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Culturally Competent[i] (Appropriate) Health and Long-Term Care Services for Older Immigrants in a Small Urban Center Of Newfoundland

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ABSTRACT: *There is a paucity of research exploring the needs of older immigrants in Canada in general and specifically of those who have settled in smaller urban centers in the Eastern region of Canada. Recently Newfoundland implemented an immigration strategy to attract more immigrants to address the skilled labor shortages, to increase the population that has been shrinking due to outmigration and to replenish a rapidly aging cohort. Most immigrants to Canada settled in larger cities. Out of the small number of immigrants in Newfoundland, many left the province shortly after arrival due to a lack of jobs and other reasons, such as lack of culturally appropriate health and long-term care (LTC) services. This qualitative pilot study explores the potential gaps in culturally appropriate health and LTC services for older immigrants. The study uses a qualitative method approach. The convenience sample consisted of 26 individuals over 50 years of age who were caregivers, care receivers and older persons from various cultural and racial backgrounds, recruited through a local community agency providing services for newcomers. Data were collected through two focus groups and four individual interviews. The findings revealed that health and LTC services in small urban centers of Newfoundland need to be more culturally sensitive. Recommendations are suggested to bridge the cultural gaps.*

KEYWORDS: *Culturally appropriate, long-term care services, older immigrants, informal care.*

I. INTRODUCTION

With the prospect of a declining and aging population in Atlantic provinces of Canada following two decades of rapid out-migration and population loss, the province has recently initiated policies to boost immigration to replenish the population base, increase human resources and entrepreneurs needed for economic growth, and meet the demand for a skilled workforce in the expanding oil and mineral sectors [1]. Most immigrants settle in large Canadian cities such as Vancouver [25%], Toronto [23%], and Montreal [20 %]; only 1% have done so in Newfoundland and Labrador (NL) [2]. Although the number of immigrants in NL is significantly smaller than that in other provinces, it has increased from 0.7% in 1996 to 1.1% in 2006. Retention rates of immigrants in NL, however, have dropped since the 1990s, and in 2007 more than half left the province shortly after arrival [3], partly due to lack of culturally sensitive services [4]. Currently policies, programs and services are based on the dominant racial and cultural group's norms and values. This raises questions about the accessibility of culturally appropriate long-term care (LTC) services for older immigrants in the province. This study, therefore, has been conducted to answer such questions.

The number of immigrants in Canada continues to rise, and they are now typically coming from East and South Asia, Africa, the Middle East and the Caribbean instead of Europe [5]. This demographic shift increases the need to address the language and cultural differences in providing health and LTC services [6]. Prior research conducted in central and western Canada revealed that immigrants faced a number of barriers to receiving health and LTC services including language, cultural differences, income, transportation, confidentiality, lack of information, lack of resources, and a poor perception of care available [7; 8; 9; 10; 11; 12; 13; 14; 15]. There is a paucity of research on the same issue in the Atlantic region; the few available studies focused either on women generally [16; 17; 18] or women who were abused [19; 20]. More specifically, early studies on immigrants in NL focused on their settlement and integration process [4; 21; 22; 23; 24] and mental health issues [25; 26, 27; 28]. Research is therefore needed to examine the extent of culturally sensitive services in hospitals and community health care in NL. The findings of the latter research will provide evidence for designing programs and policies to improve health care and settlement services, create a welcoming environment for newcomers, and possibly help to increase the retention of immigrants in the province. The number of immigrants is increasing in NL and so, too, is the number of older adults. The province has one of the most rapidly growing older populations in Canada [29].

The number of people 65 and older is projected to increase by 59.6%, while those between 15 and 29 will decrease by 23.6% [1]. In 2010, NL had the third-highest number of adults over 65, representing 15.2% of the population, and it is projected to double to 31% in 2036 [29]. This group of older adults also includes immigrants who have settled in NL at a younger age and are now aging in place. Since no study has been located that explores the availability of culturally appropriate and culturally competent LTC services for older immigrants in NL, this study has two purposes: 1) to assess the level of awareness among older immigrants and their informal caregivers of various LTC services and 2) to explore the accessibility of culturally appropriate health and LTC services for this age group. As such, this project seeks to identify potential gaps in the provision of culturally appropriate health and LTC services for older immigrant in NL's largest urban center and to document participants' recommendations for improved services.

II. CULTURALLY APPROPRIATE HEALTH AND LTC SERVICES

According to Goode and Sockalingen [30], cultural competence is "a set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals and which enables them to work effectively cross-culturally" [pp. 252-253]. Similarly Giger and Davidhizar [31] argue that cultural competence is "a dynamic, fluid, continuous process" of providing care that is based "on knowledge of cultural heritage, beliefs and attitudes" [p. 8] of the individuals to whom care is delivered. Culturally appropriate care then attempts to consciously address the many differences that are exacerbated and exploited institutionally and that allow marginalization and personal biases to creep into care provision. Werkmeister-Rozas and Klein [32] argue that "these differences are rooted in the degree of acculturation that one has experienced in socioeconomic status and in education" [p. 1]. These descriptions fit the life circumstances of many older immigrants in NL. Providers of health services and programs are not experts in the life circumstances of all groups; however, the basic premise for providing culturally appropriate health care services to older immigrants is based on at least an understanding of service users' cultural beliefs and values such as attitudes and ideas about pain, death, diet, communication styles and decision-making about health care [33; 34; 35; 36].

Several authors raise critical concerns in response to the lack of culturally appropriate health care services for immigrants in Canada [26; 27; 37; 38; 39]. According to Ontario Women's Health Network [40] "mental health, caregiving, immigration and resettlement, female specific concerns (e.g. breast and gynaecological cancers), health care access and health promotion practices and illness management" are key health-related areas that require attention to the promotion of ethnocultural and ethnoracial sensitivity when providing services for and care to older immigrant women [p. 4]. Similarly, Brotman [41] identifies that cultural interpretation services in the promotion of and access to health services are critical for older immigrants. When formal interpretation services are absent, health care practitioners rely on family members or staff who have backgrounds similar to the care receiver to provide interpretation services. Not having interpretation services negates the need for institutional supports and this also compromises the provision of health and LTC services by choosing the circumstances under which older immigrants require interpretation services. Ontario Women's Health Network [40] identifies race, ethnicity and language discrimination both in public and private services that aggravate older women's mental health and motivates higher levels of depression than non-immigrant older persons. This concurs with Lai [42] who found that Chinese women 75 years old or over had lower social functioning and mental health compared to older non-immigrant individuals because of lack of access. The research clearly shows that there are gaps in health care services to this population.

III. PARTICIPANTS AND PROCEDURES

A qualitative descriptive approach to data gathering and analysis was used [43]. The focus was on hearing and documenting the participants' stories in order to understand their feelings and identify their needs regarding access to health and LTC services. This method also allows freer, deeper expressions of feelings and perception, generating richer data that are more relevant to the research objectives. The data were collected following approval for the study from the organization's Research Advisory Committee which followed the Human Investigation Committee's ethical guidelines and process of the local university. The participants for both the focus groups and the individual interviews were selected based on the following criteria: born outside of Canada but residing in NL, older than 50 years or familial primary caregiver for older immigrant[s]. A non-probability, convenience sample of participants were recruited through purposeful and snowball sampling [44]. An introductory letter and project information packages were emailed to various community agencies that provide services to older people and immigrants. A request was made that they post the recruitment flyer and distribute the information to service users and other community agencies. Potential participants were also recruited by a research assistant who works with a local non-profit agency that provides services to immigrants. The research assistant contacted potential participants by telephone and invited them to participate in the study. Potential participants were provided with project information, which was read from a scripted information package previously prepared by the researcher. Once participants agreed to participate, they were given the choice of

attending the focus group interviews or having individual interviews. Participants were given two separate dates for the focus group interviews, and each chose the date and time that best suited them.

Data were gathered in early 2011 by way of two focus groups—one lasting 90 minutes and the other 120 minutes—and four individual interviews, which lasted approximately 40 minutes each using similar guided interview schedules. Before beginning the interviews, the research purpose was explained and questions that the participants had about the study were answered. For convenience, the two focus groups were held at local community centers that provide services for immigrants. Individual interviews were scheduled at a venue and time convenient to participants; these were held at participants' homes and private offices. The focus groups and individual interviews were tape-recorded with the consent of participants, who signed consent forms prior to data collection. Both focus groups and the four individual interviews were conducted by the researcher and supported by the staff and volunteers of the local agency where the focus groups were held. The interview guides were revised after the first focus group and individual interview and subsequently adjusted to highlight emerging themes. During the focus group interviews, the researcher kept field notes of non-verbal and verbal communications that could potentially impact participants' response and the data collected. Participants were asked to respond to four open-ended questions focused on their experiences, needs and understanding of available health and LTC services in their communities. The interview guide proved helpful by using specific questions for introduction, beginning, transition and ending. Probing questions were used when warranted and to help participants share more information. Creswell and Miller [45] suggest the use of member checking procedures to increase trustworthiness; as such, member checking was done during the focus groups and the individual interviews. Specifically, the information that was shared during the focus groups and individual interviews were clarified to ensure that the researcher understood the information as it was intended.

IV. DATA ANALYSIS AND LIMITATION

Strategies for data organization and reduction suggested by Denzin and Lincoln [46] were used. The data were transcribed verbatim; the transcriber, also a research assistant, and the researcher checked the transcripts with the recorded data to ensure correctness. The transcripts were analyzed and compared constantly by the research assistant and the researcher to avoid bias or one-sided interpretation. Transcripts from each focus group and from individual interviews were compared line by line to identify similar concepts that may have indicated a response pattern. For the qualitative section, an initial list of concepts and words was created based on observation of the focus groups and the individual interviews and the data; other themes were added as the data were explored. As suggested by Cresswell [43], the themes and patterns were then grouped into relevant categories. The research was limited by insufficient funds and strict timeline, as such, the participants were mainly recruited from the urban center where most immigrants live. The sample, therefore, did not include the voices and perceptions of older immigrants in other parts of the province. Furthermore, many eligible participants perceived that they had nothing to contribute and withdrew from the study. These withdrawals also contributed to the small sample size. Some of participants were neither caregivers nor care receivers; therefore, the information they offered was limited to their knowledge about other community members rather than personal experience. A further limitation is that older immigrants were discussed as a homogeneous group in terms of racial experience, gender dynamics, class, sexual orientation, religion and length of time in the province; consequently, the within-group complexities and differences were not explored.

V. FINDINGS

Fourteen persons participated in the first focus group, 8 in the second and 4 participated in individual interviews, for a total of 26 participants, of which 22 were female and 4 were male. Of that total, at the time of the data collection, 3 were care receivers, 6 caregivers, 14 were born outside of NL and the majority were older than 50 years. All were able to communicate adequately in English. Interpreters, therefore, were not needed. The birthplaces of participants included India, Pakistan, Iran, Germany, Kosovo, Philippines, China, Hong Kong, Bangladesh and Guatemala. They were between 51 and 90 years old (average 62) and observed various forms of spirituality including Hindu, Christianity, Islam, Bahai faith and New Age. Initially a total of 22 themes emerged from the data, and these were collapsed into three major themes as follows: cultural values and understanding of family dynamics, social and cultural integration and communication. Participants' comments focused on large institutional service providers such as hospitals, nursing homes and home care services.

5.1 Cultural Values and Understanding of Family Dynamics

Caring supports are vital for maintaining one's health and recovering from illness. The types and modes of support vary from one culture to another. Several participants perceived that health professionals' view of family structure and support conflict with that of the immigrant and his/her family members. For example, in some immigrant families, children work as a unit to support older parents. Participants noted being frequently asked by nurses in hospitals and nursing homes to identify the primary caregiver for the older adult. However,

they cannot, because the children as caregivers speak as one, so there is not one primary caregiver for the institution to dialogue with. One participant described the case for his family:

> My mom was still mobile but she just needed some assistance and … it was a major undertaking and a fight in the sense of getting the hospital staff to recognize the culture and understand the issues because they would always ask who was the caregiver, the primary person to talk to them, but in our culture the children speak together, and so there is that cultural nuance that they … really need to be aware of.

In cases where a solution was needed, families wanted time to engage in their family process and arrive at a resolution on their own, but the institutional pressures were always present and the suggestion of a quick resolution was frequently expected. Regarding cases in which older adults needed 24-hour care, one participant told her story about her elderly mother:

> … the quick solution was that she [our mother] is best living with … a daughter. Again that goes against the cultural grain and yet we did come [out] with a new understanding of what needed to be done and my mother did move in with me. But it's again … it is something that the [nursing] staff need to be trained in diversity … and cultural understanding.

Older parents lived with either sons or daughters, and it was not only daughters who provided care. One participant discussed the limitation of home care hours and the barriers that her employment responsibilities created for the family. However, she noted that "fortunately, my husband is home" to take care of her mother when she is working and home care services are unavailable. In most Asian cultures, the son and daughter-in-law bear full responsibility for caring and providing for older parents. Illness, along with the increasing fragility of older immigrants, places additional pressures on a family to provide 24-hour care and support with minimum external support. When it becomes apparent that the older person requires more care than the family can provide, hospital staff [doctors and nurses] are quick to offer a nursing home as an option. A nursing home, however, is not an option for many immigrant families in NL. One participant articulated:

> Coming from an Indian culture, that is something we would never do and it would be considered a shortcoming of the children if they ever did that. And first of all people would … children would have a hard time living with themselves and feeling that they have let down the parents, but also from a community perspective … it would be viewed as someone who didn't live up to their duties and responsibilities …

For the members of some immigrant families, the boundaries are seamless as decisions are made for and on behalf of one another. Participants were concerned that Western family values interfered with the dynamics of their family processes. In particular, they feared western social judgments that labeled their family structure oppressive and undemocratic. They suggested that this stereotyping was especially evident when decisions were being made on behalf of the older adult. As one participant said:

> … the understanding of the family structure and the family values is not [understood] as much. I made a decision for my mom and this person thought that I was abusing her and not allowing her to make her own independent decision. The boundaries that we tend to cross, or which, you know, I shouldn't say tend to cross … the boundaries that don't exist for us [is not fully understood by others]. With family members, we take on the onus of doing things without checking with them and we bear the responsibilities as well when things go wrong.

Care recipients tended to agree and added that they trusted children and children-in-law to make decisions on their behalf. They further noted that they were not concerned that their family would make wrong or inappropriate decisions. This family process was evident during one of the interviews, which was expected to be with just one individual, but instead the entire family added information as the interview continued. One female member signed the consent form, but both the care recipient and a male caregiver added their comments to the interview as they thought necessary. Individuals said that they had felt bothered in the hospital when, for example, nursing staff constantly approached care recipients to offer care directions and ask them to make decisions. One caregiver agreed and suggested that acknowledging the cultural dimensions of immigrant families is important. There is a sense that family dynamics and particularly those around decision-making are perceived as dominating. Such a perception may have racial overtones, in that the "dominating" family member is viewed through a Westernized value system as abusive, when in fact, he or she is acting properly within his/her culture and the behavior is not abusive even by Western standards and definitions. In Asian culture,

when the person gets older, he/she is expected to disengage from activities of the daily life such as making decisions so that he/she can have peace of mind.

5.1.1 Social and Cultural Integration

Participants in the study felt that they were resource rich, given that the majority of immigrants in NL are skilled and educated. This allowed them to integrate in the NL culture and community more easily but they still felt they needed aspects of their culture in their day-to-day lives, and especially when they had to live in institutions or residential facilities, where there is little or no choice. One participant identified this lack of choice when observing two immigrant seniors who reside in nursing homes and said the following:

> Both of them are well integrated into the society here. They are, you know, professionals. However, there are certain cultural touches that one is used to in their life and those are definitely missing for these two people. Now both of them are very fortunate to have community members volunteering to go and meet them regularly, bring them meals that they are used to. Cultural sensitivity is only coming through volunteer work and nothing structurally that is available to them …

Confidentiality was consistently violated once individuals were admitted to health care institutions. Specifically, health care staff [nurses] have an informal policy of contacting community members and offering information about the person admitted to hospital or nursing homes. Although this was done with the intention to provide spiritual support to individuals, it may have violated the confidentiality of the person involved. Random community persons or perceived leaders were not necessarily able to offer such support. The dissemination of confidential information is extremely problematic for some participants, given that sometimes individuals prefer to maintain their privacy. As well, contacting specific community members placed a burden on the individuals receiving the calls and put them in a conflict-of-interest position. One participant proposed the following:

> [R]ight now I believe the practice is whenever somebody from diverse [races or] cultures come in to [a health care institution], somebody from the community is automatically informed and I think that gets into the form [realm] of privacy. So it's a fine line between [support and breach] ... before you [staff] contact those [community support persons] check with people because in other religions they are not necessarily priests they are just community members, and families may choose not to inform everybody about their situation. So I think out of respect for privacy it would be a good idea to check and talk to the patient and their family to say is there anyone in the community you would like us to contact … or is there services we could help provide.

Participants identified respect for their privacy as an important factor in how they integrate in the NL society. This tension also highlights the importance of communication.

5.1.2 Communications

Although many older immigrants have lived in NL for years, some still do not speak, read and write fluently in English or French. However, health care professionals often perceived that they have language skills and do not consider this as a possible barrier to service. Participants identified that when some members of their communities become older, they prefer to speak—and often revert to speaking—their first language. When family members are not present to assist with interpretation, the lack of language skills creates additional barriers in nursing homes, hospitals and residential facilities. In cases where the family receives support through home care services, the family provides written instructions to home care workers to avoid caregiving errors and communication breakdown. A participant noted:

> I would say that language and communication [are] a very important aspect of it [caring]. People who have arrived or even some people who have been here a long time still can't speak English very well. They can't describe their symptoms.… There was a woman … on the stretcher she was having her hand on her heart and the doctor presumed it was a heart attack.

Another said:

> I know of other members of the [country name] community who have a lot of problems, a couple of them, because communication is poor. They have a [home care] worker and the family members have to leave instructions for the workers. Language is an issue.

In addition to verbal communication, recreational reading material available at health care institutions was also culturally irrelevant. Magazines were provided, but older adults without English language could not read them. A participant shared the following experience:

> [My relative] could also look at some of the books and the activities and entertainment that was often provided at [the hospital]. People would come up with magazines but she wasn't fluent in English, she couldn't write or read in English [so] those magazines were not really of any help [to her] but…[the hospitals] need to be a little more cognizant of diverse cultures as we now do have a larger [diverse] population here and if we connected with the local [ethno-racial and ethno-cultural] communities they would be able to provide many of these magazines to the hospital and donate them.

Communication in both large institutions and home care continues to pose significant challenges for older immigrants in NL.

VI. DISCUSSION

This study focused on health and LTC care services as defined previously. Participants' responses seemed to focus exclusively on experiences in hospitals and nursing homes. Most participants are unaware of what constitutes LTC services, and many thought nursing homes to be the only type of LTC services. Services such as respite care and adult day care are foreign to them. The findings of this study add support for the observations of Saldov and Chow [47], who asserted nearly two decades ago that culturally appropriate services are not available in nursing homes and other health care facilities. This lack of service was again identified in more recent studies [17, 18, 19, 26, 27]. The lack of understanding about family dynamics in caring for older adults as well as cultural norms and values with respect to family decision-making generated significant discussion. The cultural misunderstandings result in perceived exclusion of family members, especially adult children, from the care of the older immigrant. Health professionals and administrators are seen as unable to understand the values of a "boundary-less" family structure in some cultures and often consider this family dynamic as a limitation rather than a strength. The majority of participants have lived in NL for more than 20 years and some as many as 50 years; consequently, many are well integrated into NL culture and communities. They have made professional and community connections, a commitment to the province and have excelled in many areas. In spite of their length of residency and their cultural and economic contributions to the province, as expected, they are still strongly rooted in their culture, are more comfortable with their own cultural surroundings and are reluctant to challenge exclusionary or discriminatory practices for fear of being labeled unfriendly or opposing NL cultural values. In a recent study, Hekklla and Ekman [48] found similar feelings among older Iranians in Sweden who identified a sense of community, food and culture as an important aspect of their living environment. When the cultural aspects are missing, older people reported feeling isolated and excluded. Participants in this study noted that their sense of isolation and exclusion is heightened in LTC centers and hospitals where food, recreational and spiritual activities are solely based on a white NL or Canadian perspective.

Additionally, older immigrant's privacy is violated when, on admission to health care institutions, staff regularly contact perceived community members with the intention to offer spiritual support from within the patient's community without first checking with the care recipient or his/her family member. The individuals who are contacted are often not faith-based leaders. This places both the patient and the community person in an awkward position when they prefer to keep their personal situation private or choose to disclose it at their own pace. To bridge these privacy gaps, participants overwhelmingly suggested that racial and cultural diversity training be implemented in all aspects of society, including government institutions, community programs, schools and post-secondary institutions and educational programs for health and social care professionals. As such, better services can be available to immigrants, enhancing their retention and attracting more newcomers to the province. Good communication in all aspect of life is critical for better living and working. In health and LTC care communication enhances interactions between health care professionals and patients. To improve communication with patients from various cultures, several authors suggested having care providers who share the same ethnocultural background to provide familiarity and develop trust between staff and patients [49]. Others recommended using professional interpreters based on clear guidelines [50]. However, professional interpreters may not be suitable for all patients. Some perceived using interpreters as a hindrance, although needed. Hadziabdic, et al. [51] suggest that in some cases, face-to-face interaction is preferable to interpretation using the telephone. This approach would be more suitable to the population of NL.

VII. RESEARCH AND PRACTICE IMPLICATIONS

The findings have implications for health and LTC care service, education, research and policy formulation. Recommendations are suggested based on results of this study and prior research, augmented by published

literature about immigrants' health and social care. While many of these recommendations are not new, they are worth repeating especially given that participants identified them in their interviews. This may be an indication that these recommendations, although previously proposed, have not adequately implemented and that older immigrants in NL do not have access to culturally appropriate services. Funding is needed for a province-wide study using a larger sample to include better representation of various immigrants groups both in rural and urban areas.

The findings of this study not only support those of earlier studies that identified a lack of culturally appropriate services for immigrants, but also specifically speak to the lack of such services for older immigrants. While the sample of this study is small and the outcomes are not generalizable, the findings nonetheless provide at least a beginning foundation for policy makers and service providers to consider when implementing health and LTC services for the province. Newfoundland and Labrador could follow the example of Australia and Sweden, two countries that have policies aimed at reducing health care gaps for immigrants; Sweden is the only country that has enacted law requiring that interpreters be provided for patient care [52]. Research acknowledging the lack of culturally sensitive health and LTC services for older immigrants has been published for at least two decades. In the meantime, Canada continues to become more culturally and racially diverse [5] and it is easy to assume that with the changing demographics, services have become more equitable for all Canadians. This, however, is not the case. The participants in this study offered a number of recommendations to improve access to culturally appropriate health and LTC services in NL. With respect to improving access to health and LTC services, comprehensive community-based programs need to be implemented to inform NL immigrants about available health and LTC services in their communities, using various languages and different media. Emami, Torres, Lipson & Ekman [53] found that similar education and information were beneficial to older Iranians in Sweden. Receiving information is helpful, but participants advised that the health and LTC sector in NL must also engage in on-going dialogue and consultation with community stakeholders, including older immigrants, their caregivers, academics and service providers about health and LTC care needs of immigrants, so that their collective voices and perspectives are heard and acted upon. Christensen Community Consulting [54] concurs and recommends that LTC homes and associations need to "identify community resources" such as family members and religious/spiritual groups who are willing to partner in various ways to enhance cultural competency in LTC facilities [p. iii]. The research has also discussed creating spiritually welcoming space in LTC facilities, staff education and training and effective communication, which may include language interpretation or having staff who speak various languages.

VIII. CONCLUSION

Health and LTC service providers must include those from various cultural and racial groups and reflect the population of older people who use the services so that older immigrants can relate and communicate more easily in their languages. Torres, Lipson & Ekman [53] note that older people feel understood when care providers with cultural backgrounds similar to theirs provide services to them. In addition, participants in Heikkila & Ekman's [48] study identified the significance of service providers speaking the same language as older residents and their perception of the improved culturally appropriate care. Along similar lines, Christensen Community Consulting [54] suggested that a cultural "broker can facilitate mutual understanding of behaviours, service or program expectations, beliefs and assumptions among residents and their families (from small ethno-cultural, linguistic and spiritual communities) and staff. This informs program development and supports a welcoming approach to care" [p. 7]. These program implementations may require recruitment targeted for certain ethnoracial and ethnocultural groups and employment categories. Education and training is also needed to help practicing health care professionals, staff, administrators and volunteers provide culturally appropriate services. These programs need long-term commitment, with adequate financial support, to be ongoing and province wide. Professional education programs should be reviewed to ensure that cultural and racial awareness components are included in nursing, social work, pharmacy, and medicine curriculum. Of all health professionals, nurses spend more time with patients/clients/residents of all age groups, in various settings, as they provide care for them at their most important moments in life: when life begins, when life changes and when life is ending. In these moments of need, nurses will be the frontline formal caregivers for older immigrants. It is therefore crucial that they have adequate understanding of cultural differences in clients' perceptions, beliefs, values, behaviors, expectations and communication, so that the care they provide is patient-centered. Finally, policy makers need to ensure that allied health professionals' accreditation bodies and educational institutions include culturally appropriate practice as a required criterion in assessing quality of services and educational outcome. Culture has been recognized as one of the determinants of health. Attention to race and culture is important in the provision of health and LTC services and promotion of client's well-being. To meet the client's health care needs, individual care plans are preferable to a one-size-fits-all approach. Community and institutional staff must develop consciousness and sensitivity to their own biases; they must also refrain from making assumptions, generalizations and stereotyping older immigrants. At the same time,

service providers need to invest in enhancing knowledge and improving skills in order to provide better health care for older immigrants.

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[i]*This project was a collaboration with a community organization and they strongly identified with the term and want it used in the research.* Culturally sensitive *or* culturally appropriate *are more appropriate terms because they capture the essence of the need to provide unique care rather than working from a check-list approach that suggests that if providers can check off items from a list, they are providing appropriate care.*