Deber, 1999) through private or informal sources (Coyte, 2000).

The effect has often been a blurring of public and private services (Armstrong & Armstrong, 2005). Public services often include quasi-public and private agencies that are independently managed but funded through public sources, whereas private services usually include not-for-profit, volunteer, for-profit or corporate owned corporations (Baranek et al., 1999). More often however, the distinction between for-profit and not-for-profit care is poorly described, leading to a less precise understanding of their differences (Baranek et al., 1999). Debates to curb health care spending have emphasized the need for more private care, to reduce the public consumption of services (Forget et al., 2005).

Although home and community services have been perceived to enhance quality of life and prevent unnecessary hospitalizations for older adults, funding of this sector has not been deemed a priority by the federal or provincial governments (Deber, Gildiner, & Baranek, 1999). Pressure to increase funding in accordance with the increase in the aging population (Health Canada, 2011) and the governments’ emphasis upon “aging in place” (Chappell, 2001) have led to concerns about (Deber et al., 1999) the future of homecare services (Régis, 2004). While the federal and provincial governments have cited the benefits of "privatization" that would, in their
opinion encourage greater efficiency, competition and overall health outcome opponents have cited its overall risks related to the inability of lower income individuals to afford private care (Deber, 2003; Anderson & Parent, 2000), and further pressure on family members to supplement care (Baranek et al., 1999; Carpentier & DuCharme, 2003; Cohen et al., 2006; Dorazio-migliore et al., 2005).

Some research has shown that older adults have been greatly affected by the rationing of healthcare services and the associated reduction of social services (Baranek et al., 1999) along with deeming nonmedical services such as cooking, cleaning, socialization, transportation and personal care as a non-priority (Simms, 2003). In addition, eligibility requirements have been placed for public homecare services based on individual financial and medical need (Shapiro, 2002; Weisert, Chernew, & Hirth, 2003). Older adults face long waiting times for healthcare specialist appointments, surgical consultations or surgery, which have resulted in renewed calls for a two tier health care system, to allow financially able individuals to consider private care in order to access much-needed services in a timely manner (Deber, 2002; Flood & Xavier, 2008).

Private funding of healthcare services in Canada is currently relatively high, compared to most European countries or compared to Japan, where coverage is provided through insurance and out-of-pocket costs. Suggestions have been made (Kirby, 2002; Romanow, 2002) to reform Canada's long-term care program to better care for Canada's older adults (Blomqvist & Busby, 2012). However, questions pertaining to the role of Canada's federal and provincial governments in financing long-term care remain unanswered, as do concerns with respect to additional tax revenues that would be required to support this initiative. Efforts to increase cost efficiency in Canada have also been recommended by integrating healthcare services and by introducing more competition in the purchase of healthcare services (Blomqvist & Busby, 2012).
Canada's health care system has been criticized for being inferior to most industrialized countries of the OECD, such as Sweden, Portugal, Greece, Denmark, Japan and Italy due to producing inferior access by comparison, to physicians and technology, having long wait times for specialists and technology such as mammograms and MRI's. Canada spends more on health care than most industrialized countries that provide universal access to care, with the exception of Switzerland and Iceland. Compared to other countries in the OECD, Canada's health care system has been shown to be less successful in the prevention of death from preventable causes at a higher cost, with the exception of Switzerland and Iceland (Esmail & Walker, 2007). To date, the appropriate allocation and financing of care in Canada remains unresolved (Deber, 2003; Flood & Haugan, 2010).

Criticism of Canada's homecare programs also includes its low wages, few employee benefits and inconsistent work hours for homecare personnel, shown to affect the quality of the work force and difficulties in meeting homecare policy goals (MacAdam, 1993; Abelson, Gold, Woodward, O’Connor, & Hutchison, 2004).

The above fiscal policy climate is aggravated by the lack of a national homecare program in Canada. This results not only in variations in the eligibility and availability of services across provinces, but also in the provinces’ use of different homecare service models, different funding schemes and service fragmentation (Lang, Edwards, & Fleiszer, 2008).

Although there is encouragement in Canada for health services and institutions to be sensitive and respectful to population groups (Makarenko, 2010), little is known about Canada and its commitment towards the provision of public homecare services to its immigrant populations (Tucker et al., 2007). Governments and health policy leaders have recently been challenged to provide cost-efficient healthcare services for Canada's diverse immigrant groups.
Recommendations have included providing a more responsive healthcare system that would include a national homecare strategy with provisions such as those found within the *Canada Health Act*, (Romanow, 2002) to also include cultural and linguistic services. The continuing emphasis on cost containment, however, has challenged healthcare providers in having the resources required to provide culturally sensitive care (Anderson et al., 2007).

**Policy Reforms**

Policy studies that have examined Ontario’s publicly funded homecare program have criticized the government’s objectives to contain costs at the expense of homecare clients (Dally, 2004). The Health Policy debate has centered on Canada’s health care model and the limited ability of the market to distribute medically necessary care. Disputes between federal and provincial levels of government revolve around the allocation and financing of care. Policy analysts have defended the need to retain a single tier publicly funded medical system for “medically necessary” services and argue that the introduction of multiple payers would diminish equity and compromise economic efficiency (Deber, 2003).

Whereas most micro homecare studies have considered issues related to the utilization of homecare services, most macro studies have focused on policy issues (Chappell, 1994) with an emphasis on the economic, medical and cost benefit effects of homecare use (Aronson, 2004). Homecare services reduce the length of hospital stays, are linked to an actual decrease in hospital readmission rates and are perceived less costly than hospital care (Cote & Fox, 2007; Coyte, 2000; Hollander & Chappell, 2007) and a better alternative to institutional care. A number of studies have examined the underlying tensions between providers of care and their clients and have outlined strategies to reduce overall health care spending (Chappell & Hollander, 2001; Coyte, 2000; Deber et al., 1999; Maharaj, 2007 Motiwala, Flood, Coyte, & Laporte, 2005;
Romanow, 2002; Timmerman, 2009). Although some studies have cited the importance of cost-effective care (Reid et al., 2006; Tousignant, Boisy, Corriveau, & Moffet, 2006; Urquhart, Mitton, & Peacock, 2008) factors such as the importance of building a relationship with the client and the individual experiences in the receipt of care have rarely been considered (Porter, Ganong, & Armer, 2000).

Concerns have been raised about the ability to offer supportive services for individuals with chronic healthcare conditions. Policy reforms were seen to be based on a desire to maximize cost efficiency and limit excess homecare spending and public expenditures in the delivery of care, which would continue to emphasize the provision of acute services, with less attention to long-term or chronic care services (Porter, 2001).

Despite acknowledgement in the literature of the numerous changes to Canada's homecare services in the last 30 years, there remains little information on the socio-cultural factors related to the use of homecare services (Kitchen, Williams, Pong, & Wilson, 2010). Although cultural sensitive training has been shown to enhance overall ethnocultural awareness among healthcare workers (Marshal, 2005) with evidence of improved health care outcomes (Majumdar et al., 2004), there remains limited research that has considered the multitude of employment issues that would affect the labor force required to provide much-needed culturally competent homecare support (Aronson & Neysmith, 2006). Little is revealed for example, about the potential to recruit and retain staff in the provision of these services (Dicicco-Bloom & Cohen, 2003).

Although there is acknowledgment, for the need to support organizational change in the creation of culturally sensitive strategies for mentorship and training opportunities (Marshal, 2005), the focus is typically on the availability of such services in traditional medical facilities,
rather than in the homecare setting where an individual's culture and beliefs in the home are paramount in the receipt of services (Benjamin & Spacek, 2001).

Homecare clients identify the home setting as a unique environment, which unlike the hospital setting is not for public use, where in addition to its cultural and symbolic meanings (Gitlin, 2003) requires homecare providers to be sensitive and respectful of private areas (Woodward et al., 2001).

There seems to be both a temptation and a tendency in the literature to apply common principles to every home setting. Very few studies have examined social identity and its importance in the receipt of care (van Dijk, 2004). For example, when considering social identity, there is a tendency to represent the home as a unique environment, in which family dynamics and cultural traditions are considered important (Sharkey & Lefebre, 2008). Nevertheless, there is a corresponding lack of acknowledgment of the unique characteristics of every home environment. The home environment is rarely represented as a complex setting in which cultural norms are preserved and one in which the provider is required to maintain professional boundaries, while simultaneously creating a positive therapeutic relationship with the client (Preto & Mitchell, 2004).

Ongoing commitments to provide homecare services (Romanow, 2002) have greatly expanded the analysis of the home environment from different perspectives (Gitlin, 2003). There remains however, insufficient information about homecare programs and their ability to deliver culturally responsive care.

There are additional concerns about the home environment and its ability to allow for the provision of complex medical services in an environment designed for daily living, rather than for the provision of homecare services. Unlike the hospital environment which is regulated to
ensure for the health and safety of individuals, the home environment is not and is often ill equipped for the provision of nursing care. Moreover, its providers are unregulated and expected to provide medical services (Gitlin, 2003).

Examination of the home environment relative to other healthcare environments has led to the conclusion that the home environment is in fact very different. In addition to cultural and privacy concerns, studies have outlined the need to acknowledge the importance of patient safety in the provision of care (Porter et al., 2005). A dominant theme that emerges is the belief that there is a failure of systems, rather than a failure of individuals, resulting in a delivery of care that is often unsafe for both recipient and provider. Still other policy analyst researchers argue that recipients of homecare services are expected to be passive recipients rather than active members of a treatment plan, which makes them more prone to being victims of adverse events (Lang, Edwards, & Fleiszer, 2008; Masotti et al., 2010; Ayalon, 2010).

In addition, there is the risk of health safety problems stemming from poor communication among caregivers and clients due to linguistic barriers. Recommendations have been made to improve the quality and safety standards of homecare services by developing a common framework with uniform terminology, to offer consistency in the provision of care and thereby reduce the occurrence of adverse events (Lang, Edwards, & Fleiszer, 2008).

As a result of these critical gaps in the literature, more research is required to explore the complex and individual factors (Tsai et al., 2004) in the provision of homecare services (Brotman and Kraniou, 1999). The incorporation of a cultural perspective requires an understanding of individuals' caregiving experiences (Brotman, 2002) within the context of their varied backgrounds.
Summary

Despite changes in immigration patterns throughout the 20th century and into the 21st, little is known about the immigration experience of older Italian immigrants and its effects on their need for formal homecare services (Segal & Mayadas, 2005). The emphasis on community care for older adults, resulting from ongoing advances in medical research and technology, as well as budgetary cuts to health care services create a need for social workers and other healthcare providers to consider their cultural preferences for caregiving support (Nilsson, 2007; Randall & Williams, 2006; Trask et al., 2009).

Such gaps in the literature have resulted in the need for further research, to offer a broader understanding of all these complex issues. Informed by an interest in understanding the cultural factors affecting family, generational processes, gender and caregiving among older Italian immigrants is the need to consider the importance of cultural competence in the provision of their care (Jirwe et al., 2006).

Other factors to consider include family support and the role of informal support as it affects populations’ use of homecare services. Cultural caregiving norms are specific to individual ethnic groups. As a result of the dearth of research about this population, variations in levels of their caregiving support remain poorly understood. Further research to consider the experiences of the Canadian older Italian population in the receipt of homecare services, is therefore required. This information would assist social workers and other healthcare providers to better understand the effects of immigration and cultural norms, as they affect their use and preferences of caregiving support and assist in better predicting and providing them with the support that they require (Hooker & Monahan, 1997).
Chapter 3. Theoretical Frameworks

Introduction

This chapter examines the theoretical models and theories in the gerontological literature that have been used in the past to represent older adults and their need for homecare services (Dorazio, Migliore & Anderson, 2005; Meagher, 2006). The biomedical model, ecological framework, family systems framework, policy framework and cultural competence framework (Beach, Saha, & Cooper, 2006) are examined for their strengths and contributions, and the reasons they have not been selected to guide this research study. Critical gaps in the literature are discussed and the aim of the present study, to explore the meaning of culture and its importance for older Italian immigrants in their receipt of homecare services.

Successful Aging

The gerontological literature has considered biological, psychological, social health and behavioral factors (Berkman, 2000; Haley et al., 1995; Markle-Reid & Browne, 2003; PHAC, 2010; Pinquart & Sörensen, 2003) in the use of homecare services (Carriere et al., 2002). Rowe & Kahn (1997) describe "successful aging" as the avoidance of disease and disability, high physical and cognitive function and engagement in social and productive activities (Rowe & Kahn, 1997).

Studies have examined the progressive decline of biological function, where death is marked as the final event, and have linked "successful aging" to overall good physical, psychological and social health (Crosnoe & Elder, 2002), with women living longer than men (Lubitz, Cai, Kramarow & Lentzner, 2003). The physical and psychological effects of stress on the aging process have also been considered (Franceschi et al., 2000). Theories such as the Deviation Amplification Theory have examined aging from a cellular level, where cellular repair
mechanisms have been observed to become less effective over time, resulting in apoptosis or the eventual death of cells. Psychological aspects related to the aging process (Baltes & Baltes, 1990) have included theories by ego psychologists, such as Erikson, who posits that there are eight sequential stages in the development process, from basic trust versus mistrust to ego integrity versus despair, in later life (Aldwin & Gilmer, 2004). Theories such as the Disengagement Theory posited that there was a mutual withdrawal between older adults and society that led to the encouragement for older adults to disengage from society, whereas advocates of the Activity Theory proposed that older adults retained their interest in remaining actively involved in society and should be encouraged to do so (Chapman, 2004; Aldwin & Gilmore, 2004). The Socio-environmental Theory theorized that the acquisition of financial, social and health resources was an important factor to aging well (Chapman, 2004). Continuity Theory proposed that older adults wanted to remain engaged by employing strategies of past patterns with the aim of remaining socially tied to the present. The Optimization with Compensation Theory in the 1980s posited that older adults wished to retain former patterns of the past while modifying interactions with their physical and social environment (Chapman, 2004).

Although the concept of "successful aging" is still widely referred to in the field of gerontology, there remains no conclusive definition or agreed standard of its measure (Aldwin & Gilmer, 2003; Crosnoe & Elder, 2002; Katz, 2000; Levers, Estabrooks & Ross Kerr, 2006; Pruchno, Wilson-Genderson and Cartwright, 2010; Putnam, 2002; Tate, Lah & Cuddy, 2003; Wahl & Lang, 2003). Whereas earlier theories tended to focus on one aspect of adult development (e.g. personality or social), in contrast, contemporary theories tend to consider multiple influences (Aldwin & Gilmer, 2003).
The Biomedical Model

Gerontological literature has considered the medicalization of care in the provision of homecare services (Binney, Estes & Ingman, 1990; Meyer, 2001; Rikkert, Rigaud, Van Hoeyweghen, & De Graaf, 2003; Silver, 2003; Wenger, Roth & Shekelle, 2007) where the emphasis is on the treatment of acute conditions (Martin & Peterson, 2009; Nolan & Tolson, 2000; Smart & Smart, 2006) and interventions based on "medical need". The aging process is often represented as one of inevitable decline and incapacity (Estes & Binney, 1989) where older adults are perceived to be passive, in need of medical intervention, rather than with a preference to remain in control of their care (Curtis, & Dickson, 2005).

The biomedical model of care includes the medicalization of care. Medicalization is a social process that relates to the way in which the medical profession's control extends to the provision of treatments that are not directly related to biophysical disorders (Poitras & Meredith, 2008). The introduction of hormone replacement therapy to counteract lower estrogen levels associated with the normal event of menopause (Hall, Callister, Berry & Matsumura, 2007), is just one of many examples of a normal life biological event which was medicalized (Conrad, 2005; Meyer, 2001).

The effect has been an emphasis on referrals for homecare services that are medically supervised and "medically necessary", rather than on social and environmental (Binney et al., 1990; Markle-Reid et. al., 2006; Randall & Williams, 2006) factors known to influence health, such as housing, employment and income (Malhorta, 2003).

As a result, studies aimed in examining homecare services from a biomedical framework have often discounted the importance of social determinants of health, such as employment, socioeconomic factors, access to education and healthcare services, culture, social support,
finances and housing and the homemaking and personal care components that are integral to any policy reforms (Angel & Angel, 2006; Baumann, Deber, Silverman & Mallette, 1998; Kreuter, Lukwago, Bucholtz, Clark & Sanders-Thompson, 2003; Mezzich, Caracci, Fabrega & Kirmayer, 2009; Scharlach et al., 2006; Schulz, Krieger & Galea, 2002; Williams, 2002). As a result, social, cultural and linguistic challenges as they affect older Canadian immigrants remain poorly understood (Bean & Bachmeier, 2008; Cheal, 2003; Curtis & Dixon, 2005; Estes & Binney, 1989; Kaufman, Shim & Russ, 2004; McKenna, 1997).

Despite previous studies highlighting the importance of considering the effects of globalization and immigration in the provision of homecare services (Wisensale, 2006), the current homecare program aims to reduce overall disability, and discounts underlying cultural factors (Smart & Smart, 2006). Little information is therefore available to guide social workers and other healthcare providers in understanding the effects of immigration, acculturation and the aging process as it relates to immigrant groups and their need for formal care (Atchley & Baruch, 2003; Binney et al., 1990; Clark, & Flores, 2007; Horton, Baker & Deakin, 2007; McDonald, 2011; Williams, 2002).

Family Centered Care Framework

Recently a shift in care from hospital to the community has called for a paradigm shift from the former overreliance on the biomedical model of care, to that of client centered care, where the importance of joint decision-making between individuals and their providers is acknowledged (Lang et al., 2008). Family centered care has extended this process to also address the role of the family, to include collaboration between the health-care provider, client and the family (MacKean, Thurston & Scott, 2005; Durocher & Glencross-Eimantas, 2011). The current shift in care acknowledges the need for family members to provide informal or private care and
assume additional responsibility to limited formal homecare, medical and community care (Tomlinson & Åstedt-Kurki, 2008). The goal of family centered services is to empower family members by supporting their strengths, rather than identifying their deficits (Trask et al., 2009).

Gerontological studies on homecare services as they relate to the use of homecare have been largely considered by nursing, psychology and social work research. The family is considered at the individual, community and societal level, where interrelated relationships between generations and reciprocity between family members are explored (Nutt, 2007).

Family centered care has been largely informed by theories such as family systems theory and ecological theory. Family systems theory focuses on family relationships to examine patterns and relationships between family members (Nutt, 2007) and the interactions among family members and their impact upon the family as a whole (Tomlinson & Åstedt-Kurki, 2008), whereas an ecological perspective examines individuals relative to their environment.

Gerontological studies have examined the family's ability to care for older adults in the home (Boult et al., 2009; Fletcher & Hirdes, 2004; Gaugler et al., 2000; Hallberg & Kristensson, 2004; Pearlin, Mullan, Semple & Skaff, 1990). Previously, responsibility for long-term care was largely viewed as the family's responsibility which has since been re-examined as a result of women's involvement in the paid workforce, which in turn has resulted in their unavailability to provide full-time care. Differences in the availability of family care have been shown to be influenced by social class, ethnicity and gender and by cultural differences (Bolin, Lindgren, & Lundborg, 2008). Western culture places a higher emphasis upon individualism compared to ethnic minority groups, where the emphasis on collectivism would support stronger caregiving beliefs (Pinquart & Sörensen, 2005).
Two ideologies that run counter to one another individualism that emphasizes the need for self-determination, autonomy and privacy conflicts with familism, which prioritizes the importance of the family in the provision of care (Montgomery, 1999). The current debate also relates to the role for governments and family members in the provision of long-term care (Schoot, Proot, Legius, ter Meulen & de Witte, 2006). For example, the need to encourage the use of grab bars in the washroom to ensure for the safety of the client may conflict with the family's preference to do without them (Benoit & Hallgrímsdóttir, 2008). As well, a family's preference for more homecare hours and assistance may conflict with the government's plan for less assigned homecare hours (Schoot, et. al., 2006; Vaarama, 2009). Although differences in the availability of caregiving occur, often there is an assumption on the part of healthcare providers that immigrants in Western countries will present with strong family ties and a strong interest in providing care for older relatives (Curtis & Dixon, 2005; Jokinen, 2006; Matsuoka et al., 2012; Trask et al., 2009).

Although Feminist scholarship has examined gender as it relates to the provision of caregiving services for older adults (Chapman, 2004; Reid & Hardy, 1999; Remennick, 1999; Rozario, Morrow-Howell & Hinterlong, 2004), a critical area in need of being better understood is the long-term effects of acculturation on the role of women, especially as it relates to their availability to provide informal care and the resultant need for more formal care (Dyck & Dossa, 2007; Kofman, 2004).

Cultural beliefs and norms have been shown to affect the amount of family caregiving support available for older family members. Filial obligations among Asian, East Indians and Southern European immigrants have been noted. Strong family ties and the importance of caring for older family members were also found among the Greek, Polish, and Italian Canadian
families. Japanese, Chinese, Korean and Filipino immigrants also emphasized the importance of familism and filial obligations (Verkuyten, 2005). Still, living arrangements also differ amongst families, instead of some that live together, some may reside separately which may affect available informal support (Jokinen, 2006), with a resultant need for more formal care.

Policy studies have also examined the role of the family and that of the governments in the provision of services for older adults (Greene, 1989; Knight & Losada, 2010; Noelker & Bass, 1989) where in addition to conflicting views in the allocation of funding for public and private care in the home (Buhler-Wilkerson, 2007), the care of older adults is often characterized as a "burden" compared to childcare, which is often represented as a positive experience (Remennick, 1999).

**Cultural Competence Framework**

Governments and health policy leaders have increasingly become challenged to provide cost-efficient healthcare services for Canada's diverse immigrant groups. Recommendations have included the provision of a more responsive healthcare system that would include a national homecare strategy within the *Canada Health Act* (Romanow, 2002) as well as cultural and linguistic services. Proposals have been advanced to broaden homecare definitions and incorporate the importance of culture in the provision of services (Forget, Deber, Roos & Walld, 2005). The continuing emphasis on cost containment has however challenged healthcare providers in having the requisite resources required to provide culturally sensitive care (Anderson et al., 2007).

Although western ideology has traditionally prioritized individualism that favors individual responsibility for health and illness, the shift to community care, has spurred interest in cultural factors in the provision of care (Basnyat, 2011). The fields of transcultural nursing
and medical anthropology have incorporated the “Cultural Competence” Framework, where the importance of social and cultural influences on clients' health beliefs and behaviors (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003) have recently been considered as they relate to diverse immigrant populations (Campinha-Bacote, 2002).

The Cultural Competence Framework considers cultural knowledge, skill, desire and awareness in the provision of care to individuals from diverse ethnic and cultural backgrounds (Campinha-Bacote, 2002). Cultural knowledge relates to becoming knowledgeable about other cultural groups, cultural skill relates to the ability to collect data accurately, cultural desire relates to interest and motivation about cultural differences, and cultural awareness relates to the process of acquiring familiarity with diverse cultural backgrounds (Campinha-Bacote, 2002).

Culture has been defined as transmitted values, beliefs, norms and practices that are transmitted and shared among individuals. These values and beliefs are learned and shared throughout the lifecycle, as are the behavioral patterns and actions of individuals (Lai, 2004) and although linked to an individual's background, religion, family structure and language are influenced by global values and by the effects of acculturation (Capitman, 2002; Greenfield, Keller, Fuligni, & Maynard, 2003; Jirwe, Gerrish, & Emami, 2006) all of which may affect an interest in receiving care (San Antonio, Robert, & Rubinstein, 2004).

The culturally congruent care theory, developed by Leininger stresses the intersections of culture, language, history, gender, and values in the provision of culturally based homecare services. Leininger believes that healing cannot occur in the absence of culturally-based care for diverse cultural groups (Leininger, 2002). Culturally competent care incorporates the principles of client centered care, where clients' participation and preferences for care are valued (Betancourt, 2004). Both frameworks acknowledge the importance of providing services that are
responsive to individuals and consider cultural factors, while transcending a former overreliance on the biomedical model’s emphasis on disease or disability (Anderson et al., 2007). Both the Client Centered Framework and the Cultural Competence Framework have been used to frame the analysis on a more personal level, to consider the individual client and their experiences of illness as a way of reflecting clients’ preferences for care. However, the Client Centered Framework examines the quality of care for the individual client, whereas the Cultural Competence Framework considers the promotion of health equity in the provision of optimal care to disadvantaged populations. Although there are differences between the two frameworks, both acknowledge the importance of providing health care services that are responsive to the unique qualities of individuals, with particular attention to individual beliefs and values. The aim of the Cultural Competence Framework is to reduce cultural disparities, whereas the goal of the Client Centered Framework is on the provision of individualized care. Neither Framework however has been able to address all of the racial and ethnic disparities in the provision of services or to acknowledge all of the individual factors in the receipt of care (Beach, Saha, & Cooper, 2006; Julliard, Klimenko, & Jacob, 2006).

For example, alterations of cultural values and norms can often occur in response to the dominant sociocultural environment. As well, unique aspects of individuals may not necessarily conform to universal cultural patterns and norms (Lai, 2008). Moreover, the Client Centered Framework’s emphasis on the client may conflict with cultural beliefs that foster the inclusion of family members and others in the provision of care (Ward, 2012). Although cultural competence has been shown to improve client satisfaction (Betancourt, 2004) much of the focus has been on cultural and linguistic considerations in acute settings, with less emphasis on homecare or long-term care (Victoria, 2010). As well, failing disparities in health care status that have been shown
to be affected by socioeconomic factors are often not considered (Koehn & Swick, 2006). Missing as well is adequate information about individual immigrant groups and their interest in accessing formal services (Trask et al., 2009).

Furthermore, although the effects of health disparities have been considered in the gerontology research (Alegría, Pescosolido, Williams & Canino, 2011) much of the research has considered factors such as age, gender, marital status, and education in predicting healthcare use, and little emphasis upon the effects of the dominant sociocultural environment upon cultural values and norms (Lai, 2008). Moreover, there seems to be a presumption that immigrant families adhere to prior cultural patterns of caregiving, without consideration of interethnic differences and the extent to which cultural preferences for care are altered (Bengston, 2004), or affected as a result of acculturation that would in turn affect the need for formal care (Angel et al., 1997; Angel & Angel, 2006; Cummings & Adler, 2007).

Although efforts to promote the development of integrated care has led to a greater understanding of the need to improve service delivery, checklists of national and regional objectives still emphasize the importance of cost effective services rather than individuals and their experiences receiving care (Meyer, Alteras, & Adams, 2006). Whereas the effects related to the restructuring of Canada’s healthcare delivery system have been considered in the past (Baranek, 2006; Baumann et al., 1998; Binney et al., 1990; Iwarsson, 2003; Pande, 2007), such as those related to funding, staffing shortages, and safety concerns (Binney et al., 1990; Clark, & Flores, 2007), factors such as the importance of community housing, socialization, education, social identity, cultural traditions and beliefs (Angel & Angel, 2006; Cote et al., 2007) have rarely been considered (Duncan et al., 2006).
Although in Canada there is encouragement for health services and institutions to be sensitive and respectful to diverse population groups (Makarenko, 2010), little is known about Canada’s commitment towards the provision of public homecare services (Tucker et al., 2007). Prior research findings of homecare use and underlying cultural considerations have been generally fragmented and have more often neglected to consider the variability of different groups, their unique ethnocultural backgrounds and their cultural beliefs (Lai & Surood, 2010). More often however, there is a temptation to generalize older immigrant groups and to label adults under an “over 65” age group that obscures the heterogeneous makeup of their cultural and age related groups (Trask et al., 2009). Although servicing Canada's diverse cultural groups requires effective communication and care that is respectful of cultural differences, (National Advisory Council on Aging, 2005) values and beliefs (CAMH, 2006; Health Canada, 2001) sufficient information with respect to the effects of immigration on family roles and caregiving practices and their effect on the need for formal homecare services is lacking (Kim, Laroche, & Tomiuk, 2001; McDonald, 2011). Missing as well, are the facilitators that contribute towards the development of positive homecare relationships to reflect client preferences for care (Brotman, 2002; Iuliano, McWilliam, Ward-Griffin, & Allen, 2008).

As a result, there remains only a limited understanding of the social and cultural factors associated with illness and disease (Risberg, Johansson, Westman, & Hamberg, 2008) essential to consider when providing competent cultural assistance to individuals of diverse backgrounds (Yan, & Wong, 2005). Critical gaps pertaining to older Canadian Italian immigrants and their cultural beliefs, traditions and values as they affect the receipt of homecare services require further knowledge to assist social workers and other healthcare professionals in better
understanding older Canadian Italian immigrants and their specific caregiving needs (Tomlinson & Åstedt-Kurki, 2008).

The importance of articulating the caregiving needs of older Italian immigrants merits the inclusion of other factors, such as social and cultural factors, to offer a broader analysis of culture and its importance in the provision of their care. Cultural values and beliefs are linked to an individual's background, religion, family structure, language and attitudes about illness (Capitman, 2002; Greenfield et al., 2003; Jirwe et al., 2006) and health care decisions (Egede, 2006; San Antonio et al., 2004). An emphasis on the importance of cultural considerations could lead to safer homecare practices, a reduction in linguistic and cultural barriers, higher compliance rates and potentially more cost-efficient care (Anderson et al., 2007).

Anti-oppressive Framework

Anti-oppressive practice considers circumstances of oppression (Adams, Dominelli & Payne, 1998) whereby oppression is described as situations in which there is a power differential between individuals and a resultant risk for abuse. Older adults have been shown to be at risk for abuse due to society's ageist views of them as weak and infirm, as well to their lack of access to resources such as culturally- and linguistically-appropriate services or adequate financial support (Matsuoka et al., 2012). Instances of abuse in older adults may go undetected or dismissed as a result of their advancing age, infirmity or cultural factors that are often presumed to protect them from their occurrences, whereas incidents of abuse may be underreported as a result of fears of repercussions, such as abandonment, a lack of financial support and institutionalization (Walsh, Olson, Ploeg, Lohfeld & MacMillan, 2010). Anti-oppressive practice seeks to provide social reform to address these power imbalances, to empower and create equal opportunities for older
adults (Adams et al., 1998) and to address instances of discrimination based on disability, culture, gender, age and race, thus changing social attitudes and societal beliefs (Pollack, 2004).

Despite past research about older adults in their receipt of formal care, little is known about the risk for abuse and its effect upon the utilization of homecare services (Walsh et al., 2010). Individuals who are presumed to be the beneficiaries of anti-oppressive practice are rarely solicited for their accounts of their experiences (Wilson & Beresford, 2000). Another limitation relates to its emphasis on societal and organizational change, rather than micro issues, to address immediate concerns of individuals and their families (Sakamoto & Pitner, 2005). As a result, little information is available to guide social workers and other healthcare providers in understanding the potential risk for abuse in the homecare environment (Walsh et al., 2001).

Ecological Framework

Within environmental gerontology, the study of the home environment considers aspects related to "aging in place" in the provision of homecare services (Gitlin, 2003). "Aging in place" refers to the governments’ initiative to encourage older adults to remain in their current home residence (Greenfield, 2012). In addition to gerontology, its practice has been examined in the fields of sociology, geography, architecture and psychology. Environmental psychologists have examined the home and its effects on individual identity and the physical world. Sociologists have examined the home relative to the social world, while health geographers have examined the links between health, healing and the physical landscape and space, and medical anthropologists have considered the ethical challenges in conducting research in people's homes (Williams, 2002).
The ecological model considers individuals and their interactions in their environment and their interactions relative to society to frame an analysis of human behavior (Andrews & Moon, 2005; Trask et al., 2009).

Previous research has emphasized the temporal properties of the home to reflect the individual’s ability to engage in activities of daily living (ADL) (Golant, 2003) and the underlying physical barriers that limit access to the home (Iwarsson, Nygren, Oswald, Wahl, & Tomsone, 2006). The aim is to maximize the health and safety of older adults to enable them to remain independent in their home (Demiris et al., 2004). Recent studies have extended the inquiry from a basic description to that of an incorporation of an explanatory model of adaptive and task-based strategies. Previous research has mostly examined the importance of housing needs and living arrangements, safety in the prevention of falls (Lang, Edwards & Fleiszer, 2008) and adaptive devices, as well as home-based interventions. Much of this research has considered the importance of eliminating environmental barriers and hazards rather than the importance of cultural preferences for care (Campinha-Bacote, 2002). In some studies there has been a shift in inquiry from the physical aspect of the environment to the internal life processes associated with the aging process (Gitlin, 2003), and still other studies have considered the importance of the environment as it relates to individuals’ ability to feel in control of their life, and elicit changes in their immediate environment through either primary or secondary mechanisms (Sneed & Whitbourne, 2005).

Personal control theory posits that individuals strive to retain control over their immediate environment by using either primary mechanisms such as altering the immediate physical environment or instead through the use of secondary mechanisms, that may involve a modification of internal cognitions or emotions to support strategies to modify the environment.
In the context of formal caregiving, individuals may employ these coping strategies in order to maintain personal control over their feelings of vulnerability while having to submit to services from virtual strangers (Gitlin, Corcoran, Winter, Boyce & Hauck, 2001).

The attachment to the “home” emerges as an important aspect in the provision of care, due to its symbolic attachment and extension of the individual’s self-identity. The association of “home” within the community or sense of belonging highlights the home as more than just a place of residence (Leith, 2006). Private family homes in Ontario are unregulated for the receipt of homecare services and are individually maintained with respect to their distinct individual structure and composition (Gitlin, 2003). Although the home has been examined with respect to its ability to provide a safe environment for homecare services, issues related to privacy and the cultural significance of the home have rarely been considered. Privacy matters are extremely relevant in the home environment where assistance with bathing and dressing is provided. In this context, the home environment is not only a place where individuals reside and receive services, but is also intricately connected to the individual’s personal identity, privacy, cultural beliefs and overall sense of security. Their meanings and representations vary across ethnic groups (Preto & Mitchell, 2004).

Unlike other immigrant groups in North America, Italian immigrants’ cultural practice of "fare la bella figura" to project a positive image and impress others (Groebel, 1998), influenced the physical arrangement of the home, to include kitchens upstairs and in the basement. While cooking was performed in the basement kitchen, the upstairs kitchen was kept clean in order to entertain guests. Also represented was the importance of order, achievement and success whereby the pristine upstairs with well appointed furniture and mahogany floor served as a marker of financial success. As a result, the Italian home representing a distinct cultural way of
experiencing, organizing and understanding space (Pascali, 2006), emerges as a unique site to explore the effects of care, as delivered by virtual strangers.

Individuals experience feelings related to the geographical space called “home” (Leith, 2006). As people age, the “home” becomes a reminder of the multitude of experiences that have been shared with others. Apart from familiarity and access to community resources, the preference to “age in place” is often attributed to a physical location of the right “fit” between the environment and the individual’s physical and psychological competency (Cook et al., 2007). Despite the many changes that older adults typically experience in their lifetime, the effects of such change are influenced by an individual’s affiliation to their environment (Iwarsson et al., 2007). As people age, there is a tendency to spend more time at home (Iwarsson et al., 2007). Despite the importance of the "home" however, there is little research related to it and the associated cultural factors in the receipt of care (Wolff, Roter, Given & Gitlin, 2009). Research has also assessed the risk of social isolation or institutionalization and the level of independence in the home (Iwarsson et al., 2007).

The home environment differs from public facilities such as hospitals, long-term facilities or clinics (Martin-Matthews, 2007) whereby provision of medicalized care in a client’s home must account for an individual’s property and preferences for care (Sharkey & Lefebre, 2008). Although past studies have expanded analysis of the home environment from different perspectives (Gitlin, 2003), its importance in preserving former cultural traditions is often overlooked (Gitlin, 2003).

Although commitments to provide homecare services (Romanow, 2002) have greatly expanded the analysis of the home environment from different perspectives, information is still lacking with respect to its potential to deliver culturally responsive care (Gitlin, 2003). As a
result, the interrelationship between the home environment and the effects of immigration and aging as they affect care in the home, remain poorly understood (Gitlin, 2003; Wolff et al., 2009).

As a result, social workers, who play a vital role in the organization and delivery of homecare services, have very little information to guide them in understanding (Gantert et al., 2008) the cultural meanings as expressed in the home environment (Litwin, 2004) in order to offer services that are responsive to individual needs. In addition to the importance of its physical barriers in limiting access to older adults (Iwarsson et al., 2006), the cultural meanings about health and aging associated with the home and the receipt of services must be better understood. This information is required to extend the inquiry from a basic descriptive study of the physical environment to one which incorporates an explanatory model of adaptive behaviors, to better predict outcomes of homecare services.

**Life Course Framework**

A Life Course Framework was selected to guide this study, as a result of its ability to conceptualize human development and aging across the life span (Elder, 1999) to examine the social and historical factors affecting older Italian Canadian immigrants upon their need for formal care. This framework considers the notion of “linked lives”, as described by Elder (1995) in which aspects of social embeddedness and interdependence of individual lives are examined. It acknowledges the continual process of aging and human development across the life span, with disadvantages and advantages occurring throughout (Elder, 1999). Elder argued that the life course paradigm is defined through five core principles: (1) human development and aging as lifelong processes; (2) human agency; (3) historical time and place; (4) the timing of events in
life; and (5) linked lives (Daaleman, Elder, & Sheps, 2007). (See page 105 for tabular depiction).

Studies in psychology, anthropology, history, medicine and sociology have relied on the Life Course Framework to examine older ethnic adults (Benjamin, Flynn, Hallett, Ellis, & Booth, 2008; Blank & Torrecilha, 1998; Cagney & Agree, 1999; Graham & Power, 2004; Janevic & Connell, 2001; Treas & Chen, 2000) in their use of homecare services, (Blank & Torrecilha, 1998; Cagney & Agree, 1999; Graham & Power, 2004; Janevic & Connell, 2001; Treas & Chen, 2000) however to date, they have not extended the inquiry to include all racial and ethnic groups such as older Canadian Italian immigrants and their cultural and linguistic preferences for care (McDonald, 2011; Segal & Mayadas, 2005; Willgerodt & Killien, 2004). As a result, the effects of immigration and the construction of aging across cultures (Atchley & Baruch, 2003; Horton, Baker & Deakin, 2007; Williams, 2002) and their effects on caregiving practices remain poorly understood (Tsai et al., 2004). Social workers need to incorporate the voices of immigrant populations, (Gilroy, 2006) to offer a better understanding of culture and its effects upon the need for formal care (Forget et al., 2005).

The Life Course Framework focuses on the meaning of the challenges, events and experiences that shape peoples’ lives while providing interprofessional collaborative opportunities (Poochikian-Sarkissian et al., 2008). “Contemporary perspectives on the life course differ from those of an earlier period by giving greater emphasis to the temporal meanings of age and thus to the historical settings” (Elder, 1987, p. 181).

This framework highlights the multiple meanings and interpretations of health and illness, (Daaleman & Elder, 2007) in the context of social change, culture, historical events and changes in individual health events (Ben-Shlomo & Kuhb, 2002). As such, at the individual
level, it can be used to examine individual health care decisions, while at the organizational level, it can be used to consider the system of delivered care to individuals over time.

The aging process and self-appraisal continue throughout the life course across a continuum that is most often influenced by diminishing levels of resources in later years. Individuals who age well are more likely to achieve some sense of closure and resolution with respect to prior life challenges. Age is conveniently used to define opportunities, challenges, roles and achievements whereby role transitions such as marriage, parenthood and retirement are represented. The impact of age and its effects upon an individual’s social identity, relative to their many transitions over time, thus may be explored (Barrett, 2005).

The current study is also informed by the Social Identity Theory to examine Ontario’s Italian older immigrant population and aspects of their social group membership (Foley, Linnehan, Greenhaus, & Weer, 2006). The ability to incorporate the theory of social identity across the life course is linked to the notion of “linked lives,” as described by Elder (1998, p. 5) whereby aspects of social embeddedness and interdependence of individual lives are considered. An aim of this approach is to relate the changes in social identity that occur throughout the life course in order to explore the effects of immigration on these identities. Social Identity Theory offers additional guidance in examining this population and their unique characteristics (Wan, Chiu, Peng, & Tam, 2007) as it relates to their particular immigration experiences, to assess their level of acculturation, diversity, interest to preserve their unique identity, membership in their own social cultural group and their caregiving practices (Ploeg, 1999). Whereas some research has been advanced about the association between the timing of life roles and events such as marriage, employment and parenthood with respect to family, education and work trajectories,
more information is required about the effects of immigration and its influence on social roles and identities and their effects on the need for homecare services (Barrett, 2005).

Social Identity Theory was first introduced in 1959 in Britain by Henri Tajfel, who posited that an individual’s identity was influenced by his or her membership in a social group with regards to issues such as racism, discrimination and prejudice. This theory was further developed in the 1970’s by Tajfel and Turner (1979) to account for factors of the larger group that influence identity formation and an individual’s self-worth (Sloan Work & Family Research Network, 2007). Tajfel argued that “in group” favoritism resulted from the process of categorization, whereby the “in group” member was favored over the “outgroup” member and posited that group membership influences members’ perceptions of themselves in relation to others. He argued that social and psychological factors affect this process of categorization which is affected by an individual's belief systems, as defined by the relevant social structure. An individual’s social identity is derived from their perceived membership in the social group, whereby individuals define themselves based on their membership and affiliation with the “in group.” In addition to its impact upon social psychology, Social Identity Theory has been applied to research on prejudice, stereotyping, negotiation and language discourse (Haslam, 2001).

The theory assumes that individuals display various social roles and identities depending upon their perceived membership in the group (Smith, 2007). Sociodemographic attributes influence this process (Smith, 2007), as do cultural values (Wan, Chiu, Peng, & Tam, 2007). In addition, social events such as political change, migration and organizational change affect intra individual elements of individual social identities, whereby group membership becomes redefined and reevaluated. These social changes often lead to new social group memberships (Amiot, de la Sablonnière, Terry, & Smith, 2007).
Ultimately, the association with multiple groups over the course of a lifetime often leads to the convergence of multiple social identities, which are then integrated into an individual’s self-identity over time. The elements of the group are incorporated into an individual’s self-perception. Social identity results from the cognitive ability to categorize, compartmentalize and integrate contexts of change, that result in the ability to merge and affiliate with the social group. Facilitators of this process include coping mechanisms, adaptation and social support, whereas feelings of imminent harm could impede this process (Amiot et al., 2007).

The theory also accounts for social competition and discrimination that can result within the group, and which often leads to subgroup distinctiveness within an overly inclusive subordinate group. An individual’s ability to adapt and redefine his or her position in the new group is ultimately linked to how a new identity overlaps and becomes integrated within the existing dominant one. Important life events such as immigration might ultimately influence an individual’s social connections that are largely influenced by his or her coping mechanisms and social support, as well as by the characteristics of the intergroup structure. Integration of the new identities ultimately occurs as a result of the connections between these different components that can be influenced by the environment (Amiot et al., 2007).

More often, immigrants are expected to assimilate and integrate into the host’s culture, and conflicts often arise if immigrants attempt to retain their distinct identity, religious norms, values and beliefs. “Acculturation” is defined as “those phenomena which will result when groups of individuals of immigrants and members of the host with different cultures will come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” (Rohmann, Piontkowski, & Van Randenborgh, 2008, pp. 337-338). These changes may be biological or economic and may reflect social and cultural changes that include
values, beliefs, and norms. This process involves a need for both the dominant and nondominant groups to coexist. The dominant group however, often expects the nondominant group to assimilate and relinquish former cultural values and beliefs in order to adapt to those of the host country (Rohmann et al., 2008). “From the perspective of the dominant group, the two questions are whether maintenance of the heritage culture by the immigrant group is accepted and whether contact between the immigrant group and the host society is supported” (Rohmann et al., 2008, pp. 338).

Aspects related to aging have been defined with respect to social role identities, to locate individuals in relation to their social relationships and social positions (Moen, Ericson, Dempster, & McClain, 2000). The premise of Continuity Theory is the belief that individuals strive to retain their social role identities in order to maintain continuity over time. This theory assumes that individuals retain their social identity as they age and underscores the importance of social identities in coping with life changes and the need to adopt links between role identities and a new environment (Moen et al., 2000).

Social role identities locate individuals relative to their social relationships and social positions in life, to examine prior roles that may shift over time (Moen, Ericson, Dempster, & McClain, 2000). Whereas the Life Course Framework assumes that transitions are related to changes in time, based on historical events and life roles (Moen, Elder Jr., & Lüscher, 1995) proponents of Social Identity Theory regard the individual based on their personal skills and their collective qualities as derived from interactions with their cultural, social group (Day & Cohen, 2000). Key aspects of Social Identity Theory are considered relative to their life course of events that have shaped individual experiences over time (Chapman, 2005), as they relate to their level
of membership to their own social cultural group and to their specific caregiving practices (Ploeg, 1999).

The importance of an individual’s identity has also been explored in relation to factors such as race, ethnicity, gender and social status. Research has tended to rely on Social Comparison theory, whereby individuals consider themselves in relation to others in their social network. Festinger introduced the theory in 1954 to account for individuals’ proclivity to measure and compare their abilities and overall success with others (Festinger, 1954). Such comparison may lead to a desire for self-improvement. Comparing oneself to more successful individuals can foster low self-esteem and self-worth. Alternatively, individuals may compare themselves with others who are less successful, which can lead to increased self-worth and/or can diminish the desire to improve their standing in life (Buunk & Gibbons, 2007). Although this framework has been helpful in understanding social behavior, much of this research has not described gender differences and cultural norms (Barrett, 2005).

Individual adjustments in life, such as those related to the effects of immigration, follow periods of transitions and events across the life course (Chapman, 2004) that have yet to be fully understood, especially as they relate to the aging process and the need for homecare services (McDonald, 2011). Despite past attempts to link the provision of health care to role identities (Leichsering, 2004), the unique experiences and perspectives of older Italians as shaped by social, cultural and historical immigration experiences remain virtually unknown (VanderBent, 2004).

**Conclusion**

Canada is a diverse nation that is home to many immigrant populations. Despite the *Multiculturalism Act*, which encourages diverse population groups to preserve their cultural
heritage (Makarenko, 2010), the reliance on the Biomedical model runs counter to this policy. The effect is often a lack of inclusion of social, psychological and behavioral factors and of cultural considerations in the provision of care (Makarenko, 2010). Many studies to date have relied on frameworks and theories that have not been able to fully capture the individual nuances in the receipt of services, especially as they relate to cultural heritage, traditions, beliefs and language (Carriere et. al., 2002).

The current "one size fits all" approach in the provision of homecare services, offers little in the way of meeting Canada's policy on multiculturalism, aimed in the provision of culturally sensitive care (Anderson et al., 2007; Clemson, Mackenzie, Ballinger, Close & Cumming, 2008; Fitch & Adams, 2006; Lehman, 1999; Makarenko, 2010; Mold, Fitzpatrick & Roberts, 2005; Scourfield, 2006). As a result, many immigrant groups experience health disparities, whereby social, economic and political factors contribute to their marginalization. Factors related to their care are often informed by inaccurate descriptions of their cultural practices and beliefs. The ability to provide responsive services is contingent upon a well-informed understanding of their needs (Romanow, 2002).

There is currently a dearth of information on the caregiving needs of Ontario’s older Italian immigrant population (Gilroy, 2006). A review of the literature has revealed that cultural heritage, beliefs and attitudes affect the type of caregiving support required, especially in the home environment (PHAC, 2004). Barriers to homecare services have resulted in a lack of appropriate care or poor medical compliance among homecare clients. This has become increasingly apparent in Canada, where the increased cultural diversity has created a need to consider the changing ethnic and racially diverse populations and their cultural preferences for care (Willgerodt & Killien, 2004). The current study’s use of a Life Course Framework and
Social Identity Theory is intended to highlight the importance of time trajectories as they relate to the cultural and historical events relative to the need for homecare services. The aim is to address these identified gaps in the research, to better understand the complex and individual factors that may affect older Ontario Italian immigrants and their need for formal care. Social workers, policy makers, healthcare providers and other relevant stakeholders must incorporate their voices, to better understand the importance of culture, in the provision of their care (Gilroy, 2006), to meet the needs of all Canadians (Silverstone, 2005).
Chapter 4-Method and Design

Introduction

This chapter describes the methodology used to study older Italian immigrants who were receiving culturally sensitive homecare services through an assisted living facility in Ontario, to learn how their immigration, acculturation and aging experiences related to their need for formal care. A description is given of the methodology, rationale, design, sampling procedures, data collection and data analysis and concludes with a summary of the chapter.

Rationale

Study Questions and Objectives:

The central goal of this study was to explore the experiences of older Italian immigrants receiving culturally specific public homecare services in a large urban center in Ontario to identify cultural factors that might affect the nature of required support. The descriptive methodology of phenomenology was used because of its ability to explore and reveal the personal meaning of the experiences as told by the participants receiving care in their home. This method allowed for the nuances and patterns of the experiences of older Italian Canadians to be identified (Porter, 2000).

More specifically, the objectives of the study were to examine:

a. How immigration experience and Italian culture affect the use of formal homecare services by older Italian Canadians;

b. Perceptions of older Italians regarding the quality, strengths and weaknesses of homecare services;

c. What homecare services older Italian Canadians consider to be most effective in meeting their needs.
Research Design

The selection of a research method was informed by the research problem. A post-positivist research method was used to examine the subjective quality of social phenomena, with the objective of exploring, interpreting, and gaining a deeper understanding of the participants’ subjective experiences (Noor, 2008) in the receipt of homecare services. This differed from a positivist approach, which would have relied on objective measures using quantitative research methods (Noor, 2008). This study utilized qualitative research methods, specifically phenomenology, whereby the main ontological objective was to increase understanding of the meaning for individuals with similar experiences, rather than to theorize, predict or generalize relationships (Crist, 2004).

Informed by an epistemological interest in exploring the nature of their homecare experiences (Creswell, 2007), phenomenology was selected because of its concern with the paradigm of personal knowledge, emphasizing the subjective quality of an individual’s experiences and interpretations (Lester, 1999): “The basic purpose of phenomenology is to reduce the experiences of persons with a phenomenon to a description of the universal essence” (Creswell, Hanson, Plano, & Morales, 2007, p. 252). The goal is to provide a description of the essence of the experience, rather than to analyze or explain the phenomena (Creswell et al., 2007).

Two approaches are used in phenomenology: 1) Transcendental Phenomenology based on Edmund Husserl’s approach that emphasizes the descriptive interpretations and experiences of the participants, and less on the researcher’s experiences (Creswell 2007); and 2) Hermeneutic Phenomenology based on Martin Heidegger’s approach in which it is believed that the
researcher’s experiences should be incorporated and used to interpret the meaning of the phenomenon that is being described.

1) Transcendental Phenomenology

Edmund Husserl believed there was a requisite need for the researcher to set aside preconceived notions of the phenomenon, or bracket these beliefs, in order to objectively describe the phenomenon (Byrne, 2001; Lowes, & Prowse, 2001), thus relying more on the experience of the participants.

2) Hermeneutic Phenomenology

Martin Heidegger, a junior colleague of Husserl, believed that human beliefs were developed through many prior life experiences and that it was often impossible to set aside, or bracket prior assumptions (Byrne, 2001). Rather than setting aside prior beliefs, his approach in contrast, relies on the researcher’s prior knowledge to be used in interpreting the meaning of phenomena (Lowes, & Prowse, 2001).

This study was informed by Husserl’s Transcendental Phenomenology, whereby the intent was to highlight the experiences of the participants, rather than the beliefs of the researcher. According to Husserl, preconceptions are suspended through a process called “epoche” in order to allow the researcher to describe the individual’s experiences. This form of transcendental or descriptive phenomenology seeks to explore the perspectives of the participants, with the researcher first acknowledging past experiences with the phenomenon, to bracket prior views before engaging in the research study (Creswell, 2007).

Groenewald (2004) recommends that the data be analyzed using certain methods, including 1) bracketing and phenomenological reduction whereby the researcher brackets or “epochs” his/her own prior beliefs about the phenomena before considering the participants’
perspectives; 2) extracting units of meaning to gain a holistic appreciation of the participants’ views; 3) arranging units of meaning to arrive at themes; 4) summarizing each interview; and 5) extracting and organizing themes to represent perspectives of the individuals who are experiencing the phenomena (Groenewald, 2004).

The units of meaning used in the creation of themes are analyzed to describe common features (DeCastro, 2003; Porter, 2005). These structures, which are termed “phenomena”, provide a description of the experiences (Porter, 2005). Similar phenomena are grouped in categories to provide the “phenomenon” of the experience (Porter, 2005) to capture the meanings and interpretations of individuals.

**Study Design and Data Collection**

Phenomenological research is typically conducted through face-to-face interviews in order to elicit rich descriptions (Penner, 2008) and learn more about the individual’s feelings, beliefs and experiences with the essence of the experience free to emerge (Groenewald, 2004).

The intent of sampling was to purposely solicit prospective participants that had received formal homecare services through a facility in a large urban center in Ontario that offers culturally sensitive Italian care. Carpenter and Suto (2008) recommend using a small sample in phenomenological research in order to generate rigorous purposive data. Furthermore, they recommend conducting between one and three interviews with every participant until saturation of the data is achieved and interviews become repetitive (Carpenter & Suto, 2008).

*Site Selection*

The assisted living facility in Ontario that was selected for this study specializes in Italian cultural services for older Italian adults. According to Creswell (2007), when engaging in a phenomenological study, while participants may not necessarily be located at a single site, they
must have experienced the same phenomenon and be capable of reflecting on and articulating their experiences.

**Participant Information**

The sample consisted of 25 participants, with all participants completing the entire interview process. The sample comprised older Italian immigrants who were residing on their own in an assisted living facility, were 75 years and older and had been receiving specialized Italian homecare services through the facility for at least one year. The age of 75 years was selected as the minimum age in order to reflect research findings which have indicated that seniors over 75 are more likely to experience a greater need for homecare services (Lindsay, 1999). Participants ranged in age from 75-95 years with the average age being 89 years. The researcher has some knowledge of Italian and all participants, with the exception of two who preferred to be interviewed in English, were interviewed in their native language. Participants were interviewed in the presence of an Italian interpreter who was hired to assist in translating and transposing the data into English. Two participants had a daughter attend the interview, to assist them in the interpretation of Italian because they were unaware that the researcher spoke some Italian and that an interpreter would be present.

Participants were advised that engaging in this study was fully voluntary and that they would not receive any direct benefits from participating, such as additional homecare hours. Attempts were made to ensure that the participants would not confuse any elements of the research study with the provision of their homecare program.

**Participant Selection Process**

Authorization to conduct the study was first solicited from the facility’s Executive Director, who provided names of key individuals involved in the coordination and provision of
the homecare program. These gatekeepers were asked to provide more information about the particular participants’ health care status, ethnicity, gender and family status. An advertisement for participation was posted at the facility (Appendix F). Individuals who expressed an interest in participating were contacted and arrangements were made to meet on a convenient day, time and place for a confidential interview to be conducted. Participants were told in advance that their participation was for the sole purpose of this study and that they would be compensated with a $20 honorarium. Criteria for inclusion were being 75 and over, cognitively intact, physically and mentally capable of participating in a study, and receiving formal homecare services through the facility in the past year.

A pilot study was conducted with two participants in May 2009 to confirm that the recording equipment to be used in the interviews was functioning properly and to practice in the collection of data (Porter, Ganong, & Armer, 2000). The pretest revealed that the equipment was in good working order and that the interviews could be conducted within the prescribed time frame.

**Interviews**

One in depth semi-structured interview was conducted with each participant, with the assistance of an interpreter. Although all efforts were made to solicit both male and female participants, only women over the age of 75 expressed an interest in participating and met the inclusion criteria. As a result, the final sample comprised 25 Italian immigrant women over the age of 75. Although publicly funded homecare services have been utilized more frequently by women over the age of 75 who were functionally impaired and had little informal support available to them (Litwin, 2004), the lack of male participants in this sample is a limitation to the
study. The participants were asked open-ended questions through a semi-structured interview schedule (see appendix H; Hancock, 1998).

A key process in the interview was the interaction between the researcher and the participants’ trust and ability to openly share (Porter, et.al., 2000) their immigration and aging experiences, as they related to their need for formal homecare services.

Probes encouraged participants to expand on their answers, for example, “can you explain that”? “what do you mean by this?”; “did this ever happen before?”; “how often did you notice this?” Nonverbal cues such as body language were observed and participants were asked to confirm the interpretation of these cues in order to better appreciate their reactions throughout the interview process. Observations of their overall physical appearance and overall level of comfort during the interview were recorded in field notes.

The interpreter was present to ensure the translation of English was consistent and accurate. According to social constructionist, non-positivist or interpretive approaches to research, a translator’s perspectives could influence the translation process. As a result, the translator was regularly reminded to be objective while producing the most reliable translation. Only one translator was used for all written and oral translations, in order to ensure consistency (Squire, 2008). The participants were informed that field notes would be kept during the entire process to immediately record impressions of the interviews.

**Interview schedule**

Twenty-one interviews were conducted in participants’ apartments, one interview in a private area of the building and three interviews in the facility’s main office. The participants were encouraged to ask as many questions as needed, in order to ensure their concerns were addressed. Each interview lasted between 90 minutes and 2 hours and was conducted between
May 2009 and August 2009. Every participant was provided with a $20 honorarium. Digital recordings of the interviews were transcribed verbatim immediately afterwards, with the assistance of the interpreter.

Data Collection

The interview explored the participants’ perspectives on their need for homecare services, the help from family members and community agencies, the difficulties they encountered, the assistance they appreciated receiving and the barriers they experienced. Participants were asked about their marital status, family status, level of education, country of origin, length of residency in Canada, living arrangements, health issues, level of independence with respect to activities of daily living (ADL) and instrumental activities of daily living (IADL) (Lai, 2004) and the total amount of private formal and informal care that was available to them. (Please see Appendix H).

After each interview, the recorded interviews were played back in the presence of the interpreter while making notes of key statements (Groenewald, 2008). These notes along with notes recording observations made during the interview (Duner & Nordstrom, 2007) were incorporated into the transcribed interviews. This process was designed to readily identify key features in the interview (Lowes, & Prowse, 2001).

The digital transcripts were translated into English and back into Italian and then back into English by the interpreter. This method of back translation was used to validate that the translated material was accurate and to enhance the consistency and conceptual congruency of the translation process (Squire, 2008). The transcripts were read by the researcher to assess their veracity before being coded and stored in password-protected files (Carpenter & Suto, 2008). The transcriptions and field notes were converted electronically and stored on hard drives (Groenewald, 2004). Each interview was assigned a code and participants were identified by
numbers in order to protect their anonymity (Creswell, 2007). The transcripts were read and reread in their entirety in order to code and organize the data.

**Ethics**

Ethical considerations were emphasized throughout the entire process (Antle, & Regehr, 2003) to ensure that participants would be protected at all times from any potential risks (Creswell, 2007). The study was initiated in May 2009, following approval by both the University of Toronto Health Sciences Research Ethics Board and the facility’s Research Ethics Board and completed in August, 2009. Participants were provided with literature in English and Italian, outlining the study objectives, and indicating that their participation was voluntary and that they could withdraw their consent at any time.

**Informed Consent**

A study information form was drafted in both English and Italian and included the phone numbers of the researcher and the Office of Research Ethics (Endrawes et al., 2007) (Please see appendix E).

Once suitable participants were located and before they were formally recruited, a determination was made by the researcher whether they could provide informed consent and could understand the study objectives. Each participant was asked to explain the reason for their participation in the study and their willingness to voluntarily consent to being interviewed. The participants were assessed by the administrative staff, in order to ensure that they were competent, capable of residing independently in their apartment and of understanding the purpose of their homecare program, and that they understood that the interview was being conducted as part of the researcher’s Ph.D. at the University of Toronto.
The participants were provided with information about any potential risks and the value of the study (Antle & Regehr, 2003) and approval to take notes or to record interviews was solicited in advance. They were encouraged to only answer questions with which they were comfortable and to take as much time as they needed. Participants were reminded in the interview that they could withdraw at any time and that tape recording and notetaking would be stopped and that they would still receive the $20 honorarium.

Data Analysis

Creswell (2007) recommends providing a textual description of “what” the participants experienced, followed by a structural description of “how” it was experienced, by analyzing the conditions, context or situations that contributed to the experience. The researcher then provides an integrated synthesis of the thematic textual and structural analysis to convey the overall “essence” of the experience (Creswell, 1997).

The participants’ interviews were analyzed by reducing the information to significant statements or quotations (Rydeman, 2006). Statements that were perceived to reflect the research phenomenon were extracted from each interview, and the content and its significance were analyzed to allow units of meaning to emerge that would reflect the phenomenon. These units of meaning were organized into clusters. Similarities and differences among the participants’ experiences were compared, labeled and contrasted (Melander-Wikman, Faltholm & Gard, 2008). These clustered units of meaning (DeCastro, 2003; Porter, 2005) were then grouped into categories to generate the “phenomenon” of the experience (Porter, 2005), which were then organized into themes until no new themes or subthemes could be identified and saturation occurred (Groenewald, 2004).
The extraction of themes reflected key events in the participants' lives which affected their social roles, family network, identity and current need for formal care. More specifically, the effects of immigration, acculturation, culture and aging were explored, to gain deeper meaning about their life histories in the context of receiving homecare services. The interpretations of themes were then organized to provide a textural and structural description of their experiences in receiving culturally specific homecare services through the assisted living facility.

The thematic textural and structural descriptions were then integrated into a composite summary of their common experiences, to convey the overall essence of their caregiving experiences relative to their life events (Brown et al., 2006; Creswell, 2007; Ganert et al., 2008).

Analysis of the interview data relied on the participants’ words whereby their expressions, pauses and laughter were incorporated into the textural account in order to convey their representation of the experience. Quotations were included to deepen understanding of their unique nuances (Carpenter & Suto, 2008) with the objective of capturing the essence of the experience in its purest description (Butcher & Buckwalter, 2002).

The final interpretation revealed three major themes and several sub themes which are presented in Chapter 5.

Confidentiality

The researcher reassured the participants that the data would be safely stored and that the results of the study would not include any identifying information or facility identifiers in order to protect their confidentiality. All participants were informed that the interpreter would have access to identifying information and to the data, for the sole purpose of translating the material and the researcher would destroy the data after the documents would be translated. The
collection of data and their management was conducted in accordance with Canada's data protection law, introduced in 2000 (Head & Yuan, 2001). The data were safeguarded in a locked filing cabinet in the researcher’s home. Password protected computer files and the filing cabinet and computer were in a locked room in the researcher’s home. All material will be disposed of within three years of analyzing and reviewing the results (CIHR, 2012).

**Credibility**

Qualitative research is an iterative process, whereby the researcher checks, analyzes and confirms that the data are accurate (Lincoln & Guba, 1985). The need to remain impartial is reflected by the researcher’s attempts to offer explanations and interpretations of the data that reflect as accurately as possible the participants’ descriptions of the phenomena (Patton, 1999). This process is followed to ensure that the findings correspond with reality as depicted by the participants, thereby enhancing the accuracy of the data (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Efforts to enhance the procurement of data were also undertaken through written accounts of the entire process (Angen, 2000). In addition, various sources of data were involved including observation, interviews and review of artifacts such as photographs of the participants and their family at different stages in life, and checking and confirming the accounts with the participants at the end of the interview. The participants were asked to provide feedback on the researcher’s interpretations, to confirm that the findings were accurate and reflective of their intentions (Crist, 2005).

This was all done with the objective of enhancing the consistency and accuracy of the results (Patton, 1999.) Probes were used to encourage participants to expand their answers in order to solicit more information (D’Cruz, 2002; Shenton, 2004). Although credibility could have been further established by member checking, which would have involved asking every
participant to comment at a subsequent interview whether the interpretation of findings (Brown et. al, 2006; Padgett, 2009) captured the essence of what they described (Lincoln & Guba, 1985) only one interview however, was conducted, as a result of the vulnerability of the sample group. All of these measures were employed to enhance the rigour and credibility of the research findings in generating themes (Carter & Little, 2007; Lincoln & Guba, 1985).

**Researcher’s Experiences with Phenomenon of Interest**

These reflections, relate to both personal and professional experiences. I grew up in a predominantly Italian area of Montréal, Québec. I worked at the former Downsview Rehabilitation Hospital (Workers Safety Insurance Board), as an Occupational Therapist from 1981-1991 where I treated many Italian immigrants who had sustained work related injuries. I conducted interviews in Italian and as a result of having treated many Italian immigrants over the years, became familiar with their immigration histories and challenges in Canada. In 1991-1992, I worked at Sunnybrook Health Sciences Center where I referred patients for homecare services and became familiar with Ontario’s public homecare program. In 2000, I articulated with the Ontario Ministry of Health and Long-Term Care’s Legal Services Branch, where I considered Ontario’s health care program from a legal perspective. In 2001, I was hired to provide part-time legal counsel for Baycrest Hospital and conducted legal research related to Ontario’s health care program. In 2004, I interned with Health Canada’s policy department and examined Ontario’s homecare policies. My husband’s mother's family is Italian and as a result of all of these experiences, I became extremely familiar with Italian immigrants in Canada, their challenges in a new country and Ontario’s homecare program. Moreover, as the child of European immigrants, I grew up understanding the challenges often faced by new immigrants and could therefore appreciate and relate to these participants’ accounts.
My personal understanding and prior experience of the phenomenon have thus far been highlighted and bracketed, in order to offer an unbiased account of their experiences, to allow for these individuals’ personal accounts to emerge instead (Penner, 2008).

**Methodological Limitations of the Study**

There are methodological limitations to the study. Although stringent efforts were made to recruit a rich sample, the study is descriptive and not generalizable to the general population (Whittemore, Chase, & Mandle, 2001). Despite the researcher’s attempt to “Bracket out” previous homecare experiences, the elimination of all assumptions is not fully achievable (Creswell, 2007). In addition, other eligible participants who did not participate in this study may have had other views. As well, ethical concerns pertaining to the vulnerability of the sample population restricted collection of data to only one interview, thus potentially limiting fuller and richer descriptions to emerge with the benefit of more interviews. Furthermore, described experiences, derived from interactions between participants, the translator and the researcher, may be subject to diverse interpretations. Transcripts of translated language data when translated into English may not have fully captured the participants’ meaning. Finally, the participants’ subjective recollection of facts, often from the distant past, may not have been accurate (Polkinghorne, 2005).

**Summary**

This chapter provided a rationale for using Transcendental Phenomenology, which was deemed best suited for the purpose of exploring the experiences of older Italian immigrants receiving homecare services, to inform understanding of culture’s effect on their caregiving needs (Forget et al., 2005). The analysis of the data generated 3 major themes.
Summary: “Cultural Considerations in the Delivery of Homecare”

- Different income levels
- Marital status
- Level of financial status
- Gender
- Level of education
- Cultural heritage—ties to past
- Place of residence
- Level of disability

Physiological, Psychological, Environmental, Socioeconomic Risks → Aging process, Arthritis, cardiovascular/neurological disease, etc. → Disability and need for homecare services
Chapter 5: Research Findings: A Culturally Specialized Homecare program in Ontario

Introduction

This chapter provides a summary of the research findings including a description of the 25 participants, as well as an overview of the 3 central themes and subthemes that emerged with respect to the participants’ experiences in receiving culturally specific homecare services through an assisted-living facility in Ontario.

The key themes are: 1) the importance of communication and relationship building in the provision of care and the barriers in accessing health care services; 2) retaining identity and control; and 3) facing an uncertain future. Informed by the Life Course Framework and Social Identity Theory, aspects related to social changes, culture, historical events and shifts in health over time were examined as they affected the participants’ homecare experiences. Included in their descriptions were stages across the lifespan, such as family life in Italy and in Canada, marriage, raising children and grandchildren, widowhood, and the eventual reversal in role from former caregiver to recipient of care. At the core of their desire for homecare services is the shift from the previous practice in which older adults resided with adult children, to the current preference of residing independently, while relying on both informal and formal support. This chapter ends with a summary of the key elements of the chapter.

Their preference to receive culturally specific Italian homecare services emerged as an essential factor in the participants’ wish to receive services in Italian due to their inability to converse in English and their desire to retain their Italian traditions and beliefs.

Culturally Sensitive Homecare Programs

All 25 participants were receiving a maximum of 3 hours of homecare services weekly through the assisted living facility. The services included one hour of bathing or showering
assistance and two hours of combined cleaning and laundry support from homecare workers who spoke with them in their native language. The participants’ homecare workers were immigrants like themselves, of either Spanish or Italian heritage, who shared similar immigration challenges and were familiar with their cultural traditions and beliefs.

**Participants**

The final sample included 25 Italian immigrant women over the age of 75 and no male participants. Twenty-three of the participants were widowed, one was divorced and one had never married. Four participants either never had, or no longer had any living children and the other participants had children and grandchildren living close by.

The majority of the participants arrived in Ontario in the 1950s and 1960s. Only six participants had worked before their arrival to Canada whereas twenty had worked in Canada. Four had never worked in either Italy or Canada and remained at home to care for their family.

Twenty-three participants were interviewed in Italian and two participants who were fluent in English were interviewed in English. Twenty were receiving homecare services from individuals that could speak to them in Italian, whereas five participants were receiving homecare services from workers who only spoke to them in English, because these participants could understand some English.

All 25 participants began receiving formal homecare services when they first began to experience some ADL/IADL limitations. The participants presented with various chronic conditions/illnesses such as cardiovascular disease, osteoporosis, cataracts, chronic pain and rheumatoid arthritis. Many attended physical therapy and some received homecare nursing visits in addition to their weekly three hours of homecare support. Prior to moving to their assisted living apartment, they had all lived in a home in a predominantly Italian community in Ontario.
All of the participants had family members who were informal supports, supplementing their need for additional assistance. Twenty participants were dependent on their pensions, whereas five relied on their children for additional financial support. All 25 participants described themselves as having financial difficulties. They all chose the particular assisted living facility because it was situated in an area with access to many Italian resources.

All of the participants were extremely forthcoming in sharing their stories, experiences and immigration challenges. Key events in their lives, such as marriage, having children, working, retirement, bereavement and chronic illness were discussed as these influenced their preferences for care. Their accounts revealed the significant influence of their language and cultural considerations on the care they received. The central themes that emerged included: 1) the importance of communication and relationship building and the barriers in procuring healthcare services; 2) retaining identity and control; and 3) facing an uncertain future.

Although each theme is unique, the themes are interconnected by the challenges and fears that are described by all 25 participants. Each theme depicts their current struggles as well as their positive experiences in receiving linguistically and culturally sensitive homecare services. Each theme also reveals the importance of identity and cultural heritage in decreasing a sense of social isolation, increasing participation in cultural and spiritual programs in the community that is described as having helped them to be more capable of living independently and more in control of their living circumstances. The incorporation of cultural and linguistic considerations in the provision of their care emerged as important factors in their interest to receive services.

Their descriptions reveal the importance of their social group where the retention of cultural practices and beliefs are preserved through strong connections to family, community and
spiritual practices. The reversal in role from that of former caregiver to recipient of care is also profiled.

The following themes and subthemes relate to the participants’ social and historical events through time, as they affect their receipt of homecare services. Although uniquely reflected in their accounts, they are not listed in any particular order of importance.

1. The Importance of Communication and Relationship Building and Barriers Encountered in the Receipt of Healthcare Services

This section provides a description of the participants’ experiences in receiving medical and homecare services. Their previous and current experiences in the receipt of Ontario’s healthcare services are described relative to life course events that highlight the importance of relationships in the delivery of care and the strategies needed for their caregiving needs. Their accounts reveal long wait times for healthcare specialist appointments, surgical consultations and surgical care, as well as very little emphasis on the importance of ethnicity and cultural practices. Their descriptions center on their dissatisfaction with the governments’ healthcare reforms and reduced healthcare expenditures that place little emphasis on community care and the cultural needs of older immigrant women. As a result of their limited facility with the English language, they described having been unable to express and represent themselves in receipt of prior health care services and as a result became sullen and despondent while receiving care.

This is in contrast to descriptions given of their current homecare program through the assisted living facility, where in addition to homecare services being provided in Italian, attention is also placed on the incorporation of their cultural practices such as the availability of Italian cuisine; the inclusion of family members in discussions related to their care to reflect the cultural importance of the family; access to a Catholic church on-site, and Italian cultural and
recreational activities, such as bocce, card games "brisk" or "scopa", gardening and conversational Italian.

Because the office staff in the facility in which they resided respected their cultural preference to involve their family in homecare discussions, the participants reported feeling able to trust the administration in providing their homecare services. They reported that all of these arrangements in their care made them feel respected and understood by the staff and thus created a sense of equity in their relationship with their homecare service providers.

All of the participants were receiving homecare assistance as a result of experiencing a chronic disability or physical condition. Ten participants reported that the weekly two hours of combined cleaning and laundry assistance were insufficient for their needs. All of the participants complained about the lack of assistance provided for particular activities, such as cleaning their oven for example, and all complained about their maximum entitlement of one weekly shower or bath. For example, one participant (19) stated, “In two hours they can’t move everything and put it back, if you want to keep the house really clean you need time….two hours isn’t enough, no…” Another participant (23) explained that the homecare provider “gives me an hour and a half because she gives me a bath, you know? She cleans up the bathroom and everything and leaves right away and it’s not enough you know, it’s one hour and a half this one and then one hour, it’s peanuts.”

Although every participant had a bathroom that had been modified and was accessible for them, they couldn't bathe independently. As one participant (5) explained, "This morning one came just for a bath… I am happy because I find that I can do what I can but, to get into the bathtub it is hard for me to get in there" and another participant (7) reported, “That’s why they
give me this woman to clean the house because I cannot do it myself. In the bathroom there is a chair for me to sit, when I take a bath.”

The majority of the participants described a prior admission to hospital and general dissatisfaction with their medical care at that time. They felt their medical complaints were discounted because of their age and reported not being diagnosed or treated properly. One participant (15) explained, "All these specialists this and that….they didn’t give a hoot. The specialist said there is nothing that we can do at this age and we would only do damage to the brain … when we reach a certain age they give up.. okay…we look at things differently and they look at things in a different way…not the way we look at them.”

In contrast, all 25 participants felt satisfied with their homecare assistance at the facility, which they characterized as respectful of their needs. All of the participants explained that they had chosen to receive homecare services through this assisted-living facility because of its reputation for catering to Italian people. The participants spoke highly about their experiences with the office staff and appreciated being able to converse with their homecare workers in their language, which they considered essential to their care. They talked about having access to critical information such as knowing whom to contact in the event of problems. As one participant (1) explained, overall satisfaction with her services was due to her ability to communicate with her homecare workers in Italian: “A lady comes and speaks Italian comes twice a week, they speak Italian and I like to speak English too but when someone understands your language they understand you better and it’s better to explain yourself much better when they know Italian like if something might be wrong I’m able to explain this.” Another participant (8) explained that being able to communicate in Italian was essential for her because she could otherwise not communicate as well: “Yeah….even if one talks, when they send the ladies to
clean they are to do personal services only, bath and stuff like that, other things nothing...so then, when ... the one that comes she is Italian but when these other people come they just look at you in the eye and keep their mouth shut, they just say yes, yes, yes, if they don’t understand, they don’t understand the language...there is the Italian. Oh yes, it’s your language you know."

Many participants spoke about the homecare services they had previously received through other agencies in which the workers did not speak Italian. The participants felt these services restricted them from being able to communicate and develop trusting relationships with their providers. They reported that they were more comfortable receiving services from their current providers because they could speak to them in their own language and relate to their cultural practices and beliefs. One participant (6) explained that her previous providers had not spoken Italian: “No, the homecare worker that came was Yugoslavian ...I never thought of anything but the language mostly... other than that.” Another participant (8) was more satisfied with her current homecare program because her providers were Italian and could communicate with her in Italian: “The homecare program is good because they are Italians.”

The majority of the participants preferred to have the same homecare worker on a regular basis. The issue of trust emerged as a very important factor in their ability to be open to formal homecare services and receive assistance with the most intimate task of bathing and personal care from virtual strangers for example, explaining that their private bathing needs would be too embarrassing for them, if they had to undress in front of new workers all the time. They explained that their ability to establish a trusting relationship was based on their ability to trust the administration in the selection of their workers and regularly receive the same workers, as well as their ability to communicate with them in their language and receive consistent care.
The participants all described themselves as extremely proud, independent individuals who needed to feel in control of their homecare program. They wanted to reciprocate for the care they received, to lessen their embarrassment, for example, by offering food to their family and homecare providers.

The inclusion of Italian and ability to develop relationships with providers emerges as an important factor in individuals’ interest to receive care. In the past, linguistic and cultural barriers limited their access and desire for services. This was in contrast to descriptions of their current homecare program that incorporated their language and cultural traditions. Their main complaint centered on their limited entitlement to nonmedical care, which restricted them from maintaining a tidy home and for those whose allergies to dust exposed them to potential health risks.

2. Retaining Identity and Culture

This section reports on the discussions with the participants pertaining to the importance of their cultural identity, specifically as it relates to their receipt of homecare services. Their interests in preserving their identity and cultural norms are discussed in relation to their current health care challenges and willingness to receive formal homecare services. Within this context, their perceptions of the quality and type of homecare services considered to be most effective in meeting their needs are revealed. They expressed the importance of accounting for their language, food, spiritual affiliation, and attachments to family, friends and community in the environment in which they receive services. The participants’ accounts reveal their preference to receive services from providers who understand their language, cultural background, customs, practices and religious beliefs. When describing the social and historical changes that influenced their living arrangements and need for caregiving services, the participants described the importance of their physical environment in adapting to their personal challenges. According to
their accounts, this was facilitated by an accessible environment and the incorporation of their language, cultural and spiritual norms into their homecare program.

The majority of the participants claimed to have been initially hesitant to receive services, due to their unwillingness to admit to their physical limitations and their fear of allowing virtual strangers into their home. For most participants, needing homecare services was triggered by the loss of their spouse who had been their primary caregiver. They had all lived in Canada for over 50 years, having arrived from poorer areas of southern Italy and Sicily or from Rome in search of better employment and better education opportunities for their children. The majority could not converse in either English or French. One participant (18) related that when she had arrived to Canada she had been unable to speak any English: “I would always say here, there was no one to really speak to, it was difficult but slowly I learned some words and here we are today.” Another participant (20) explained that she had arrived in search of better employment opportunities: “I came in 1955 to Canada, so many years ago... (laughs)... because there was no work available in Italy...” Their initial hardship and eventual resignation to life in Canada included descriptions of the importance of their cultural identity and of receiving culturally competent care.

- **Home**

The participants’ home and community were described as a place where social bonds were established and where their cultural practices could be practiced.

They spoke about their previous homes, including the layout to the garden where they would cultivate their own vegetables, as had been the practice in Italy. Every participant spoke about how hard they had worked to save enough money towards a down payment for their home and to pay off the mortgage.

All of the participants’ apartments were adorned with murals, paintings, family portraits...
and memorabilia that depicted their lives in Italy and also served as a record of their lives in Canada. A large dining room set was central in every apartment and had been used in their previous home for family gatherings. According to one participant (18), “Before I was in a house…before I had a garden to maintain…”, whereas one another participant (20) talked about having sold her home and relocating to the facility soon after the loss of her spouse: “I stayed for 40 something years…I bought a new bungalow first we all stayed with my brother in a house after the kids grew up we moved on and bought…For 23 years my husband has been dead, and I kept my house for 18 years, I stayed alone but my kids came and my neighbour was nice, we were like a family.”

The participants spoke about the importance of remaining in control of their cultural traditions in the home, which for them included the importance of preparing Italian food. Notwithstanding their need for formal care, the majority of participants very much felt the need to cook on their own and prepare food according to their cultural traditions; they had no interest in receiving assistance with food preparation, even if available. They explained that cooking felt therapeutic and allowed them to feel more self-sufficient. Their limited number of homecare hours affected their preference for care as they indicated a desire to receive assistance only for those tasks they could no longer physically manage to do on their own. Cooking was described by most of the participants as something that they could still physically do. According to one participant (4), she was cooking because her homecare program did not provide this assistance: “I am cooking myself because these ladies don’t even have time to cook for me an extra hour. Still another participant (7) explained that cooking was something she could still manage to do with the assistance of her walker: "I cook by myself until now…I do it myself…Slowly. I have a walker. I put everything on the walker and go down myself…” Others claimed to prefer to cook
on their own because they found that food prepared by others was often not soft enough for older adults who have difficulty chewing. One participant (14) explained: “No, they don’t cook well enough too hard, maybe for the young it’s okay but for the older people they can't eat it like that.”

Many wanted to continue to cook because of their limited finances and their inability to afford purchasing ready-made meals. Three of the 25 participants, however, admitted having difficulty cooking on their own and were consequently receiving precooked meals which they warmed in the microwave every day. One of the participants (5) reported relying on her children to bring her food which she later warmed in the microwave: “I don’t cook…no, they don’t cook for me, no. I have stuff in the freezer. I have three kids. The other day my daughter was here, they bring me everything.” Another participant (24) claimed to rely on assistance from her family if she was unwell and couldn't cook: “I do cooking…yes, no lots, but until now I do it, when I can’t I call to send me food you know…oh yeah, sure….well, one day most Italian, one day not, you know, it’s not the same everyday, but you know, I like it.”

- **Changed Position from Former Caregiver to Recipient of Care**

  Discussions also centered on the change in role for the participants from that of former caregiver to that of recipient of care. The family emerged as very important, providing a network of interrelated relationships and informal assistance as a result of the limited 3 hours of formal care. The participants all spoke fondly of their current affiliations with family members. The assisted living facility's inclusion of family members in all decision-making processes fostered a supportive, collaborative approach that enhanced their autonomy, while preserving strong family ties. Their strong belief in family values was also supported by their homecare workers, who
understood their cultural norms that emphasized the importance of the family and provided culturally sensitive care that included family members' perspectives in their treatment plan.

Although the practice in Italy had been for older adults to reside with their adult children, in contrast, the participants did not wish to live with their children. According to a participant (19), who did not wish to ever live with her children, “my kids wanted me with them but I said no.” Most reported considerable stress as a result of needing to rely on their children for support as they did not want to be a burden to their family.

The participants’ relationship with their children and their spouses were reported to be important factors in their ability to receive informal support. According to them, their close relationships with family members encouraged them to request and receive additional assistance from them. The informal support which they relied upon included assistance with their banking, doctor appointments, grocery shopping or for their transportation needs. One participant (19) explained, “My daughter helps me, she helps me to the doctors you know.” Another participant (18) similarly depended on her son to purchase heavy grocery items: “For groceries, my son comes Friday to bring me shopping and just to get out and walk once in a while I use my walker just to get milk, bread. I do a little bit of light shopping for myself and when the weather is not great my son comes.”

Purchasing private care was not an option for the participants as a result of their financial limitations and its relatively high cost. As one participant (6) explained:, "I don’t know, I don’t have too much money. I would like everything to be clean but… I don't have the money." Still another participant (19) explained, it was financially beyond her ability to consider: “You have to pay $20 an hour, if you call the agency it's $20 an hour, it’s too much money, for us $20 an hour is a bit too much, too much.”
The majority of the participants claimed it was physically too difficult for them to visit with their children in their homes for very long. Having cared for their families in the past, they reported feeling embarrassed to no longer be able to assist their children in their homes. Moreover, they claimed that whereas their apartment had been adapted for their physical needs their children's homes were physically inaccessible for them and as a result too difficult for them to navigate. As one participant (12) explained, “I told her by midnight you have to take me home, I can’t sleep…no I don’t have a pole, the beds are higher, I place myself here and with the cane I am able to jump up.” Another participant (4) felt happy visiting with her children but commented that they had their own lives and work: “I am happy where I am and I can't bother my kids so I just go to visit my kids for the day. They have their lives, they work.”

Their descriptions of being self-sufficient and independent in the past were contrasted with their age-related challenges that according to the respondents were greatly eased by the location of the assisted living facility. Its proximity to Italian resources, as well as to their children enabled them to still feel in control and connected to their cultural group. There was an ongoing conscious attempt by the participants to continue to provide emotional support to family members, which was related to their strong attachment and need to preserve family and cultural ties.

- **Italian**

Although 17 of the participants preferred to receive homecare services from someone who could understand some Italian, the other participants reported that it was equally important for them to have a homecare worker who was kind, gentle and sensitive to their needs. For these participants, language was not as important, as long as they could make themselves understood. As one participant (5) explained, there was overlap between the Italian and Spanish languages,
and she could make herself understood with a Spanish worker: “Yes, Italian, sometimes Spanish, they're good,” whereas another participant (18) explained that it was important for her to communicate in Italian: “Yes for me it is important because I understand Italian.”

- **Spirituality/Church**

  Another aspect the participants felt was enhanced in their current homecare services was the spiritual aspect of their care. The participants explained that the church which was on the main floor of the premises offered daily mass in Italian, thus reflecting both their spiritual and cultural identity.

  Every apartment contained pictures of the Pope, their Lord Jesus Christ and various bishops and priests, as well as rosary and crosses, reflecting their strong spiritual beliefs and traditions. The participants all said that their religious beliefs enhanced their well-being and ability to cope in life. They felt the need to live in an area in which a church was close by. For example, one participant (16) explained that Mass was held in Italian at the church in the facility and Italian was spoken throughout services: “That’s right…yes…it helped, you go to the church and the mass was Italian.” Another participant (19) who reported that her faith sustained her found it beneficial to have a church next door: “The priest told me that I was destined to accomplish more and I came here, seven years in September it will be, I like it, I have the church next door.”

- **Socialization**

  Every participant expressed an interest in socializing with other residents and talked about the benefits of being able to converse in their language with others who shared a similar immigration history and also needed formal and informal support. One participant, for example (18), welcomed the ability to forge new relationships with other residents, stating: “I get out, go
downstairs; there are festivities that go on…I am happy because I have everything…yes, I have many friends.” Another (16) commented that there were always many people around with whom to socialize and spend time: "There are a lot of friends and just to pass time we play games."

Some participants were interested in cultivating only casual relationships as a way of avoiding conflict that could occur if closer relationships were developed. One participant explained that if she argued with someone in her building, she would still have to see this person daily which would make her uncomfortable. Another participant (18) believed it was better to cultivate casual acquaintances and be friendly but not close to other people: “My dear, yes, I have many friends but not close, I say hi, good morning, how are you? you know?…we all say hi to each other…but to be close you can’t be …” Similarly, still another participant (5) preferred to be friendly to others without having to develop close friendships: “I am a friend to everyone. Good morning, how are you? Yes, that’s it.”

- **Education**

Participants explained that they immigrated to Canada to improve their standard of living. As a result of their limited language and formal skills many of them worked as laborers. Their strong cultural identity included the importance of hard work and self-sufficiency as well as the expectation that their children would pursue higher education in order to achieve financial success and avoid their parents’ employment hardships.

Many participants had worked in either factories or stores and explained that they therefore prioritized education for their children, hoping to provide them with better career opportunities. It was vitally important for one participant’s (16) children to attend University: “All my children have a University education plus post doc, excuse me...okay I thought education was necessary so, my children are all University graduates….I made sure of
that…education to me was most important.” Another participant (19) also believed education was crucial as it enabled her children to secure professional careers: “Education for them very good….oh yeah, University, yeah thanks God they have a good job, all 3, one does the research for the hospital….yeah, she does research, the other one she is a lawyer.”

- Physical Appearance / the Aging Process

Participants spoke about the effect of aging on their physical appearance. They reported feeling unattractive and embarrassed as a result of such physical changes as hair loss, sagging and wrinkled skin, age spots, stooped posture and arthritic deformities. For example, one participant (12) said her arthritis affected both her mobility and appearance: “The arthritis has crippled me…..you see….I use to put my leg on the bed but now I have to go to the orthopedic at the end of the month to raise my other leg…this one no, not anymore…look, this one used to be swollen.” Another participant (15) proclaimed: “I can’t do anything …old age is ugly.”

Their physical appearance emerged as an extremely important issue. Issues in the facility exacerbated their feeling old. For example, being able to have only one shower or bath a week made the participants feel unattractive and diminished their self-confidence. As none of them could wash independently, they were left dependent on homecare assistance for their bathing needs. The inability to bathe more than once every week was described by each participant as humiliating and contrary to their cultural practice of fare la bella figura referring to the desire to make a positive impression on others. As a result of only having one hour for bathing and two hours for cleaning, the participants reported feeling embarrassed and unclean and felt they lived in an untidy home. Their wish to impress others was evident by their initial hesitancy to disclose their functional limitations and reveal their physical modifications made in the washroom to accommodate these limitations.
One participant (8) stated that changes to the homecare program should include providing more baths or showers a week: “I told you that the bathing is most necessary, if they want to do more, than I will say thank you to that.” Another participant (4) explained that she couldn’t clean anymore and therefore more hours for cleaning should be provided as well: “I was always cleaning even when I was younger and I’m old now.”

- **Work**

The theme of ‘work’ emerges as important for the participants whereby working outside of the home became the norm for many of them after they arrived in Canada. The participants spoke at great length about their work history, both in Italy and in Canada and the cultural and social forces that affected their roles. They described how very few women in Italy worked outside of the home and that most worked at home. The participants spoke about their relatives and friends providing them with connections for work and housing in Canada. They had mostly worked in labour positions, such as factories, textiles, furniture or food processing industries. Their husbands had typically worked in construction, brick laying, stone masonry, cement work or plastering. Many explained that they had been unprepared for the kind of life that awaited them in Canada which, in addition to their lack of English included other challenges. One participant (1) explained that for her life was easier in Italy because she did not work there: “Italy was way better. I didn’t like it because in Italy I didn’t work. I first worked in Canada cleaning people’s homes and then later worked in a factory sewing socks.” Another participant (8) explained, as a result of the stress at her work she became very ill: “I came ’65…because of my brother, he called and said to come, because you know you can change your life. I was missing the language ….yeah, that’s it….(*laughs*)….when I came here I got sick, all the problems started, oh when I came and even after I worked a little bit…”
Many participants explained that they had no choice but to work in order to support themselves, as there was no social assistance when they arrived. A participant (20) explained that there were very few social benefits available at the time to assist new immigrants: “There were no social benefits. When we came nobody helped us, not even the government.” Another participant (8) explained not having a choice but to work if they wanted to survive: “We worked, if you wanted to eat you had to work.”

Many described how difficult it had been for them because of their inability to speak English and their need to adjust to shift work hours or to factory work in Canada, stating that the stress took a toll on their physical health. A participant (4) talked about the challenges of shift work, which created great stress that ultimately contributed to healthcare problems: “Sewing pants and then a factory with dolls I got hurt. I couldn’t sleep during the day I was going crazy.” Another participant (25) explained there had been no choice but to work very hard: “Yes, I worked hard and I did piece work…. …you need a lot of money…. cushions when I did piece work what else was there to do…eh, you know what….I no eat, eat, and work, eat and work….you know what?”

As a group, the participants’ membership to their ethnic cultural group is fostered through retaining cultural practices such as the importance of the home, Italian language, spirituality/Church, socialization, education, physical appearance and work history, where they forged friendships with other Italian immigrants. These sub-themes emerged as particularly important to participants who highlighted the importance of retaining their cultural identity in receiving homecare services. Their need to preserve their identity and cultural norms are expressed as they relate to their current health care challenges and willingness to accept formal homecare services.
3. Facing an Uncertain Future.

The issue of an uncertain future emerged as an important theme and was central to contributing to their need for homecare services. Their accounts highlight their unique life events, as they relate to their fears associated with their social, health care, caregiving and housing needs.

The participants provided rich descriptions of the loss of relatives and friends and fears of greater loss in the future, such as friends dying due to advanced age or chronic health related conditions. Many described the loss of their parents and the need to assume the housework duties for the entire family. All spoke at great length about their physical losses and chronic medical conditions and the consequent need for both informal and formal care. Many participants used mobility aids, as well as other assistive devices. As one participant (7) explained: “To stay in a house alone after my husband died you know was too hard to keep the house, to do this, to do that, so I decided to come here and I am really happy.” Another participant (9) similarly explained that she had to move after her husband passed away, which was when she moved to the facility: “After my husband died, I couldn’t get any help at home, so I decided to come to the facility – have been here for 22 years.”

3.1 Loss

- **Loss of Loved Ones**

The majority of the participants were widowed (23). As their spouse was their primary caregiver, companion and source of financial assistance, the loss resulted in a need to sell their home and rely on formal and informal support. One participant (5) revealed that her husband had been her primary caregiver and after his death, she required formal homecare assistance: Another participant (7) reported that, after her husband passed away, she required formal care and as a
result elected to move to the assisted living facility: "I decided to come here and I am happy because to stay in a house alone after my husband died you know was too hard to keep the house."

- **Loss of Former Roles**

  The loss of their spouse resulted in the need to relocate to the assisted-living facility, which meant the loss of their role as homemaker. According to one (19) participant, her husband had been her primary caregiver and his death necessitated that she receive formal and informal assistance: "I fell and hurt my arm and I couldn’t work any longer. They even sent me a woman for my house because I couldn’t take a bath alone, I couldn’t do everything, my husband helped me with a few things but he was older than me, ten years older and used to help me before he died and then I found this and I’m happy…yes…"

- **Loss of Physical Health**

  All of the participants suffered with at least one chronic condition and reported feeling unwell most of the time. Many cited their immigration challenges, having to work, learning a new language and adjusting to a new way of life as having contributed to their overall physical decline. They described their inability to walk for prolonged periods of time and not being able to shower or bathe independently. As one participant (5) explained, she was suffering from many healthcare problems and was taking lots of prescription medication: "I have a lot of problems, a lot. When I went to the doctor he signed this list of medications that I take… I take the pills.”

Another participant (6) explained that she was suffering from problems with her heart and as a result had difficulty walking for prolonged periods of time: "I have a heart problem, I can’t do everything…especially my heart, I can’t walk too long, I have to sit down.”
• **Loss of Work**

Many of the participants spoke about their forced retirement. Many stated that their former employment had enabled them to feel financially secure and capable of contributing to the family income and that after their retirement, they experienced a loss of their usual routine. One participant (5) explained feeling very sad to have had to leave her job and still missed the people: “I worked in the cafeteria for eleven years because I really liked that job very much, I was very happy there and I had to leave.” Another participant (14) explained, she had worked for 3 years at one company and then 21 years at another one and was ultimately forced to retire at the age of 65: “I worked here for three years and see the picture over there. After one year I worked at the factory for cars where they have parts for cars…twenty-one years in the factory … work was good. I was there for twenty-one years.”

• **Loss of Independence**

Every participant spoke about losing their independence, which coincided with their need for homecare services. Their inability to do their own bathing, cleaning, laundry and heavy grocery shopping was experienced as a significant loss of independence. They all described themselves as “proud” individuals who overcame many challenges and expressed the need and desire to be active members of their homecare program, rather than as passive recipients of care.

• **Loss of Home**

The participants spoke about having sold their house and moving to the facility resulting in their relocation away from neighbours and friends. For many, this also meant the loss of their garden and the home that had served as a reminder for them of their former role as homemaker and nurturer. As one participant (5) explained, “Very old, very old I have a lot of antiques…now, when I move and die my kids….all finished, this I use to have in the basement, now I have this. I
use to have a nice dining room but now I am happy here.” Another participant (19) still missed her home and especially her garden: “I had a beautiful garden that I worked in and I couldn’t take care of the garden …that’s life.”

- **Loss of Family Members.**

  Every participant spoke about the loss of their family members both in Italy and in Canada and believed the associated stress contributed to their physical decline and consequent need for formal care. According to one participant (8) who had lost all her siblings: "My brothers and I grew up close….I went through a lot of problems… how I remember…..yes….. but…. they're all gone now.” Another participant (12) explained that she no longer had any family members alive in Italy, as they had all since passed away: “There’s nobody really there to phone, my parents are dead, 3 or 4 brothers and my sisters are dead; 2 brothers and a sister died.”

  For the 23 participants who were widowed and adjusting to life on their own, loss of their spouse was associated with their need to cultivate new relationships. They found that couples no longer wished to socialize with them once they were not part of a couple. Collectively, they reported connecting with other residents and learning important facts and processes from the other residents. For example, after learning about others’ positive experiences in receiving formal care, they described being less fearful about allowing virtual strangers into their home to assist them with their caregiving needs. This mutual solidarity that developed through sharing their experiences with other residents was described by all of them as a factor that increased their desire to receive formal services.

- **Loss of Youth**

  The loss of youth emerged as an important theme. Many participants reported having had to mature very quickly and assume responsibility for their family soon after arriving in Canada.
As one participant (16) explained, "the culture difference is a shock, …I was, I was robbed of my youth because of necessity, so I didn’t have much of a youth…” Another participant (19) revealed that she became increasingly despaired as a result of her need to assume so much responsibility upon her arrival to Canada: “Well, when I arrived I cried a lot… I took care of all of them.”

- **Loss of Privacy**

  Although every participant acknowledged the importance of their individual privacy, they reported being less self-conscious (for e.g., about being seen naked), as a result of having the same homecare workers on a regular basis. Because they were able to converse with their providers in their language, they felt more comfortable in their presence. Participants also reported that their homecare workers displayed a high level of respect for their personal space and personal effects.

- **Loss of Identity**

  Home ownership in Canada was described by every participant as an important source of financial security, and the home was where they raised their family and transmitted their cultural values to their children. Most had purchased a home in the early 1960s, in an Italian residential area, in an effort to preserve their cultural identity in this new country. For example, a participant (18) related that she purposely chose to live with other Italian people: “I didn’t speak English, I was always looking for someone who would speak Italian, and I still haven’t learned it….what else can I say?”

  As members of a group, the participants not only shared a common immigration history, but as individuals, they were united by their multitude of losses. They all described their fear of losing their identity and as a result valued being able to live with other Italian immigrants as they
could forge new relationships with others who shared their cultural beliefs and traditions. Their interest in receiving homecare services was enhanced by its location to Italian resources, thereby enabling them to preserve their cultural identity.

A few participants (8) described their inability to drive as a loss that made them more reliant on others. They spoke at great length about the effects of their losses on their self-identity. They were all reluctant to define themselves as "dependent" or in need of “charity” or “pity.” Rather, they strived to portray themselves as self-confident and self-sufficient. They talked about deriving satisfaction from their achievements and in particular from their success in having immigrated to a new country. Their ability to overcome enormous challenges in the past provided them with considerable self-confidence in knowing how to survive yet another chapter in their life.

Many of the participants admitted to feeling lonely at times and described their appreciation of their homecare providers, who offered them companionship in addition to personal care. According to one participant (13), her homecare worker took a personal interest in her well-being: “She is so friendly, she says I pray for you when I can’t move.” Another participant (8) related that her relationship with her homecare worker evolved into a very close friendship that made her feel more like a trusted family member: “The maid is like your family, like a sister, a mother”. Their positive experience with homecare services was linked to their ability to converse with their providers in their own language. According to the participants this fostered a supportive relationship and enabled them to be active members of their treatment, which assisted them in coping with their losses. The importance of language therefore emerges as an important factor in their interest in and satisfaction with formal care.
3.2. Fear

The participants also disclosed their many fears, such as their fear of falling, fear of becoming a victim to crime, fear of loneliness and isolation, and fear of losing their cultural identity and of aging.

- Fear of Falling

Most of the participants reported that they were always fearful of falling, especially outside in the wintertime. Although their apartments were modified to reduce the likelihood of falling, they remained afraid because they felt weak and frail. All of the participants had various ailments such as a visual impairment, reduced muscle strength, or a neurological or a cardiovascular disorder that resulted in poor mobility. Some of the participants had previously fallen which made them even more fearful. Although they were fearful of falling when taking a bath, they reported trusting their homecare providers because of their ability to speak to them in their language. According to the participants, the providers caution them to prevent them from slipping. Their fear of falling was also lessened by adaptive aids in their apartment and in the hallways and the facility’s care inside and outside of the facility to ensure residents would be safe, for example, ice and snow removal.

The participants described being especially fearful of falling outdoors during the winter on the ice or snow and as a result, tended to remain indoors. As one participant (13) explained, she preferred to sit indoors during the wintertime because of her fear of slipping on the ice: "I want so much to just sit here ….no, no, I am scared of ice." Another participant (5) explained that she too was fearful of the ice: “I am scared of the ice, it is dangerous for me."
• **Fear of Further Deterioration**

In addition to describing their current physical status, the participants expressed feeling fearful of ongoing physical decline and of requiring more assistance in the future. Although the participants described feeling embarrassed having to use mobility or adaptive aids, they were more fearful of falling without them. As one participant (1) explained, she relied on her walker even when she was cooking: “I cook alone I even did it when I was with one functioning leg. I did it slowly I had the walker and I would slowly move in the kitchen,” whereas another participant (7) reported, she relied on her walker to do her shopping: “The bus comes on Thursday, I take the bus and they help me to put the walker on, they give us an hour to shop, I go with my walker.”

Participants explained that they felt less scared and vulnerable as a result of living in an assisted living facility with other older people like themselves who had similar limitations. Every participant expressed a fear of further deterioration and ultimately being placed in a nursing home. One participant (19) said that being placed in a nursing home would be tantamount to death: “I can’t….., you go over there it looks like your life is finished.” Another (21) explained, "I pray every day. I don't want to go to a nursing home.”

• **Fear of Crime**

The participants expressed fear of becoming a victim of crime as they felt vulnerable because of their physical challenges. They admitted to feeling especially fearful at night and believed the administration should offer additional security. As one participant (4) explained: “the one thing that I don’t like here is that there is no security at night, there is no security here.” They coped with their fears by such means as seeking solace in church, keeping busy with their activities and socializing with other people.
Virtually every participant confessed to fearing for their personal safety as a result of the limited security and poor lighting at night in the assisted living grounds. Their fear of being victims of crime related to their advanced age, functional decline and new living environment. Despite their familiarity with the assisted living facility’s location, it was nevertheless far from former neighbors. As one participant (20) revealed, her former neighbors had looked after her before, which had made her feel safe: “I kept my house for 18 years, my neighbour was like family, very close like a family; we really took care of each other.”

- **Fear of Loneliness and Isolation**

Many of the participants explained that their former interactions with their neighbours also enabled them to feel socially very involved. In fact, a fear of loneliness was a common theme that emerged in the discussions with every participant. Their desire to receive homecare services was very much influenced by their interest in being able to reside at the facility and socialize with other residents. As one participant (7) explained, she welcomed the ability to socialize with other participants by playing bingo: “We play bingo downstairs, two times a week you know.” Still another participant (22) revealed there were always people with whom to socialize in the main area of the facility: “I used to go back and forth but always here in the main area of the building to talk to other people. So where did we leave off?…yeah… the other people come for example to get together and talk and it helps to spend the time.”

- **Fear of Losing their Ethnic Identity**

Their fear of losing their identity is a recurring theme. Many explained that their ability to receive culturally competent services has enabled them to remain connected to their cultural group and therefore less fearful of losing their cultural identity.
• **Fear of Aging**

Their fear of aging is expressed relative to their fear of becoming dependent on others. The participants explained that their older relatives in Italy had been cared for by their parents and as a result had also had their financial needs looked after, in addition to their caregiving needs. The change from previous patterns of caregiving not only created a need for the participants to depend on others for their formal and informal support, but also contributed to their financial hardships. Despite their fears, no participants admitted to fearing death, but reported rather, a fear of suffering when alive.

They also shared their fear of becoming physically weaker and financially unable to purchase any private care or meal preparation assistance. Six participants reported exercising at the facility to keep more physically active in order to avoid any future physical decline. As one participant (7) explained, she appreciated the benefit of having exercise programs available at the facility: “I want to go there to do exercise and some activities you know something so I take, whatever I am going to pay and I go because I want to go out, I do something I don’t want to sit in my chair all day…” Still another participant (13) reported there were many activities available for them: “They have the activities, yeah and we would go in the morning, we have gymnastics….exercise, after we go to the church.”

• **Poverty**

The issue of poverty emerges as a major theme, especially as it relates to their current financial circumstances and their fear of not having sufficient funds to continue living at the assisted living facility. None could afford private care and were consequently dependent on their family members to supplement their need for additional care.
The participants all described their experiences and memories of the Depression and their resultant fear of poverty. One participant (4) explained, “We are old people living with our pension now I am paying $700 and come July I have to pay $710 they’re increasing my rent.” Another participant (24) explained, living on a government pension was proving to be extremely difficult for her: “You know, and the money you know, just with the pension, Canada pension, it’s not lots of money, so they give you a small supplement. Where am I going to get the money? I don’t have enough… they give you eighty-three dollars.”

The participants’ losses, fears and emotional well-being were described in relation to homecare services and reveal their appreciation to deal with their uncertain future by being able to speak Italian, have access to church and Italian resources and forge new friendships with other Italian immigrants. As mature older women, their cultural traditions remain extremely important in the services they receive and in coping with current struggles and uncertain future.

3.3 Emotional Well-Being

The participants spoke about their pride and interest in attending future family events that assisted them in coping with their fears of an uncertain future. Many described their excitement in seeing their grandchildren get married. Their ability to participate in social and family events was an important motivator for them to receive formal homecare services; because of receiving these services, they could conserve their energy and attend these celebratory events.

- Resiliency

The participants credited their religious beliefs in remaining emotionally strong. They claimed that their strong belief in God assisted them in coping with their challenges.

As one participant (12) explained: "God helps me…I pray to him and he gives me strength.” Another participant (21) explained, she was able to remain strong and optimistic about
her future because of her strong religious convictions: “I pray every day, my rosary…faith, they say there are two nuns in Italy (giggles) ….now I relax, I wait when God call us, I pray.”

- **Attitude**

  All 25 participants reported being extremely proud individuals who desperately wanted to be remembered for their overall courage and emotional strength. They displayed a positive attitude and reported being gracious and nice to other people. As one participant (13) explained, it was important to be considerate to others: “Be nice to people and people will be nice to you.” Another participant (20) revealed that it was important to learn how to be self-sufficient and not depend on others. As she reported, it was a lesson she had learned soon after her arrival to Canada, when she had to manage without much help from anyone: “Nobody helped, nobody, immigration didn’t help us.”

- **Appearance**

  All 25 Participants were well-dressed and appeared to have devoted considerable time towards their appearance. They claimed to be extremely conscious about their physical appearance and continued to regularly have their hair done. They all spoke about the importance of their appearance and their need to feel attractive and comfortable when interacting with others.

  The participants’ desire to make a good impression on others and portray themselves positively extended to their embarrassment about their lack of fluency in English. Many attributed having not learned English to raising a family while having had to work full-time, together with always having lived in Italian neighbourhoods and working with other Italian people. One participant (8) explained that because she worked in a factory with other Italian people she never learned how to speak English. Another participant (6) explained, “I don’t speak
English very well because I just stayed at home. I didn’t go to work, just my husband went to work. I didn’t work…”

- **Appearance, Embarrassment and Shame**

Their interest in making a good impression on others was not only restricted to their physical appearance, but was also extended to the appearance of their home. Every participant apologized for the appearance of their apartment and claimed that they were embarrassed that it was not as clean and as well appointed as they would have liked to have kept it. Many described having maintained a former neat, clean, organized home with a kitchen in the basement reserved for cooking so that the upstairs kitchen was always tidy and clean when guests arrived.

They all reported living on meager incomes, some on limited pensions and others on the small amount they had accumulated throughout their lifetime. They explained that their poor financial status impeded their ability to dress more fashionably, or to furnish their apartment in a more contemporary manner. Still, many of the participants took great efforts in trying to represent themselves as strong and self-sufficient and only disclosed their need for some additional formal and informal support when probed. Many of the participants reported feeling embarrassed for having to request additional help from their family members, despite knowing it was readily available.

Many of the participants explained that their embarrassment related to having arrived in Canada in search of better economic opportunities and the irony that they were now living on a meager government pension or on their very small life savings. Every participant reported being embarrassed about having an unclean stove as a result of the lack of cleaning assistance for their stove. One participant (4) explained, “They don’t want me to clean my stove or anything because it is dangerous. However, give me an extra hour then for cleaning. I need these things. I was
always cleaning even when I was younger and I’m old now and not young now.” Another participant (8) explained their homecare workers provided light cleaning only and as a result there was always dust and dirt left behind: “I don’t know…how I see it?….it’s always that, they don’t move the couches, fluff the pillows to get rid of the dust….the stove, the fridge, I’m not saying for them to do it all the time, at least once a year to clean behind, there is dust.” They considered their limited ability to maintain a clean apartment as interfering with their standard of cleanliness and also as a health hazard.

Summary

This chapter provided an overview of the participants and the themes that emerged through the interviews about their experiences receiving culturally specific homecare services through an assisted living facility in Ontario.

The 3 major themes reveal the importance of communication in accessing health care services, the importance of cultural considerations in the provision of care and the alterations to social roles, as a result of immigration, acculturation and the aging process and a resultant need to submit to formal and informal care, as well as fears of an uncertain future.

The participants’ rich descriptions profiled events throughout their life course that included events in Italy, immigrating to Canada and eventually moving to the assisted-living facility. As a result of their immigration to Canada, most had worked while caring for a family, faced language barriers as a result of not having learned English and were also separated from family and friends and were confronted with a new culture while striving to retain their own and eventually struggled with health and age-related issues. Their experiences are also described as they influenced their social identity and interest in preserving their language and cultural practices. Their positive experiences in receiving services were enhanced by their environment,
which included access to food and resources from Italian stores, homecare workers with whom they could converse to in their own language, as well as relate to their cultural practices and beliefs which assisted them in being able to entrust them with their most personal care, such as bathing and dressing. Despite frustrations in receiving limited hours of homecare support, their positive experiences were contrasted with descriptions of prior difficulties in accessing health care services that were virtually void of any linguistic or cultural considerations.

In addition to receiving homecare services, they were receiving informal assistance from family members to supplement their need for additional care. Their financial limitations restricted them from being able to consider private care.

Their Italian culture, immigration and employment history are all factors that have greatly affected them and impact their experiences related to receiving homecare. Their stories reveal the origins of their struggles, their traditions, their unwavering religious faith and their overall contentment in their latter years.

Their ability to receive cultural considerations in the provision of their care emerges as an extremely important factor in their interest to receive services. This finding has several practice and policy implications related to the effects of immigration and acculturation, where altered family roles and caregiving practices have resulted in a need for formal care.

The following chapter provides a discussion of the research findings and offers additional insights into the participants and their experiences.
Chapter 6: Discussion and Implications

Introduction

This chapter provides a discussion of the research findings and review of the study’s contributions to the field of social work, its limitations and implications for practice. Social workers face challenges in providing homecare services for older Canadian immigrants who often experience language barriers and difficulties in accessing much-needed care. The aim of this study was to attempt to respond to gaps in the literature on older Italian immigrants and their experiences in receiving homecare services, in order to inform policies in the provision of services for Ontario's older immigrants that are culturally reflective of their needs.

The issues of identity, culture and language emerge as important factors in the provision of services for older Italian immigrants in Ontario. At the micro level, the findings reveal the importance of the participants’ immigration history and cultural traditions in shaping their preferences for care and at the macro level, the findings reveal the importance of providing care that incorporates the cultural dimensions of individuals and their families. Three major themes emerged: 1. the importance of communication and relationship building in the provision of care and the barriers in accessing health care services, 2. retaining identity and control, and 3. facing an uncertain future. The participants’ stories reveal the origins of their struggles and interest in retaining cultural bonds, traditions and practices in their later years. Their accounts reflect changes to health and social roles leading to their eventual relocation to an assisted living facility in which they received specialized homecare services. Their interest in receiving homecare services relates to their ability to receive culturally competent care that incorporates their linguistic, cultural, and spiritual norms.
The Life Course Framework and Social Identity Theory informed the analysis of the participants’ homecare experiences and their caregiving practices. The Life Course Framework guided the analysis to acknowledge the process of aging and human development as one that continuously occurs across the life span, to profile their early years in Italy and their immigration and adaptation experiences in Canada. Thus linking the multiple life stages of their life through trajectories in time provided a conceptual framework of their struggles, adjustments, and current challenges as they related to their need for homecare services. The incorporation of Social Identity Theory provided additional guidance in exploring their social roles through various stages in their life.

These experiences have been described as altered since their arrival in Canada. The focus of the Life Course Framework on specific key events in time allowed for an examination of the participants’ life transitions (Voyer, 2004), and Social Identity Theory assisted in understanding the cultural influences of their life histories (Day & Cohen, 2000), as well as historical changes that affected their need for formal care. At the core of these transitions, are immigration experiences and alterations to former caregiving practices.

Life changes and transitions, such as marriage, having children, working, retirement, bereavement and chronic illness were discussed relative to their preferences for care.

1. The Importance of Communication and Relationship Building and Barriers Encountered in the Receipt of Healthcare Services.

This section considers the first theme of communication and relationship building and barriers encountered in the receipt of healthcare services. Findings from this study reveal that communication and relationship building in the receipt of care are enhanced through access to linguistically and culturally competent care. This major theme relates to the importance of
cultural and linguistic considerations in the provision of homecare services and the need to incorporate a broader conceptualization of health and aging across the life course.

Findings from this study reveal past linguistic and cultural barriers, resulting in a need for family members to provide translation assistance at medical appointments. The association between the ability to communicate in English and quality of health care services is supported by research linking limited English skills with barriers to healthcare services and dependency on family members for translation assistance (Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003; Ngo-Metzger et al., 2003). Examples include inaccurate interpretations in care (Koehn, 2009) and poorer health care outcomes (Partida, 2012) when relying on friends and family for interpretation.

Findings from this study reveal a supportive relationship with providers as a result of the program’s inclusion of language and cultural considerations. This finding supports earlier research, that an awareness and understanding of cultural traditions and beliefs is associated with better client provider relationships (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003; Butcher & Buckwalter, 2002; Campinha-Bacote, 2002; Dreher & MacNaughton, 2002 Purnell, 2000; Shapiro, Hollingshead & Morrison, 2002). Evidence shows that immigrants often experience language and cultural barriers when receiving care (Casado, Negi, Hong, 2012; Health Canada, 2002; Hyman & Guruge, 2002; Kirmayer et al., 2007; Zanchetta & Poureslami, 2006), and that ethnicity influences cultural preferences for care (Matsuoka, 1999). Factors such as lower educational, social and socioeconomic status are associated with poorer access to healthcare services (Lasser, Himmelstein & Woolhandler, 2006). In addition to language, former lifestyles and continuity of cultural practices have been shown to influence health behaviors (Van Dijk, 2004).
The results from this study also suggest that establishing a supportive relationship with providers and feeling respected is an important factor in receiving care (Olaison & Cedersund, 2006), and relates to the individual being an active and equal member of the treatment plan (Duner & Nordstrom, 2007).

On a micro level, workers who display intricate knowledge of their clients' family values can develop effective relationships. Older adults prefer to be actively involved in decisions related to their care rather than passive recipients, whereby decisions are made for them (Aronson & Neysmith, 2001; Gantert et al., 2008; Sciegaj, Capitman, & Kyriacou, 2004). On a macro level, knowledge about contemporary society provides a level of interaction that reflects understanding clients and their cultural variations (Essén, 2008).

Moreover, supportive relationships with older adults are promoted when providers respect their need for independence and autonomy. Ethical dilemmas arise when providers confuse physical impairments with cognitive ability, thereby impeding the right to self-determination and free choice (Bowker & Tuffin, 2004; Minkler et al., 2002; Linzer, 2002). The right to autonomy and self-determination is based on the ethical imperative that individuals with cognitive ability and decisional capability are able to exercise their right to free choice (Egan & Kadushin, 1999).

Furthermore, the literature has found that formal care recipients are often able to trust and establish supportive relationships with their providers (Muncey, 2002) when they regularly work with the same providers (Duner & Nordstrom, 2007; Olaison & Cedersund, 2006). In contrast, brief encounters have been identified as barriers to establishing trust (Gantert et al., 2008; Porter & Jones, 2000). Unrealistic measures of homecare need and consumption patterns can be affected by poor understanding among healthcare providers about the specific needs of
immigrant populations (Porter & Lasiter, 2004) and the effects of acculturation on the need for services (Gushulak, 2007). Language, linguistic and cultural considerations, as well as consistency in the provision of care, need to therefore be considered when assigning services.

In addition to cultural and linguistic factors, race, gender and class, affect the receipt of healthcare services whereby inaccurate assumptions and generalizations about cultural groups can affect access to vital services. For example, a lack of communication that can lead to misinterpretations of cultural specific interpretations of illness has been found to lead to inappropriate referrals for medical care (Koehn, 2009). There is evidence in the gerontological literature of ageist attitudes among providers which contribute to older adults being marginalized (McKenna, 1997) and receiving less preventative care, or ignored or dismissed due to the chronic nature of their complaints (Magnan, 2001).

Findings from this study indicate that the need for formal and informal care was associated with functional loss and difficulties living alone. This is consistent with earlier research which found that functional loss and resulting disability (Boerner & Wang, 2010), associated with advanced age often result in a greater need for assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) (Chen & Wilkins, 1998). Furthermore, the initiation of homecare support is usually delayed until physical impairments become too difficult to manage (Kadushin, 2004). Individuals who live alone are more likely to require assistance (Carriere, 2006).

Women tend to lose their functional independence prior to men and are more likely to experience difficulties, with the greater probability of being disabled in their lifetime, as a result in part to women living longer than men. A loss of mobility usually occurs first, followed by difficulty with reaching and a loss of hearing, vision, dexterity and cognition. Lower extremity
problems typically occur prior to upper extremity problems, resulting in difficulties with weight-bear, climbing stairs, bending or carrying heavy objects. Individuals are also likely to lose their ability to engage in IADLs such as taking transport, driving and cooking (Seidel et al., 2009).

Findings from this study reveal a limited entitlement to homecare assistance and a lack of funds for private care, resulting in family members still providing the bulk of care for older relatives. The reliance on informal support was in part created by cutbacks in formal homecare services and decreased institutionalization. This is consistent with earlier research which revealed that family members provide informal care for older relatives as a result of the current emphasis on cost containment (Hollander, 2006), which has resulted in fewer healthcare resources such as nursing staff, interpreters and hospital beds (Anderson et al., 2007).

Use of publicly funded homecare services in Canada has been affected by long waiting lists for admission, linguistic and cultural barriers, high employee turnover rates and limited homecare hours. Despite these shortcomings, Canada continues to refer more people for publicly funded homecare services on average, than most other countries (Macadam, 2004). .

Lower homecare use in jurisdictions such as in the United Kingdom, in Japan and in Australia, compared to that in Canada and in the United States (Macadam, 2004), is in part related to differences in living arrangements of older adults. For example, in Japan greater numbers of older adults live with their adult children compared to other countries. In 1997, 50 percent of older adults lived with their adult children compared to 10–20 percent in these other countries (Anderson & Hussey, 2000).

The literature reveals that 75-80 percent of homecare use in Canada is utilized by individuals over the age of 75 who reside alone and experience health care problems (Markle-
Reid et al., 2008). Individuals who lived alone relied more on formal support than did individuals who lived with their families. In 2001, less than 10 percent of women over the age of 65 and five percent of men in this age group resided in long-term care facilities, with the vast majority of older adults over the age of 85 living in the community. One million Canadians over the age of 65 were living in the community, and dependent upon formal and/or informal support. (Cranswick, 2003).

The literature reveals differences in health care utilization rates in urban and rural areas of Canada (Kitchen et al., 2011). Ontarians in rural areas are more likely to depend on informal support than on formal nursing care, compared to those in urban areas. Older women, especially widows with lower incomes and poorer functional health status are more likely to utilize homecare services (Kitchen et al., 2011).

Because acute hospital and physician services have been prioritized over long-term care, activities such as feeding, cleaning, laundry and cooking, have been classified as nonmedical care, placing additional pressure on families to provide informal care or finance private care (Armstrong & Armstrong, 2005). The existing literature points to spouses being the most common providers of informal support, with children likely to offer assistance in the absence of a spouse (Cranswick, 2003).

The literature confirms a growing reliance on private and informal support in Canada to supplement the need for more care, as a result of ongoing budget cuts to public healthcare services (Keefe & Fancey, 1999). In 2002, 39 percent of women and 46 percent of men received assistance through informal sources. Many older adults over the age of 80 lived in the community and depended upon assistance from family members and friends for their activities of daily living, such as bathing, dressing, eating and for assistance with instrumental activities of
daily living, such as shopping, banking and transportation (Wodarski & Williams-Hayes, 2002). Women were more likely to provide this informal support than men (Dally, 2004) and to provide assistance for activities of daily living, whereas men were more likely to assist with instrumental activities such as yard work and financial management (Wodarski & Williams-Hayes, 2002).

Findings from this study suggest that unavailable private care is associated with financial difficulties, whereby the fear of poverty is greatly affected by recollections of past experiences, such as during the Great Depression. The research indicates that many older adults face income, housing and social welfare concerns in their retirement years (Brotman, 1998; Dorazio-Migliore, et al., 2005; Laird, 2007; Saraswati: 2000; Smith & Ley, 2008) with older women emerging as especially vulnerable (Coulter, 2009; Dholakia, 2003; Sampson, 2007) because of their longer life expectancy and financial need, which are linked to higher morbidity and mortality risks (Andrews, 2008).

Older adults often rely on income from investments, pensions and government transfers, including Canada Pension Plan (CPP), Old Age Security (OAS) and Guaranteed Income Supplement (GIS). Older adults residing with family members tend to have a higher individual income level (Markle-Reid et al., 2008). Older individuals aged 75 or older that live alone and do not have sufficient funds to meet their expenses for the duration of their retirement years, face higher morbidity and mortality risks (Markle-Reid et al., 2008). This finding points to Canada's health care policies that prioritize the reduced healthcare expenditures, rather than the financial and caregiving support of older adults with chronic care conditions (Aronson, 2002; Aronson & Neysmith, 2001; Mosoff, 1999).

Budgetary cuts to homecare services have prioritized medical care and cost-efficiency (Aronson, 2004), rather than the importance of socialization for older adults (Aronson &
Neysmith, 2001). This barrier to care calls into question Canada’s “Medicare” program, which when initially introduced, favoured five core principles: universality, accessibility, portability, public administration and comprehensiveness (Deber, 2002; Whiteside, 2011).

Canada’s population of 31,612,897 in 2006 reflected a 5.4 percent increase since 2001 that was greatly attributed to net international immigration, with 18 percent 65 or older, compared to 11 percent Canadian born (Zheng & Hart, 2002). It has been predicted that life expectancy in Canada will likely reach the age of 82 years for males and 86 years for females by the year 2031, with a corresponding increased demand for homecare services (Martel, Bélanger, & Berthelot, 2002). As a result, governments, policymakers and health care providers will be increasingly challenged to develop appropriate health and social services for Canada's ethnic and racially diverse populations, taking into account their cultural preferences for care (Willgerodt & Killien, 2004).

To summarize, findings from this study suggest that the effects on the care of older adults of recent reductions in health care expenditures with the associated emphasis on community care must be understood. The current emphasis on cost containment to health care services has created a vital need to consider ethnic and racially diverse populations and their cultural preferences for care (Willgerodt & Killien, 2004) to reliably predict their need for formal care and create strategies to assist families in providing informal support. Prior recommendations for a national homecare program and a common framework and terminology (Lang et al., 2008) that could be shared among provinces and territories (DiCicco et al., 2003) should be considered in order to provide additional assistance in furtherance of these goals.
2. Retaining Identity and Control

This section considers the second theme of retaining identity and control. As a result of major events and transitions, such as immigration, marriage, retirement, parenthood, widowhood and physical challenges, a renegotiating of self occurred, from independent to dependent and in need of assistance.

Central to the discussion of homecare services, is the issue of culture and the important factors such as membership to one’s social group, whereby strong connections to family and friends reveal the importance of culture, housing, spirituality and socialization in the context of receiving homecare services.

Findings from this study emphasize the importance of identity as it relates to the geographical setting of the home in which services are received. There is support in the literature of former homes and neighborhoods being linked to the physical, social and psychological dimensions of care and residential history (Hulchanski, 2007). Home ownership for both native born and immigrants has been shown to be affected by socioeconomic factors, such as income, education, employment, marriage status and family composition (Constant, Roberts & Zimmermann, 2009).

The literature on home ownership reveals its importance for Italian immigrants whose rates of home ownership in Canada have been higher compared to native born residents (Ben-Amar & André, 2006; Constant, Roberts & Zimmermann, 2009; Haan, 2005). For example, by the 1980s, 86 percent of Italian immigrants owned their own home, versus 70 percent of native born Canadians. In 1996, homeownership rates were 68.2 percent for immigrants, compared to 63.9 percent for native born residents. Higher rates among immigrants are usually tied to their interest in remaining in Canada, income, household size, length of time in Canada and the
availability of affordable housing (Edmonston, 2004). The Italian home served to provide a connection to the participants’ past, which included sharing cultural practices and beliefs with family members and friends. The purchase of a home signified an investment in their financial future, and commitment to a new life in Canada (Edmonston, 2004).

Findings from this study of lifecycle events such as marriage and the arrival of children were linked to the acquisition of a home, whereas the sale of a home usually followed the loss of a spouse. This finding is supported by the literature that has shown that the loss of a spouse usually results in the sale of a home and relocation to an alternate residence due to poor physical health and old age (Gyimah, Walters, & Phythian, 2005).

The findings from this study reveal the importance of identity in receiving services and retaining connections to family, friends and the community. This is consistent with earlier research that has shown that feeling attached to one’s residence and community, is an important factor in the receipt of services (Dale, Söderhamn & Söderhamn, 2012) and is positively linked to an identity and feelings of control (Theodori, 2001).

Evidence indicates that older adults must negotiate their sense of self, after moving to an assisted living facility. A move to an assistant living facility often follows a loss of health or loss of a spouse, which necessitates assistance with activities of daily living. More often, a move is usually prompted by the individual's inability to maintain their former residence, the person’s need for personal care along with a desire to live in the community while avoiding or delaying institutionalization (Chen et al., 2008). The literature has indicated that following the move to an assisted living facility, individuals strive to retain their sense of self. In addition to the lack of privacy, the change in social roles creates the need for individuals to re-evaluate their sense of
self (Perkins et al., 2012). More often, individuals struggle with their need for independence, while having to submit to long-term care (Perkins et al., 2012).

The findings from this study suggest that individual identity and control were retained, after relocating to the assisted-living facility through recollections of the past, with pictures and memorabilia re-creating aspects of the former home. There is support in the literature for the importance of individuals redefining aspects of the self, whereby the meaning of “home” reflects the individual’s ethnic, social and cultural traditions and beliefs (Rowles & Chaudhury, 2005).

The findings from this study also point to the importance of cleanliness in the home as a way to remain in control of personal space. This finding is consistent with Social Identity Theory and the gerontology literature, suggesting that individuals feel empowered in a new place of residence when they feel engaged and in control of their environment (Knight, Haslam & Haslam, 2010).

The literature reveals that the Italian home in Canada that included two kitchens represented a high standard of cleanliness, control, privacy and organization in order to maintain formal appearances when entertaining, associated with the cultural practice of “fare la bella figura” thus making a good impression. The decorated upstairs for entertaining was an indicator of wealth and immigration achievement. The literature notes its historical origin dating back to 19th century Italy when the spatial segregation of homes included separated kitchen/food preparation areas to protect guests from odours associated with food preparation (Pascali, 2006). This finding highlights the cultural importance of the home in defining individuals (Pascali, 2006). Social workers and other health care providers should be alert to the symbolic attachment of the home and its special cultural meanings. Strategies to define professional boundaries must consider individual privacy and control over living space (Martin-Matthews, 2007).
Emerging from the data is the importance of retaining their identity, as it relates to the cultural practice of family involvement in the care of older relatives. The study findings reveal strong bonds to family members, despite changes to patterns of caregiving in both Italy and Canada. This is supported by the gerontological literature (Williams, 2001) which suggests that in Italy, caregiving was provided on an informal basis predominantly by women, whereas upon arrival to Canada, women worked outside of the home and had to balance work with family responsibilities.

The retention of cultural values and traditions includes the importance of filial norms that results in an expectation for the family to provide ongoing informal support to older relatives (de Valk, & Schans, 2008).

Caregiving has been shown to be influenced by cultural norms, whereby cultural dissonance associated with younger generations departing from traditional practices may challenge caregiving expectations (Koehn, 2009). The construction of older age in Western society is affected by ageist attitudes and beliefs (Sampson, 2007) with independence reinforced, thus often making it difficult for older adults to request help because of the embarrassment (Koehn, 2009; Motenko & Greenberg, 1995).

Findings from this study reveal a preference for the participants to reside on their own and depend, on sources of informal and formal care, rather than living with adult children. Such reliance on family members for additional care is considered to be an imposition on children who work and is very different from the former practice of older relatives living with and being cared for on a full-time basis by children. The expressed preference to live alone corresponds to adult children’s lack of availability on a full-time basis as a result of the need to work full time. Furthermore, the availability of informal support is greatly affected by the location where family
members reside (Hallman, & Joseph, 1997) and by the emotional attachment and quality of family relationships.

The life course perspective provides additional guidance in appreciating the temporal qualities of family roles, whereby alterations in roles occur over time, such as a role reversal in which a child becomes their parent’s caregiver (Elder, 1987). Older adults may be affected by declining health as they age, which can result in reversing roles, from former caregiver of children and grandchildren to recipient of care. The family is thus confronted by major adaptation challenges requiring reorganization and adjustment. The reversal in role and status from self-sufficiency to dependency and need for assistance, has been shown to contribute to considerable inter-generational tension and shame among families (Koehn, 2009). More often, older adults worry about becoming a burden to their family (Walsh, 2012).

The literature supports this finding (De Rait, 2007) and indicates that changes to previous caregiving practices, due to globalization and neoliberalism have challenged traditional forms of caregiving, by emphasizing the accumulation of wealth (Epps & Flood, 2002; Fook, 2002), rather than nurturing caregiving behavior of older adults. Neoliberalism originated in the 1960s prioritizing and rewarding individuals that are financially and physically independent. In contrast, those that are disabled, old or in need of financial and personal care are seen as depleting economic resources. The provision of care is conceptualized and equated with dependency (McDaniel, 1999; Sampson, 2007) whereby the need for help is viewed negatively, thus making the need for help required by older adults embarrassing and difficult to request (Motenko & Greenberg, 1995). More often in North America, expectations are that ethnocultural groups will willingly provide informal support. Such expectations stem from assumptions about close family relationships, cultural traditions revering older adults and innate caregiving skills.
(Dorazio-migliore et al., 2005). Such assumptions and expectations often result in inaccurate predictions for care (Koehn, 2009) with a corresponding decrease in the older adults’ entitlement to much-needed homecare services (Brotman, 2002; Wiles, 2005).

The findings from this study reveal an inability to spend considerable time at their children’s homes because of such factors as the many stairs to climb, the lack of grab bars, and insufficient lighting, all of which makes their homes inaccessible. Such issues have been identified in the literature, whereby families are confronted with the need to provide care in homes that are physically unsuitable for caregiving (Peter et al., 2007). Unlike the hospital setting that has been designed to provide healthcare services, the home is often ill-equipped for such services (Lang et al., 2006; Peter et al., 2007).

The study results identify health and economic barriers to retaining control, such as a lack of funds to hire private care, and reliance on informal care to supplement the need for additional support. This finding is confirmed in the literature that has shown that informal support continues to be an extremely important source of assistance for older Italian family members (Aranda & Knight, 1997). Although portrayed as a close-knit group that values the family, there are degrees of cultural assimilation in Canada and resultant changes in living arrangements and patterns of care. These alterations often include women’s participation in the paid workforce, making them unavailable to provide full-time caregiving for older relatives (Kausar & Wister, 1984).

This finding points to the importance of the family and the need to offer strategies to assist in the provision of this much-needed care. Homecare services should be tailored to encourage the cultural practice of family involvement and participation in providing care.
Findings also highlight the alterations in caregiving patterns and the need to better understand the role of caregiving and family norms and values in providing caregiving for older adults.

The findings from this study reveal that in addition to being able to communicate with providers in Italian, the incorporation of cultural practices such as attending church services into their care was positively associated with an interest in receiving formal care. The literature supports the importance of language in constructing identity and the adherence of cultural practices and traditions. Canada's linguistic profile reveals that 18 percent of Canadians identify Italian as their first language (Dib, 2001). Moreover, ethnicity has been shown to influence cultural preferences for care and language, along with former cultural practices influence health behaviors and outcomes (Van Dijk, 2004). Ethnic identity is related to how individuals perceive their own cultural identity relative to others. External aspects include observable behaviours such as practicing cultural traditions, speaking a particular language and participating in cultural activities, whereas internal aspects comprise subjective perceptions and feelings. A strong ethnic identity has been associated with a positive self-image (Lai, 2012).

An individual's identity is affected by life events such as bereavement, retirement and relocation, as well as ethnic background, gender, class, health and financial status. Ageist views of older adults as frail and incompetent may impede their ability to overcome and transcend these effects. Older adults are more likely to retain the attitudes and cultural traditions acquired during their formative years, although interpretation of life events may often be influenced by historical events, such as immigration or the 1930s Depression (Arber & Evandrou, 1993).

The findings from this study reveal that feeling a bond to other residents and staff, based on a shared history, language and cultural traditions enhanced their ability to retain their cultural identity. There is support in the literature that the construction of identity among older
individuals relates to the process of defining oneself within a broader social context, whereby individuals identify themselves in relation to others, which is affected by factors such as health (Tajfel, 1981).

Identity development evolves through identification with a broader social context. An ethnic group comprises individuals who share a common history and origin and that maintain a connection to one another by sharing cultural customs and practices such as language, music, cuisine, literature, dress and art. An individual's involvement and practice of cultural traditions has been identified as a positive strategy for coping with discrimination and life's challenges (Umaña-Taylor, Yazedjian & Bámara-Gómez, 2004) and has been positively linked to well-being (Sharma & Sharma, 2010). This is consistent with Social Identity Theory (Tajfel, 1981), suggesting that an individual's identity is developed based on their attachment to a particular group (Amiot et al., 2007).

Identity formation was also considered by Erikson, whose theory of ego identity formation stresses the importance of exploration and social interaction. An individual’s identity evolved (Umaña-TaylorYazedjian & Bámara-Gómez, 2004) through eight stages of development: basic trust versus mistrust, autonomy versus shame, initiative versus guilt, industry versus inferiority, identity versus confusion, intimacy versus isolation, generativity versus stagnation and integrity versus despair (Erikson, 1959). The process of identity formation was further explored by existential philosophers such as Heidegger, Jaspers, Kirkegaard, Camus and Sartre, who examined the human condition in relation to concepts of freedom, meaningless, isolation and death. They theorized that individuals exercised free will and sought out others in deriving meaning to their life (Strang et al., 2002).
Individual identity has also been shown to be influenced by age related changes, such as external visual cues of graying hair, stooped posture, baldness and frailty, whereby age is used to categorize and socially locate individuals (Williams & Garrett, 2002). Further, identity is linked to historical meanings, as defined by cultural values and norms. The construction of self is linked to an individual’s social identity and personal history (Tajfel & Turner, 1986). Immigrants often associate with members of their own ethnic group when having to confront a new culture, as these connections with members of their own community facilitate adaptation to the host environment (Nesdale & Mak, 2003).

Issues related to identity have also been informed by poststructuralism in which discursive theories of identity have enabled researchers to better understand the effects of language, or discourse on shaping individual conceptualizations of identity. According to Foucault, individual identity was affected by circumstances, rules and ideas, and by the cultural and historical context within a given time. Foucault argued that discourse was used to connect knowledge and power with identity, and argued that individuals were capable of negotiating their own identity (Mackey, 2007). Foucault spoke about the self as motivated by self agency, yet affected by the historical and discursive forces in an individual's life (Zingsheim, 2011). For example, discourse used to describe "old age", was based on sets of rules imposed by those in power (Powell & Khan, 2012). Moreover, the subjective experience of aging would alter the evolution of an individual's identity over time. Thus the relationship between the individual and his/her identity becomes radically changed throughout the life course as a result of internal and external factors (Zingsheim, 2011).

The findings from this study reveal multiple identities throughout the life course such as child, adult, parent, employee, grandparents and older adult and a preference to remain
autonomous while receiving care. This finding supports the gerontological literature, that older adults often amass multiple identities throughout the life course (Sundsli, Espnes & Söderhamn, 2013), and relates to fostering autonomy in the provision of services, to promote self-care and independence (Sundsli et al., 2013).

The findings from this study also reveal that offering homecare providers and family members, beverages and food, enable individuals to feel more in control and less embarrassed about their need for care. This finding finds support in the literature with respect to a link between an individual’s ability to reciprocate for help and feel less embarrassed about the need for assistance (Porter et al., 2000). In addition to feeling less embarrassed about the need for help (Gantert et al., 2008) social exchange theory posits that certain norms and rules of exchange such as reciprocity occur in relationship building and contribute to trusting and loyal relationships (Cook, Cheshire, Rice & Nakagawa, 2013).

These findings demonstrate the importance of the home and cultural factors in influencing receiving homecare. The significance of reciprocity and the right to autonomy should be acknowledged by permitting older adults to demonstrate their appreciation for their care (Arber & Evandrou, 1993; Porter et al., 2000). Cultural competence training should be highlighted in future homecare reforms (Stommel et al., 2005) with individual beliefs, language, self identity and customs in the home to be acknowledged and understood (Koehoorn, Lowe, Rondeau, Schellenberg & Wagar, 2001).

Research findings also reveal the importance of cultural identity as expressed by affiliation with other Italian immigrants whereby ethnic solidarity is considered significant in an individual's ability to remain emotionally strong and connected to cultural customs and traditions. This research finding is supported by the literature that reveals a link between group
membership and higher self-esteem and identifies group membership as being psychologically beneficial for individuals (Masi et al., 1993). This is in contrast to Disengagement theory which posited a mutual withdrawal of older adults from society. Rather, the more recent Activity theory argues that older adults prefer to remain socially engaged and actively involved (Cumming & Dale, & Söderhamn, 2012).

The gerontological literature reveals that older adults develop social ties in assisted living facilities as a way of retaining their identity and reconstructing their social networks (Park, Zimmerman, Kinslow, Shin & Roff, 2012). Social engagement includes emotional and social connections to people and positively influences individual health and psychological well-being. Social ties change throughout the lifecycle, as a result of life changes. According to socioemotional selectivity theory, older adults become more selective in developing quality relationships due to being selective with their remaining time. The selective optimization with compensation posits that older adults restructure their social network within their physical ability by compensating for their physical limitations. The assisted living/supportive housing is a relatively new component of care in Canada that promotes congregate living and social engagement, with a focus on independent living and provision of supportive services for older adults (Hollander, 2006).

This finding relates to the importance of geographical location and proximal social supports to enable older adults to retain social contacts (Walters & Bartlett, 2009).

Research findings also point to the construction of identity based on former roles in the workforce. The literature highlights the influx of many Italian immigrants (Edmonston, 2004) whose contributions to the labour force were evident in the construction industry, factories, the textile industry and retail market. Factors such as education, language and age affected their
ability to secure employment, with many securing employment through relatives or friends and working with other Italian immigrants thus enabling them to converse in Italian and retain social bonds (Giampapa, 2001; Sturino, 1984). Despite their involvement in the paid workforce, the literature reveals that older women often struggle financially to meet their expenses for the duration of their retirement years because of their longer life expectancy (Andrews, 2008).

All of these findings underscore the importance of a culturally supportive environment that acknowledges individual identity and life histories in the provision of care. In the climate of health care reform and cost containment, social workers and other healthcare providers must consider immigrant populations and the environment as a positive resource in the provision of homecare services. Social workers can assist older adults by being alert to their concerns (Moneyham & Scott, 1995). Their representation could include advocating for the inclusion of cultural considerations in the provision of care, to facilitate their ability to “age in place”.

3. Facing an Uncertain Future.

This section considers the third theme of facing an uncertain future that relates to the effects of loss, fear and resiliency in the receipt of services. Western culture values certainty and predictability of outcomes, with resulting uncertainty of the future associated with stress and psychological distress. Perceived uncertainty of the future, is a cognitive state associated with a lack of sufficient information to accurately predict outcomes (McNulty, Livneh & Wilson, 2004).

A major loss described is that of a spouse, and is supported by the literature that reveals in addition to sorrow, changes to residence and pre-existing social networks often occur (Bess, 1999; Eisenbruch, 1984). It appears that widows seek out other single women usually through their religious or volunteer organizations. There is acknowledgement in the literature of the
importance of social networks in providing emotional support for individuals during difficult times, which is linked to better emotional and physical health (Hutchinson, Yarnal, Kerstetter & Staffordson, 2008).

Also identified is an association between income levels and loss. Individuals with lower income levels often experience greater difficulty recovering, than those with access to more funds (Hira, Rock & Loibl, 2009). The importance of financial, social and cultural independence is supported by the literature whereby older adults’ identity is positively influenced by their ability to live independently and have access to transportation and income (Dale et al., 2012).

It is important for healthcare providers to recognize sources of grief and loss, especially if the process becomes prolonged and harmful to the individual (Harwood, 2005). The term grief is derived from the Latin word "gravare" and means to cause sadness or distress and is triggered by a loss. Loss has been described as that which follows the absence of something dear or as a deprivation of being without (Reed, 2002). A loss is often accompanied by feelings of sadness and grief. Grief can be caused by various sources such as the loss of a residential location, a change in household membership, the death of a loved one or the loss of a role in life. Whereas loss refers to having lost something, bereavement is defined as a loss resulting from the death of a person (Pomeroy, 2011).

Kubler Ross (1993) described five stages of grief that follow a loss from death: denial, anger, bargaining, depression and acceptance. In the first stage, denial, individuals have difficulty accepting the loss. The second stage includes anger about the loss and the third stage involves bargaining and relates to the individual's process of bargaining and questioning their life, whereas the fourth stage relates to the individual's feelings of sadness and depression, followed by the fifth and final stage in which there is acceptance and resolution of the loss.
According to Kubler Ross (1993), most individuals experience some degree of these stages but not necessarily in any sequential order.

Although every individual experiences grief uniquely, there are cultural variations. Moreover, an individual may experience prolonged or abnormal grief reactions which may delay the outcome of grief (Dunne, 2004). Whereas grief is considered normal, traumatic grief or prolonged grief disorder is described as a condition in which there is a dysfunctional or pathological grieving process with the individual ruminating and obsessing about the person and presenting with feelings of guilt, anger or disappointment about the loss (Shear & Mulhare, 2008).

The loss of a spouse can result in depression, suicidal ideation and functional physical decline and can be particularly difficult for individuals that are childless. There are noted differences in the literature in how widowers and widows respond to bereavement. There are higher rates of mortality and morbidity associated with the loss of a wife. There is evidence that a woman is more likely to establish new social contacts and to be able to cope better than a man (Chou & Chi, 2000; Möller-Leimkühler, 2003).

The results of this study indicate the need to tailor services whereby older adults have ample opportunities to express their fears and challenges. Social workers must be alert to the symptoms of grief in order to provide support to those experiencing loss. It is important to identify individuals who may have difficulty expressing their emotions, for example, other cultural groups in which the display of grief is not encouraged (Read, 2002) or language barriers that may impede individuals’ ability to express themselves. Social workers are well equipped to recognize signs of grief and develop treatment options to assist individuals and their families in
dealing with their losses, developing policies in dealing with loss and addressing palliative and end-of-life issues (Pomeroy, 2011).

The findings from this study reveal a search for meaning to life’s challenges that included recollecting immigration struggles. This finding is supported by the literature. Tornstam’s theory of Gerotranscendence, introduced in 1989, offers guidance in understanding the process of self-exploration in which older adults often engage. This is considered the final process of maturation, at which time individuals reevaluate their life choices and relationships. The process involves more desire for solitary activities, with less emphasis upon materialistic pursuits. Individuals seek meaning for their life accomplishments. This process of introspection is thought to result in greater awareness about the meaning of life, an ability to better cope with death and greater life satisfaction (Tornstam, 2011). During this process of redefinition of self, individuals question their past accomplishments and current life goals and may feel a sense of urgency to complete remaining tasks in life. The quest to find meaning offers an opportunity to transcend the immediate present, to consider aspects of the past and as a result, to better respond to challenges of the future (Malette & Oliver, 2006).

The findings from this study indicated the importance of regular physical activity, cognitive reframing strategies (Horowitz & Vanner, 2010), socializing with family and friends (Gillen & Hunter, 2009; Hendricks & Hatch, 2009; Horowitz & Vanner, 2010; Park, Jennings, Shin, Martin & Roff, 2010) and the importance of spirituality and religious beliefs in coping with losses.

There is evidence that older adults often reconcile the multitude of their losses by seeking solace (Bickerstaff, Grasser, & McCabe, 2003) in their religious and spiritual affiliations (Bickerstaff et al., 2003) that have been linked to positive outcomes in coping with stressful life
events (McNulty et al., 2004). The literature (Gall et al., 2005; Michael, Crowther, Schmid & Allen, 2003) reveals that Roman Catholicism is the prevailing religion in Italy and that immigrants retain their affinity for their religious practices even after immigrating to a new country (Palmisano, 2010). The research data reveal strong spiritual and religious beliefs as enabling individuals to remain positive about their future. Nursing and palliative care literature has considered the importance of spiritual and existential effects on the healing process. Spirituality is defined as that which provides life and breath and assumes a deeper meaning for both religious and nonreligious individuals (Strang, Strang, & Ternestedt, 2002).

The evidence stresses the importance of the spiritual dimension that assigns a purpose and meaning to life rather than only a religious belief. Religion refers to a belief, tradition or worship that connects individuals who share the same views. It embodies a cultural component, with common norms and behaviour practices. Religion encompasses spirituality while providing a set of beliefs and practices to enable individuals to connect to their spiritual self (Strang et al., 2002). Prayer and religious participation have been linked to lower levels of depression and have been shown to be good sources of social support that have been linked to lower morbidity and mortality levels (Aldwin & Gilmer, 2004). This finding has implications for clinical practice in incorporating cultural and spiritual practices in the provision of care, to assist coping with losses and enhancing overall health (Koenig, George, Titus & Meador, 2004).

Also surfacing were fears related to such issues as falling, being a victim to crime, aging, further physically declining and relocating to a nursing home, as well as fear of losing one’s ethnic identity. According to the gerontological literature, fears are a normal part of adaptive reactions to real or imagined threats. Moreover, age-related stressors, such as declining health,
have been associated with fears related to falling, income, housing and social welfare concerns (Dorazio-migliore et al., 2000).

The research findings reveal that a fear of falling is especially problematic in the wintertime. According to the literature, approximately 30 percent of individuals over the age of 65 are at risk of falling in the community, which is even higher among individuals who are institutionalized. On average, most falls are likely to occur in the home environment and are associated with risk factors such as cognitive and visual impairment, chronic illness, impaired balance and gait, advancing age, postural hypertension, the use of medication, neurological or musculoskeletal impairment and environmental hazards (Murphy, 2002).

Falls are a leading cause of disability and even premature death (Gillespie et al., 2003) and usually result in 40 percent of nursing home admissions (Murphy, 2002). In addition to the physical effects of falling, many individuals become afraid of future falls (Hatch, Gill-Body, & Portney, 2003). The study findings point to the importance of language, in the receipt of personal care, such as bathing, where a fear of falling is lessened by an ability to communicate in one’s language.

A fear of crime is also cited in the research that has shown that older people are often fearful of becoming victims of crime, as a result of their advanced age and functional decline. Older women have reported feeling more vulnerable than older men, often because of past experiences of harassment or victimization (Pain, 1995).

The research findings also suggest that a fear of losing one’s ethnic identity and connections to the community is common with advanced age and relocation to an assisted living facility. Ethnic identity has been described as the retention of cultural values, practices and traditions. The Italian ethnic identity includes the use of the Italian language, social interactions
with other Italian people and typically practice of the Catholic religion. Italian people in Canada have continued to practice their religion and speak Italian in their homes, despite their ability to speak English, French or both. Canada's linguistic profile reveals that 18 percent of Canadians identify Italian as their first language rather than English or French (Dib, 2001). They have also lived in Italian residential areas in which their strong cultural beliefs are preserved (Laroche et al., 1998).

The study findings also reveal a fear of aging, mostly as a result of society’s negative perceptions of older people. The literature supports this finding and reveals that societal fears about aging have been linked to the effects of "ageism" that have resulted in discrimination and misunderstanding of older individuals based on their age (Butler, 1969). Ageism is prevalent in Western society and is often evident among healthcare providers, in the workplace and in society at large. Health care providers have often been criticized for ignoring or dismissing the chronic complaints of older adults and for focusing instead on the acute health care problems of younger patients (Magnet, 2001).

In Western culture, women are particularly influenced by the social construction of age as portrayed in the media as something to be feared, which in turn influences their interpretation of themselves (Sobh, 2008). Cultural standards of attractiveness are internalized over the life course and are retained by older women, whose evaluation of themselves is interpreted relative to their self perception (Altschuler & Katz, 2010).

Findings from this study suggest that cultural standards of body image and attractiveness affected services. Descriptions of being “wrinkled,” “old” and “unattractive” are incorporated into disclosed fears of becoming more frail and weak. Their cultural practice of "fare la bella figura" (Moss, Cogliandro, Pennacchini, Tambone & Persichetti, 2013), referring to wanting to
make a good impression on others, is linked to an association of body image with self-worth and interpersonal relations (Brint, 1989).

Their interest in making a good impression on others by appearing, strong, successful and independent is also contrasted with their ongoing need for personal care. Individuals who emphasize the importance of their appearance are more likely to be sensitive to interpersonal feedback, whereby negative feedback will result in poor affect and decreased self-esteem (Forand, Gunthert, German, & Wenze, 2010).

Older women with impairments have been shown to be more prone to perceive their physical challenges in a negative way especially when affected with mobility and coordination impairments (Taleporos & McCabe, 2002).

Although, the issue of body image is typically considered regarding adolescents and younger adult women, there is support in the literature to indicate its relevance for older women as well who may often display dissatisfaction with their appearance and present with a distorted body image based on years of prior social conditioning.

An individual's emotional well-being is especially affected by cultural attitudes towards aging. The high value placed on Italian women's appearance, for social acceptance (Moss et al., 2013) highlight the importance of recognizing older adults’ concerns about appearance and body image as it affects social avoidance (Moss et al., 2013) and suggest that an individual's self-esteem is affected by current homecare policies, where restrictions in bathing are particularly humiliating and embarrassing especially with the heat and humidity of summer. The ability to make a good impression on others is especially difficult to achieve as a result of the inability to bathe more often.
Programs designed to encourage social activities for older adults, should consider the effects of this policy on self worth and ability to form interpersonal relations. Moreover, body image (Forand et al., 2010) and psychological adjustments to age-related physical changes should be considered (Moss et al., 2013) as they affect the receipt of services.

An individual's emotional well-being is also affected by their attitude towards aging. The research results suggest that culturally supportive services can assist individuals in viewing aging in a positive way.

A positive attitude towards aging enhances self-esteem. Moreover, having a satisfying social network and a sense of security, related to feelings of trust and attachment to a place of residence and neighborhood are equally important (Dale et al., 2012).

The research results suggest that culturally supportive services can assist individuals in viewing aging in a positive way. This finding relates to the importance of body image as viewed through a cultural context.

The results from this study reveal a very high value placed on individual independence in addition to attractiveness whereby the reversal in role from being independent to dependent and needing formal and informal care is stressful and difficult to accept. This finding is supported by the literature with findings that older adults value their independence and thus homecare relationships that support their autonomy and active participation in all decision-making (Crist, 2005).

Findings from this study also indicate a fear of further decline, associated with a fear of being placed in a nursing home. The literature reveals that the Italian culture views the practice of placing older individuals in a nursing home as unacceptable and extremely embarrassing (Bellamy, 1993). According to some research, older individuals often regard moving to an
assisted living facility more positively than to a nursing home. Such a facility is viewed as offering assistance with personal care, while permitting individuals to retain their independence and preference for family involvement (Bishop, 1999; Cheng, Fung & Chan, 2009; Imamoglu, 2007).

The research data suggest that the environment plays an important part in promoting an interest in receiving services. Mutual solidarity appears to enhance understanding of the homecare program and interest in receiving services. Moreover, the inclusion of spiritual and cultural activities was shown to lessen fears while encouraging independence. Homecare providers' culturally meaningful communication is identified as an important factor in bridging the gap between the past and present and as facilitating coping with an uncertain future. This finding is supported by the literature, whereby coping relates to taking all efforts to deal with challenges to manage demands (Monahan & Scott, 1995).

Access to social and environmental resources assists individuals in coping with stress and has been linked to better healthcare outcomes and reduced depressive symptoms (Hervé, Alaphilippe, Bailly & Joulain, 2010) as well as lower morbidity and mortality rates (Aldwin & Gilmer, 2004). Whereas previously older adults have been perceived as more vulnerable to the effects of stress, (Moneyham & Scott, 1995) this finding supports the importance of providing homecare services that foster the inclusion of social, cultural, and spiritual support.

Examination of the home environment showed linguistic and cultural barriers, and unregulated homecare setting (Porter et al., 2005). The results from this study reveal the importance of providing services that are safe and in environments that are suitable for the receipt of formal care. The findings highlight the importance of fostering individual autonomy in
the homecare environment, while ensuring that individuals are protected from harm when receiving services (Porter et al., 2005).

Health care policies must be reflective of older adults and their cultural beliefs (Masi, Mensah, & McLeod, 1993) and include safety standards for the home environment (Lang, Edwards & Fleiszer, 2008; Preto & Mitchell, 2004). Although policies have been implemented to address the importance of safety in the hospital setting, there remains a lack of emphasis on safety in the home (Doran et al., 2009).

These study findings demonstrate the need for social workers and other healthcare professionals, to be alert to the importance of cultural meanings in the provision of care. Interventions to enhance individuals' emotional well-being have been positively associated with reduced levels of psychological distress (McNulty et al., 2004), resulting in improved health care outcomes and lower healthcare costs (Sobel, 1995). Older adults should be encouraged to be active in their treatment planning, in order to enhance, their self-confidence and self worth. Ontario's current homecare program should be evaluated to consider older adults’ needs that should extend beyond the traditional biomedical model of care, to incorporate cultural considerations.

Limitations

There were a number of limitations in this study. Despite stringent efforts to recruit a rich sample, there were only female participants and therefore a lack of perspective of male recipients. In addition, Italian immigrants who were receiving homecare services through the CCACs were not included, and their views may have differed. This study examined homecare services through an assisted-living facility, which may differ at other settings. As well, this
sample had access to transportation, informal and social support, which may not have represented the general population of older Italian women living in the community.

The study was restricted to residents who were cognitively intact and as a result the experience of those with some degree of cognitive impairment is lacking. As well, the participants were affected by specific historical events in their lifetime that affected their experiences in receiving homecare services, for example, the Great Depression and the Second World War that resulted in their intense fear of poverty which was exacerbated by their current financial challenges. It is likely, as a result that individuals from different historical times would have had different experiences.

As this study was conducted during the summer months, the participants' recollections of their challenges in the wintertime with the snow and ice, may not have been as well represented. Although every effort was made to solicit in-depth information from each participant, it is possible that their responses were framed to limit disclosure of their actual need for care, as a result of their fear of institutionalization, and fears of reprisals that would affect their services (Aronson & Neysmith, 2001). Although the participants spoke at great length about their immigration history and challenges in Canada, it cannot be determined whether their recollections about their past were in fact accurate and reliable since memories have been shown to be experienced and affected by physical, psychological and social changes. Changes for example in life resulting from retirement, physical deterioration or residential relocation create unique experiences. Many of these memories may become distorted, not as accurately recollected, forgotten or else poorly remembered, or inaccurately described as a result of the cumulative effects associated with the passage of time (Rowles & Chaudhury, 2005).
Furthermore, these findings are not generalizable, even though they provide additional insights into the experience of receiving formal homecare services among this sample group.

Although the researcher speaks some Italian, an interpreter was used throughout the entire study to assist in obtaining information from these participants in Italian and transposing the data from Italian into English. Despite all efforts to capture their unique experiences, there is a limitation associated with the translation of material from Italian into English. Although all efforts were taken to translate the material as accurately as possible, certain expressions or words that are unique to Italian could not be directly translated into English. Although this would not have affected the overall content of the material, it is however a limitation to this study.

Despite all of these limitations, the findings provide additional insights into the value of relationship building, the changes in social roles and caregiving practices, the importance of the home environment and the importance of cultural considerations in the receipt of care.

**Conclusion**

The findings of this study indicate the importance of the home environment and the need for social workers to consider culture in the provision of care. Canada's immigrants are diverse and present with varying cultural and spiritual beliefs and different risk factors for physical and psychological problems. Many new immigrants face increased risks of racial discrimination, social isolation, acculturative risk challenges, as well as barriers to much-needed health care services.

The findings indicate a lack of follow-up care following early discharges from hospitals for older adults and the provision of limited public homecare services. Homecare services are provided in homes that are often unsuitable and inaccessible for the receipt of care. Services such as social support, housekeeping and meal preparation are not considered "medically
necessary" components of care and as a result are often not included in the provision of services, resulting in families needing to arrange for private or informal support. The participants were on a relatively fixed retirement budget and living independently was due to their ability to afford formal care and have access to informal care. Needing to be viewed as strong and self-sufficient resulted in their desire to reciprocate with those providing them with care. Their interest in receiving formal homecare services related to their ability to receive linguistically and culturally competent care.

The cultural meaning assigned to their image emerges as an important finding. Participants being able to receive only one bath or shower every week interfered with their cultural practice of making a favourable impression on others and sense of confidence and security. Their receipt of services is influenced by the historical context of their immigration challenges, where their past experiences promoted their self-sufficiency and independence. The home environment emerges as a key factor, in which family roles and cultural traditions are shared, and aspects of individual identity are preserved and homecare services are ultimately provided.

The limited number of homecare hours available to older adults is related to the emphasis on cost containment, which has challenged social workers and other healthcare providers to provide cost-efficient responsive services to Canada's diverse immigrant populations. The need for culturally sensitive services requires a homecare model that is supportive of Canada's diverse immigrant populations for both their acute and chronic health care conditions (Anderson & Parent, 2000).

The following chapter provides recommendations for future research, as well as the conclusion that summarizes the key findings of this study.
Chapter 7: Conclusion and Future Research

Introduction

This chapter briefly summarizes what the study findings add to social work practice, followed by recommendations for future research. The purpose of this study was to explore the life histories of older Italian immigrants who were receiving culturally sensitive homecare services, through an assisted living facility in Ontario and to examine the cultural factors that influenced their need for care.

What This Study Adds

Despite the limitations in the study, the findings have important implications for social work research and practice. The location of the assisted living facility emerges as important in facilitating access to the participants' former social ties and cultural resources, thus promoting retention of their cultural identity. Also important is the facility's inclusion of culturally and linguistically competent homecare services and promotion of resident autonomy and self-sufficiency.

The findings reveal the importance of the family in advocating on behalf of older family members and in retaining cultural values and norms despite changes to former caregiving practices, as well as the need to include family members in program planning. The effects of loss and fears of an uncertain future were lessened by access to spiritual, social and cultural support in response to age-related challenges. Also vitally important is an understanding of the cultural factors that affect individuals in seeking health and social services (Soskolne & Auslander, 2007). Social workers are well-positioned to respond to the complex needs of older immigrants, to ensure that they have the requisite resources and assistance required.

Cultural competence training should dominate homecare reforms (Stommel et al., 2005) whereby individual beliefs, language, self identity and customs in the home are acknowledged.
and understood. More emphasis upon health human resources is required in order to ensure Canada's homecare future. Greater efforts to recruit and retain highly skilled personnel must be undertaken to offer consistent quality care. The work environment must be a top priority for healthcare planners in the promotion of policies for both providers and their clients.

Efforts to reform ageist attitudes (Lloyd, 2006) in both research and professional practice (Powell, 2007) are necessary in homecare planning, by including realistic appraisals of age-related losses and physical decline (Silver, 2003). Also important is the provision of integrated, consistent and timely care that is culturally and linguistically appropriate. A commitment to the development of a highly skilled, regulated work force is needed in order to offer the quality of care required for older adults (Koehoorn, Lowe, Rondeau, Schellenberg & Wagar, 2001).

**Implications for Future Research**

1. Every participant relied on informal support to supplement their formal homecare support. More research is needed to increase understanding of the role of informal support in the provision of homecare services, the competing demands on families (Coyte, 2000) and contributions made by family members, especially women who still provide the bulk of informal assistance (Remennick, 1999; Clark 2007). Often overlooked are the challenges of balancing caregiving with work and childcare responsibilities (Wisenale, 2005), as well as the effects of role reversal on individuals and their family members (Blakemore, 1999; Koehn, 2009).

2. The participants received culturally competent homecare from the same providers, thus offering continuity and relationships. Further research is needed to examine the importance of continuity and integrated care for older adults with complex chronic conditions (Vitacca, Isimbaldi, Mainini, & Melazzini, 2011). Further research should assess levels of cultural competency among other homecare providers and its effects upon the use of homecare services.
(Constant, Roberts & Zimmermann, 2007; Howse, Ebrahimand, & Gooberman-Hill, 2005; Hunt & Swiggum, 2007; San Antonio, Robert, & Rubinstein, 2004; Lasser, Himmelstein, & Woolhandler, 2006; Warburton, Bartlett, & Rao, 2009) as well as variations in wages and educational standards, as they affect the recruitment and retention of homecare workers (Stacy, 2005; Wiles, 2005).

3. The participants complained about their financial status and their difficulties in financing any private care. Further research is required to examine the financial and emotional effects of widowhood, and retirement on the use of formal homecare services (Donnelly & Hinterlong, 2010) and choice of residence for older adults.

4. The participants spoke about their fear of falling and their gratitude in being able to converse with their providers in their language which they believed reduced their risk of falling. Further research should examine the inclusion of linguistic and cultural factors in the delivery of homecare services (Partida, 2012) and its effects on risk for adverse events.

5. The participants depicted a favorable portrayal of the assisted living facility that emphasized the social, cultural aspects of their care and promoted their autonomy. Further research is required to evaluate living arrangement preferences and housing needs of other cultural groups in Canada (Haldemann & Wister, 1993). Homecare services that are delivered through assisted living facilities should be evaluated for their cost effectiveness and potential to provide overall improvements in health care status (Aronson, 2004; Chen et al., 2008) and potential to postpone or avoid institutionalization (Horowitz & Vanner, 2010).

6. The participants’ fears were lessened by access to spiritual and social support. Further research should consider diverse cultural groups and their coping strategies (Moneyham & Scott,
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1995; Walters, & Bartlett, 2009), and examine the effects of gender, marital status, cultural and social influences (Angel, Angel, & Henderson, 1997).

7. The assisted-living facility's incorporation of culturally competent services extended to its inclusion of family members and the symbolic importance of the home environment that contributed to the participants' interest in receiving services. Also relevant was its geographical location, in facilitating the participants' retention of their cultural norms. Further research should evaluate the effects of family support and decision-making ability (Aronson & Neysmith, 2001; Davies & Nolan, 2006; Jenkins, 2000; Wiles, 2005) as well as the effect of geographical location (Banks, 2004; Public Health Agency of Canada, 2001; Van Dijk, 2004) on the utilization of homecare services and healthcare outcomes (Walters, & Bartlett, 2009).

8. The participants were initially hesitant to reveal the extent of their physical limitations. Further research should examine cultural variations in health sharing behavior and the factors affecting responses, to improve upon knowledge on health seeking behavior among different population groups (Angel & Angel, 2006).

9. The participants preferred to socialize with other Italian immigrants, in large part due to their limited ability to converse in English. More research is required to identify immigrant populations at risk for social isolation, as a result of language barriers (Edwards & Mawani, 2006; Park, Zimmerman, Kinslow, Shin & Roff, 2012).

10. The Italian "home" and its symbolic importance emerged as an important factor in the receipt of services. More information pertaining to the symbolic utilization and meaning of space (Gitlin, 2003) is required (Aronson, 2004) among other cultural groups, to evaluate its effect on the receipt of services (Martin-Matthews, 2007).
Conclusion

This study was conducted in response to increases to Canada's older Italian immigrant population and the dearth of information currently available about their caregiving needs. The aim was to increase understanding of their experiences in receiving formal homecare. This study addressed a gap in the research related to homecare, which was the voices and experiences of Canadian older Italian immigrants (Crist, 2005).

As home to immigrants from many countries, Canada continues to experience changes in its demographic profile. Its influx of immigrants in the last few decades has greatly contributed to its economy and to its older population that is expected to result in an unprecedented challenge for healthcare providers and policy makers, to provide cost-effective and affordable health care services (Bonnet, Gobillon & Laferriere, 2010). It has been estimated, that life expectancy in 2031 will reach 82 years for men and 86 years for women and that three percent of Canada's population will be 85 years or older (Andrews, 2008).

Much of the focus on cultural competence in the last decade has considered culturally and linguistically care in acute and long-term care settings, with much less emphasis on its importance in responding to Canada's increasing diverse older immigrant populations in the home environment (Victoria, 2010). As a result, homecare providers and policy makers will require further evidence to better understand the value and potential for homecare services to provide cost-effective and optimal health care outcomes for Canada's older adults (Coyte, 2000).

Future health care reforms will have to take into consideration its diverse cultures; prior attitudes, immigration experiences, spiritual affiliations and cultural identities, all of which will need to be considered in the formulation of homecare programs. More often, the arrival in Canada can lead to a disruption to families, as a result of family members being left behind and
the need for women to secure employment, changes which often result in alterations to former patterns of caregiving.

Strategies must be incorporated that embrace Canada's immigrants and their social identities, reflective of their heritage and cultural beliefs. Research is needed to add to a better understanding of the cultural beliefs and traditions among different population groups, to develop strategies reflective of the aging process, gender, culture and socioeconomic status (Matsuoka, 1999).

The current healthcare emphasis on cost containment has dramatically shifted the provision of health care services from hospitals to the community (Coyte, 2000). The ability to offer accessible and sustainable services will continue to challenge health care providers and policy advisers to create a system that is both responsive and affordable (Porter et al., 2000).

Demographic changes are expected to continue having a profound effect on the provision of homecare services, with ongoing commitments in providing services in the home considered a cost-effective alternative to institutionalization. There are currently too few studies about the complexity and symbolic meaning of the home environment (Aronson & Neysmith, 2001) as it affects Canada's diverse racial and ethnic populations throughout the aging process and life span (Matsuoka, 1999).

Social workers are involved in the referral and follow-up process of homecare services and therefore well-equipped to contribute to the multitude of health care and social issues that affect older adults in the community (Kasperski, Power, & VanderBent, 2005). In addition to their role as advocates, social workers have the ability to guide in the development and expansion of homecare services (Egan & Kadushin, 1999), to optimize the individual experience for older adults in their care (Gantert et al., 2008).
Social workers and other healthcare providers must take into account the home environment, to reflect the importance of home spaces and associated cultural and symbolic significance in the provision of homecare services. The caregiving preferences of Canada’s older immigrants must be articulated and represented in all future homecare debates, to provide services reflective of their cultural values and beliefs. Central to this issue, is the need for adequate healthcare personnel, trained and skilled in culturally and linguistically competent care.

Ongoing public education should be aimed at eliminating ageist attitudes and beliefs about older adults (Spencer & Soden, 2007). Moreover, healthcare policies need to be reformed to eliminate health disparities (Charbonneau, 2011) to ensure provision of accessible care. Social workers must continue to strive for issues of social justice and forge partnerships with other healthcare providers, governments and other stakeholders in order to support greater autonomy of Canada's older adults (Barnes & Mercer, 2005). More interventionist policies can be achieved through their shared vision and that of Canada's older immigrants, to integrate cultural considerations in the delivery of homecare services.

It is hoped that findings from this study will encourage future research to explore the way in which environmental factors affect (Matsuoka, 1999) immigrant populations (Gitlin, 2003) to support their need for social assistance, ongoing autonomy and ability to feel valued and connected to their community (Boerner & Wang, 2010). Social workers, policy makers, healthcare providers and other relevant stakeholders must take into account the voices of all immigrant populations, in future health care reforms (Gilroy, 2006) in promotion of their cultural needs, for the benefit of all Canadians.
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Appendix

Appendix A-Ontario Immigration Population Characteristics

The population in the Greater Toronto Area in 2001 was estimated at 2,456,805 people of which 1,198,815 were born in Canada, compared to 1,214,630 that were immigrants. 697,995 people had immigrated to Canada before 1991 and 516,630 had immigrated between 1991-2001. In 1995, 11% of Toronto's population were aged 65 years or over. In 1991, 92% of all people aged 65 and over lived in a private household. A large percentage of these seniors lived alone and 8% lived with members of their extended family. 38% of all seniors were women and 53% of those aged 85 and over, lived on their own. (Statistics Canada 20001 census retrieved on August 12/2008 at: http://www12.statcan.ca/english/profil01).

<table>
<thead>
<tr>
<th>Immigration Characteristics</th>
<th>Toronto, City</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td>Total - All persons</td>
<td>2,456,805</td>
<td>1,186,865</td>
</tr>
<tr>
<td>Canadian-born population (23)</td>
<td>1,198,815</td>
<td>591,500</td>
</tr>
<tr>
<td>Foreign-born population (24)</td>
<td>1,214,630</td>
<td>574,160</td>
</tr>
<tr>
<td>Immigrated before 1991</td>
<td>697,995</td>
<td>327,630</td>
</tr>
<tr>
<td>Immigrated between 1991 and 2001 (25)</td>
<td>516,630</td>
<td>246,530</td>
</tr>
<tr>
<td>Non-permanent residents (26)</td>
<td>43,360</td>
<td>21,205</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visible Minority Status</th>
<th>Toronto, City</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td>Total population by visible minority groups</td>
<td>2,456,805</td>
<td>1,186,865</td>
</tr>
<tr>
<td>Visible minority population (31)</td>
<td>1,051,125</td>
<td>505,155</td>
</tr>
<tr>
<td>Chinese</td>
<td>259,710</td>
<td>126,305</td>
</tr>
<tr>
<td>Language(s) First Learned and Still Understood</td>
<td>Toronto, City</td>
<td>Ontario</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td>All persons (19)</td>
<td>2,456,805</td>
<td>1,186,865</td>
</tr>
<tr>
<td>English only</td>
<td>1,271,960</td>
<td>613,965</td>
</tr>
</tbody>
</table>

The table above shows the distribution of first language(s) learned and still understood by gender for Toronto, City and Ontario. The numbers are rounded to the nearest whole number.
Most Canadian Italian immigrants began to arrive in Canada sometime after the Second World War but there is even evidence of arrival dates, dating back to 1665. Today there are estimates of over 1 million Italian immigrants that are living in Canada. In fact, 1,270,370 Canadian residents claimed that they had Italian ancestry in the 2001 Census of Canada, 726,275 reported having uniquely Italian origins while 544,090 reported being partly of Italian origin. Italian-Canadians make up an estimated 4.3% of Canada's population. The majority of Italian-Canadians live in Ontario (781,345) where they comprise close to 7% of the population, while another 249,205 live in Quebec (Statistics Canada, 2001).

Italian-Canadians by province and territory

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Italian-Canadian population</th>
<th>Per cent of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland and Labrador</td>
<td>1,180</td>
<td>0.2%</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>605</td>
<td>0.5%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>11,240</td>
<td>1.3%</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>5,610</td>
<td>0.8%</td>
</tr>
<tr>
<td>Quebec</td>
<td>249,205</td>
<td>3.5%</td>
</tr>
<tr>
<td>Ontario</td>
<td>781,345</td>
<td>6.9%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>18,550</td>
<td>1.7%</td>
</tr>
<tr>
<td>Province</td>
<td>Population</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>7,565</td>
<td>0.8%</td>
</tr>
<tr>
<td>Alberta</td>
<td>67,655</td>
<td>2.3%</td>
</tr>
<tr>
<td>British Columbia</td>
<td>126,420</td>
<td>3.3%</td>
</tr>
<tr>
<td>Yukon</td>
<td>500</td>
<td>1.8%</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>400</td>
<td>1.1%</td>
</tr>
<tr>
<td>Nunavut</td>
<td>95</td>
<td>0.4%</td>
</tr>
<tr>
<td>Canada</td>
<td>1,270,370</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

Approximately 33% of the 1.3 million Italian-Canadians (903,375) were born in Canada and 315,455 Canadian residents were born in Italy. Almost half (46.7%) of all immigrants arrived in Canada before 1961, 38.3% between 1961 and 1970, and approximately 10.3% between 1971 and 1980. Only 50% of Italian-Canadians (670,300) reported that English was their mother tongue, 81,000 reported French as their mother tongue and 469,485 reported that Italian was their mother tongue.

The majority of Italian-Canadians had above-average incomes ($34,871 average employment income compared to the average salary of $31,757 among Canadians) and below-average unemployment rates (5.4% compared to 7.4% within the rest of the Canadian labour force).

Appendix B - Demographic Surveys

Participants

1. Age.
2. Gender.
3. Race.
4. Social Support.
5. Living Arrangements.
8. # of years in Canada.
10. Self rated level of ADL and IADL impairments.
11. Ambulation- mobility aids if any.
12. # of years affiliated with the facility.
13. # children/grandchildren and their whereabouts.
14. # of years receiving publicly funded homecare services-reason for referral.
15. Level of education.

Assisted Living Facility

1. History of the facility.
2. Organizational Structure.
3. Certification.
4. # of Beds and # of residents.
5. Government funding/private funding.
7. Facility Case Mix.
8. Services.
9. # Homecare hours available.
10. Homecare training and educational requirements.
11. Payment Rate for personal support workers.
12. Patient demographics-ratio female versus male, level of physical function i.e. level of ADL/IADL and homecare assistance required (Miller & Weisssert, 2003).
## Appendix C- Demographics Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Birthplace</th>
<th>Arrival to Canada</th>
<th>Arrival to the Facility</th>
<th>Gender</th>
<th># Children</th>
<th>Worked in Italy</th>
<th>Worked in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>87</td>
<td>South Italy</td>
<td>1951</td>
<td>2002</td>
<td>F.</td>
<td>0</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
<td>84</td>
<td>Calabria</td>
<td>1950</td>
<td>2004</td>
<td>F.</td>
<td>0</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3.</td>
<td>84</td>
<td>South Italy</td>
<td>1962</td>
<td>2002</td>
<td>F.</td>
<td>0</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>4.</td>
<td>84½</td>
<td>Calabria</td>
<td>1968</td>
<td>2005</td>
<td>F.</td>
<td>1 son</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5.</td>
<td>87</td>
<td>Abruzzi</td>
<td>1957</td>
<td>2005</td>
<td>F.</td>
<td>1 daughter and 2 sons</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>6.</td>
<td>83</td>
<td>Calabria</td>
<td>1953</td>
<td>1990</td>
<td>F.</td>
<td>1 daughter and 1 son</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7.</td>
<td>86</td>
<td>Bari</td>
<td>1951</td>
<td>2004</td>
<td>F.</td>
<td>1 daughter and 1 son</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>8.</td>
<td>87</td>
<td>South Italy</td>
<td>1965</td>
<td>1991</td>
<td>F.</td>
<td>1 daughter and 1 son</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>9.</td>
<td>94</td>
<td>South Italy</td>
<td>1920</td>
<td>1987</td>
<td>F.</td>
<td>1 daughter</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>10.</td>
<td>90</td>
<td>Born in</td>
<td>1955</td>
<td>1991</td>
<td>F.</td>
<td>2 daughters</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Toronto</td>
<td></td>
<td></td>
<td></td>
<td>and 1 son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>94</td>
<td>Rome</td>
<td></td>
<td></td>
<td>F.</td>
<td>2 daughters</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and 1 son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>90</td>
<td>Bari</td>
<td>1965</td>
<td>1999</td>
<td>F.</td>
<td>2 daughters</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and 2 sons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>89</td>
<td>Sicily</td>
<td>1966</td>
<td>1996</td>
<td>F.</td>
<td>2 daughters</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>14.</td>
<td>89</td>
<td>Cosenza</td>
<td>1959</td>
<td>2004</td>
<td>F.</td>
<td>No children</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>15.</td>
<td>95</td>
<td>Sicily</td>
<td>1961</td>
<td>2005</td>
<td>F.</td>
<td>4 daughters</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and 1 son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>89</td>
<td>Sicily</td>
<td>1956</td>
<td>2001</td>
<td>F.</td>
<td>2 daughters</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and 1 son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>90</td>
<td>Ferrara</td>
<td>1969</td>
<td>1989</td>
<td>F.</td>
<td>1 surviving daughter</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>18.</td>
<td>86</td>
<td>Abruzzo</td>
<td>1957</td>
<td>2004</td>
<td>F.</td>
<td>1 daughter and 1 son</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>19.</td>
<td>86</td>
<td>Abruzzo</td>
<td>1960</td>
<td>2003</td>
<td>F.</td>
<td>3 daughters</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 daughter and 1 son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>89</td>
<td>Calabria</td>
<td>1955</td>
<td>2004</td>
<td>F.</td>
<td>1 daughter</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and 1 son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>89</td>
<td>Lucania</td>
<td>1953</td>
<td>1999</td>
<td>F.</td>
<td>2</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No.</td>
<td>Age</td>
<td>Location</td>
<td>Year of Birth</td>
<td>Year of Death</td>
<td>Sex</td>
<td>Daughters</td>
<td>Daughters in 1 son</td>
<td>Surviving Daughter-in-law</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
<td>----------</td>
<td>---------------</td>
<td>---------------</td>
<td>-----</td>
<td>-----------</td>
<td>-------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>22.</td>
<td>75</td>
<td>Sicily</td>
<td>1957</td>
<td>2008</td>
<td>F.</td>
<td>2 daughters</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>23.</td>
<td>81</td>
<td>Calabria</td>
<td>1957</td>
<td>2006</td>
<td>F.</td>
<td>Children passed away-surviving daughter-in-law</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>24.</td>
<td>89</td>
<td>Rome</td>
<td>1952</td>
<td>2003</td>
<td>F.</td>
<td>1 daughter and 2 sons</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>25.</td>
<td>84</td>
<td>Rome</td>
<td>1966</td>
<td>1991</td>
<td>F.</td>
<td>1 daughter and 1 son</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The majority of participants were receiving homecare services from individuals who could speak some Italian. Although some of these homecare workers were Spanish speaking, they could still converse to their clients in Italian because the languages were similar to one another. Only 5 participants, or 20% of participants, were receiving homecare services from homecare workers who could not speak Italian and spoke English to their clients. These 5 participants were either able to speak English fluently or had sufficiently mastered the English language in order to be able to understand them.
## Appendix D

### Homecare Support-Language Used by Homecare Workers with Clients

<table>
<thead>
<tr>
<th>Participant</th>
<th>Italian</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>8.</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>10.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>11.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>12.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>13.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>14.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>15.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>16.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>17.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>18.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>19.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>20.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>21.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>22.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>23.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>24.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>25.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Appendix E

Consent Form

Date: September/08.

TITLE: Cultural Considerations in the Delivery of Homecare

INVESTIGATOR: Anna Walsh Ph.D. Student University of Toronto

CONTACT: Email: hedy.walsh@utoronto.ca
Mailing address:
246 Bloor Street W
Toronto, Ontario
Canada M5S 1A1
Phone: 416-978-6314

RESEARCH SUPERVISOR: Dr. Faye Mishna
(416) 978-3255

You have been invited to participate in a research study that will be considering the importance of culture in the delivery of publicly funded homecare services. Your consideration and interest are very much appreciated. Your right to withdraw at any time is outlined in addition to other important matters.

Purpose
This research is aimed in adding to the body of social work knowledge: to explore the experiences of Italian Canadian elderly immigrants with the publicly funded homecare program.

Procedures
This study will involve a face-to-face interview that will also include a list of questions. Participation is purely voluntary and you are able to withdraw your consent at any time. A questionnaire has been attached to the consent form and is estimated to take around 10-15 minutes. The interview will be audiotaped with your prior permission and consent to discuss your homecare experiences. You may withdraw your consent at any time and request to have the audio taping stopped at any time.

Participation
Your participation in the study is purely voluntary and your consent to participate may be withdrawn at any time. In addition, you may decline from answering any question or from participating at any time.
Confidentiality
The names of participants will be kept anonymous. The privacy of all participants will be strictly adhered to. All information will be kept confidential and stored at the researcher's home in a secured filing cabinet. All data will be destroyed 3 years after the results have been analyzed and reviewed.

Compensation
Participants will be reimbursed for any assumed expenses involved in the participation of this study.

Questions/concerns
Please address all questions/concerns to Anna Walsh at: hedy.walsh@utoronto.ca or at 416-978-6314.

Consent for Survey
I understand the purpose for completing the survey and am freely electing to participate. I understand that I can withdraw my consent at any time without any penalty and will still be reimbursed for any expenses.

Name (Please Print): __________________________ Signature: __________________________ Date: __________________________
Siete stato invitato a partecipare ad uno studio di ricerca che considererà l'importanza della cultura nella consegna di un servizio delle case di riposo fondato pubblicamente. La vostra considerazione ed il vostro interesse sono molto apprezzati. Il vostro diritto di ritirarsi in qualsiasi momento è descritto, oltre ad altri argomenti importanti.

**Scopo**

Questa ricerca è mirata nell'aggiunta al corpo di conoscenza del lavoro sociale: per esplorare le esperienze, le interpretazioni, la credenza e le preoccupazioni degli anziani italiani che risiedono in una comunità italiana a Toronto e stanno ricevendo i servizi delle case di riposo attraverso la villa Colombo. Questo studio è inteso per esplorare come l'identità e le storie di vita forse hanno influenzato le esperienze di alcuni di ricezione dei servizi pubblici convenzionali delle case di riposo (Maxwell, 1996).

Questo studio è mirato (1) al corpo di conoscenza attuale degli immigrati anziani italiani di Toronto e la loro esigenza dei servizi (2) aumentando la conoscenza degli assistenti sociali sugli immigrati anziani italiani e per una (3) migliore comprensione sugli effetti di immigrazione delle precedenti tradizioni di assistenza per gli anziani e dell'esigenza dei servizi convenzionali specializzati delle case di riposo (Kaplan & Maxwell, 1994).
Procedimento

Questo studio coinvolgerà un'intervista faccia a faccia che inoltre comprenderà una lista delle domande che è stata allegata alla forma di consenso. Il ricercatore gli farà queste domande durante l’intervista che durerà da 90 minuti a due ore. La partecipazione è puramente un atto volontario e potete ritirarvi in qualsiasi momento. L'intervista sarà audiregistrata con il vostro permesso ed acconsentirà di discutere le vostre esperienze delle case di riposo. Potete ritirare in qualsiasi momento il vostro consenso e fare la richiesta che la registrazione dell’audiocassetta venga fermata.

Partecipazione

La vostra partecipazione allo studio è puramente un atto volontario ed il vostro consenso di partecipare può essere ritirato in qualsiasi momento senza alcuna pena. In più, potete rifiutare di rispondere a delle domande o alla partecipazione in qualsiasi momento.

I rischi/ I benefici

Non ci sono benefici diretti connessi con questo studio. Ci sono alcuni rischi psicologici/impressionabili, nel caso dovesse condividere alcune difficili esperienze con le case di riposo. Un rinvio a consigliare i servizi sarà offerto a ciascun partecipante che sarà molto afflitto o che richiederà questo supporto. Qualsiasi problema che si presenterà inaspettatamente durante lo studio, verrà immediatamente segnalato al ricercatore sopravintendente Dott. Faye Mishna.

Risarcimento

Ai partecipanti sarà dato un onorario di $20 per la loro partecipazione a questo studio.

Accedere ad informazioni/ riservatezza

Il ricercatore e l'interpretatore traduttore avranno accesso ai dati. Il vostro nome sarà mantenuto anonimo e sarà usato preferibilmente uno pseudo-nome. La vostra segretezza si attlerà rigorosamente. Tutte le informazioni saranno mantenute confidenzialmente e saranno memorizzate in casa del ricercatore in un casellario in una stanza bloccata. Un interpretatore avrà accesso ai dati per l'obiettivo unico dell'interpretazione traduzione delle informazioni dall’italiano all’inglese e sarà tenuto per distruggere i dati dopo che i documenti saranno stati tradotti. Tutti le annotazioni scritte e i questionari saranno fissati sicuro in un casellario bloccato, in una stanza bloccata del ricercatore con l’unico obiettivo di completamento dei requisiti dello studio di Ph.D. e sarà disfatta tre anni dopo che i risultati saranno stati analizzati ed esaminati. Tutte le cassette audio veranno distrutte subito dopo essere trasposte. Un compendio dei risultati della ricerca sarà messo a disposizione del direttore esecutivo della villa Colombo, che distribuirà una copia a tutti i partecipanti. Nel caso, che questo studio verrà pubblicato, ve lo comunicheremo in anticipo ed inoltre verrete forniti di una copia dell'articolo. Una copia della forma di consenso sarà fornita.
**Domande/preoccupazioni**

Si prega di porre tutte le domande/preoccupazioni a Anna Walsh a: hedy.walsh@utoronto.ca or
at 416-978-6314.

Potete anche mettervi in contatto con l'ufficio dell'etica di ricerca in qualsiasi momento, se avete alguna domanda circa la partecipazione allo studio.

Ufficio dell'etica di ricerca: ethics.review@utoronto.ca or 416-946-3273.

**Censo per l'indagine**

Capisco lo scopo per il completamento dell'indagine, alla quale scelgo liberamente di partecipare. Sono a conoscenza di potere ritirare in qualsiasi momento il mio consenso senza alcuna pena.

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<tr>
<th>Nome (stampi per favore)</th>
<th>Firma</th>
<th>Data</th>
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<table>
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<tr>
<th>Firma del ricercatore</th>
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**Censo per l’audiocasetta**

Capisco lo scopo di fare l'intervista audioregistrata e che scelgo liberamente di essere audioregistrato. Capisco che gli audionastri saranno utilizzati per l'unico obiettivo dello studio e non saranno utilizzati per nessun altro motivo tranne per questo studio. Sono a conoscenza che soltanto il ricercatore e l'interpretatore traduttore avranno accesso agli audionastri. Capisco che questi audionastri verranno distrutti una volta che verranno trascritti. Sono a conoscenza che potrò ritirare in qualsiasi momento il mio consenso di essere audioregistrato senza alcuna pena e potrò chiedere di interrompere in qualsiasi momento l'audio registrazione dell'intervista. Accetto a fare trascrivere gli audionastri ed acconsento all'uso della trascrizione scritta ai fini di questo studio. Sò che la mia identità verrà mantenuta confidenziale, che nè il mio nome nè altre informazioni d'identificazione saranno associate con la trascrizione.
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<th>Nome (stampi per favore)</th>
<th>Firma</th>
<th>Data</th>
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<tr>
<td>________________________</td>
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Firma del ricercatore ______________________ Data ______________________
Appendix F- Advertisement

Research study: TITLE: Cultural Considerations in the Delivery of Homecare Services
INVESTIGATOR: Anna Walsh Ph.D. Candidate University of Toronto

RESEARCHER: Dr. Faye Mishna

SUPERVISOR: (416) 978-7065

Anna Walsh: CONTACT: Email: hedy.walsh@utoronto.ca
Phone: 416-978-6314

I am looking for Canadian Italian individuals aged 75 and older, that are living alone and are receiving homecare services, to participate in a research study. This study will explore the importance of the Italian culture in the delivery of publicly funded homecare services.

Your participation would involve 1 interview for 90 minutes -2 hours at your convenience. An interpreter would be made available at all times. You would be paid $20 for your time. Your identity would be kept confidential.

For more information or to volunteer for this study please leave a message for Anna: at: 416-978-6314.

Appendice Pubblicità

Ricerca studio: TITOLO: Considerazioni culturali nella fornitura di servizi Homecare

INVESTIGATORE: Anna Walsh Ph.D. Candidato Università di Toronto

RICERCA: Dr. Faye Mishna

SUPERVISORE: (416) 978-7065

Anna Walsh: CONTATTI: E-mail: hedy.walsh @ utoronto.ca

Telefono: 416-978-6314
Cerco Canadian individui italiani di età compresa tra 75 e più anziani, che vivono soli e ricevono servizi domiciliari, di partecipare a uno studio di ricerca. Questo studio analizzerà l'importanza della cultura italiana nella fornitura di servizi di assistenza domiciliare finanziati con fondi pubblici.

La vostra partecipazione comporterebbe 1 intervista per 90 minuti -2 ore a vostro piacimento. Un interprete sarebbe stato reso disponibile in ogni momento. Si sarebbe pagato $ 20 per il vostro tempo.

La tua identità sarà mantenuta riservata.

Per ulteriori informazioni o per volontariato per questo studio si prega di lasciare un messaggio per Anna: a: 416-978-6314.
Appendix G

Questions to the Homecare Coordinator

1. What are the mission, vision and values of your facility?

2. Could you please describe the history of your facility? Is it affiliated with other organizations?

3. How long have you been the Homecare Coordinator of your facility?

4. Could you please describe the management and administrative structures of your facility?

5. How many employees are employed on a full-time basis/part-time basis?

6. Is there a physician available on site?

7. How many homecare workers are employed at your facility? How many of them are Italian or can speak Italian?

8. Do your employees participate in ongoing educational programs? Is this optional or compulsory?

9. Is it difficult to recruit and retain home care workers? What type of benefits do they receive?

10. Can homecare clients request the same homecare worker?

11. Could you please provide a profile of the clients that receive homecare services? Do they have to pay for these services? What are the rates that they are charged for any of these services? Do any of your clients receive any other type of caregiving services?

12. How is your homecare program different from other homecare programs in the community that do not cater to the Italian population? Do you feel that your clients and their families benefit from a homecare program that is aimed at servicing the Italian population?

13. What changes would you make to the current homecare program if you were able to i.e. regulations, procedures, budgets, policies and practices?

14. How is the quality of Homecare services measured and monitored?

15. Is there a waiting list for a client to receive homecare services? How is the process overseen and coordinated? How often are family members involved in the initial process and throughout?
Appendix H

Questions for Homecare Recipients/ Domande per Domiciliare Destinatari:

Nome (si prega di stampa):
Firma:
Data:

1. Do you live by yourself or with someone?
1. Vivete da solo o con qualcuno?
2. What is your ethnic background?
2. Da dove proviene la vostra generazione?
3. When did you arrive to Canada and did you always live in Ontario?
3. Quando hai arrivare in Canada e ha sempre vivere a Ontario?
4. How old were you when you left Italy?
4. A qua le età avete lasciato E’ Italia?
5. Did you work in Italy?
5. Avete lavorato in Italia?
6. How large is your family and where do they live?
6. Come grande è la vostra famiglia e dove vivono?
7. How old are you?
7. Quanti anni hai?
8. How long have you been receiving homecare services?
8. Da quanto tempo state ricevendo I servizi sociali?
9. Why were you first referred for homecare Services?
9. Perchè in primo luogo aveti fatto riferimento dei servizi sociali?
10. Who referred you for home care services?
10. Chi vi ha fatto riferimento per i servizi?

11. What services do they provide for you?

11. Quali servizi pervedono?

12. How many times a week are you receiving homecare services?

12. Quanti volte alla settimana ricevete i servizi per voi?

13. Does the same homecare worker provide these services for you?

13. Lo stesso operaio della servizi sociali fornisce questi servizi per voi?

14. Does the homecare worker respect your need for privacy and allow you to remain in control of your home/living space?

14. Il lavoratore a domicilio rispetto per la tua segretezza e permettono di mantenere il controllo della vostra casa/ spazio di vita?

15. What homecare services are helpful?

15. Che cosa sono i servizi a domicilio?

16. Does the homecare worker communicate to you in Italian?

16. Il lavoratore a comunicare a voi in italiano?

17. Is language ever a problem?

17. Lingua è sempre un problema?

18. Does the homecare worker show respect for your background, customs and traditions?

18. Il lavoratore a domicilio mostrane rispetto per il vostra sfondo, le usaze le tradizioni?

19. Should your cultural background be an important consideration in the receipt of Homecare services? Why?

19. Dvrebbe la vostra proita culturale essere una considerazione importante nella cricevuta dei servizi sociali? Perchè?

20. Are you receiving enough hours of home care services?

20. State ricevendo abbastanza ore dei servizi domestic di cura?

21. How do you manage when you are not receiving homecare services?
21. Come controllate quando non state ricevendo i servizi sociali?

22. Could you manage without your homecare services?

22. Potrebbe controllare senza i servizi sociali?

23. If you have a problem with your homecare service, do you know whom to call?

23. Se hai un problema con il tuo servizio di assistenza domiciliare, sai chi chiamare?

24. Does your caseworker arrange to see you very often to make sure that you are happy with your program? Does your caseworker speak to you in Italian?

24. La vostra caso lavoratore organizzare vederla molto spesso per assicurarsi che si è soddisfatti con il vostro programma? La vostra "caseworker" parlare a voi in italiano?

25. Does your homecare worker know how to help you make traditional Italian meals?

25. La vostra domiciliare lavoratore sapere come per aiutarli a fare pasti tradizionale italiana?

26. What would you like to see changed about your homecare program? If you could change one thing about your homecare program what would it be?

26. Che cosa volete vedere cambiato domiciliare sul tuo programma? Se si potrebbe cambiare una cosa sul vostro programma di assistenza domiciliare che cosa sarebbe?

27. Who took care of your parents when they were old?

27. Che si prese cura dei vostri genitori quando sono stati vecchio?

28. Who took care of your grandparents when they were old?

28. Che si prese cura dei vostri nonni quando erano vecchi?

29. Did you ever expect to need home care services?

29. Ti è mai bisogno di aspettarsi di servizi di assistenza a domicilio?

30. Would you ever want to move into a nursing home?

30. Avrebbe mai desidera spostare in una casa di cura?
Appendix I- Assisted Living Facility-Home Support Services

- **Housekeeping**
  Assistance for light housekeeping, laundry and shopping.

- **Personal Care**
  Assistance is provided for basic hygiene, hair-washing, bathing, denture care, assistance with dressing.

- **Additional Services**
  24 hour emergency response system
  Chiropodist on-site/Physiotherapy Clinic
  Information and referral services
  Medical clinic
  Transportation to shopping

Homecare Services 2009

**Homecare Staff (HS)-2009:**

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>FTE</th>
<th>Hours</th>
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<tbody>
<tr>
<td>HS Coordinator</td>
<td>0.90</td>
<td>1,755</td>
</tr>
<tr>
<td>HS Workers</td>
<td>12.00</td>
<td>23,400</td>
</tr>
<tr>
<td>Case Worker Maria</td>
<td>0.90</td>
<td>1,755</td>
</tr>
<tr>
<td>Driver (Shopping Banking)</td>
<td>0.40</td>
<td>780</td>
</tr>
</tbody>
</table>

This does not include the staffing for the Emergency Response System and the office receptionist.

**Italian speaking homecare staff:**

The coordinator, case worker, and 10 out of the 15 home care workers speak Italian. The remainders do understand some Italian but do not speak it fluently.

**Ongoing education requirement for homecare staff:**

Education is provided on an ongoing basis with respect to Health and safety, dealing with hazardous material and also dealing with clients who suffer from dementia, privacy, and emergency procedures etc. These educational programs are compulsory for homecare staff.

**Recruitment and retention of homecare workers:**

As a result of the salaries in the community services sector for homecare worker’s being much lower then in the hospitals and long-term care facilities (unionized), it is very difficult to recruit staff.
Benefits for homecare workers:

Full-time workers receive group health and dental benefits (including life insurance, long term disability and short term disability) and they contribute to a defined contribution pension plan (HOOP pension). Part time staff is eligible to enter into the pension plan one year after having worked 700 hours in one calendar year. They are ineligible for any health or dental benefits or for any sick time.

Homecare workers staffing schedule:

Homecare clients can request the same homecare worker. The facility strives to accommodate their needs but there are times when it is not possible.

Homecare scheduling:

CCAC is not involved in the coordination of their homecare services. They do however provide nursing services when required.

There is a waiting list for homecare services and the facility is struggling with increasing needs and limited resources. The Coordinator oversees the delivery of service and supervises the homecare workers. The case worker does the assessment and coordinates the care with the facility and other service providers.

Family involvement:

Most of their clients are competent and therefore capable of making their own decisions therefore, family members are involved at the client’s request. However, in the Italian culture most of the seniors choose to have their family be very involved throughout the entire process.

Homecare assessment:

All of the residents are assessed using a standard assessment and the number of hours they receive is determined by their Maple Score using the: Resident Assessment Instrument-Community Health Assessment (RAI-CHA). The RAI-CHA, is a standardized assessment tool that is used to identify the specific health care needs of frail older adults. The residents receive a maximum of three hours per week of homecare services but are also entitled to additional access to security checks, emergency response, diners program, Meals on Wheels and participation in one of the day programs.