FILIPINO FAMILY CAREGIVERS AND AGING PATIENTS FOR *KAPWA* (SHARED IDENTITY) AND PEACEBUILDING:

CONFLICT TRANSFORMATION FOR RACIAL JUSTICE IN HEALTH CARE SERVICES IN CANADA

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This article examines communication challenges faced by immigrant Filipino family caregivers and senior patients when engaging with health care providers in Winnipeg, Manitoba. Our study revealed that health care providers exhibit judgment, implicit bias, and poor management of chronic illnesses, often leading to expressions of power over patients and low levels of trust on the part of patients and caregivers. Participants' testimonies stress the need for health care providers to seek pathways for *kapwa* and peacebuilding to address racial/ethnic health care disparities, poor health service utilization, and poor health outcomes. The Filipino concept of *kapwa*, an Indigenous philosophy, embodies peace values such as respect, mutual help, compassion, sensitivity, and community, and calls people to navigate relationships collectively rather than alone. While *kapwa* acknowledges personal identities and differences, it encourages a sense of oneness, the unity of the self and others. *Kapwa* can be conceptualized as an Indigenous form of peacebuilding as well as a conflict transformation approach that can be used in health care settings to achieve oneness and racial justice. This research suggests the use of anti-racist education to reduce oppression, a key cause of adverse health-based inequities affecting racial/ethnic minorities in Canada.

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INTRODUCTION

Immigrant women and men, regardless of gender, race, class, ethnicity, and country of origin, experience barriers in accessing the Canadian health care system. [1] Many find themselves taking the lead role in negotiating cross-cultural caring for their families, who have specific emotional and socio-cultural needs in how they receive and provide care to their children, parents, or relatives.[2] Immigrant women frequently experience a lack of support while having heavy obligations as caregivers for ill family members; they often have a low income and/or jobs with limited flexibility and experience a lack of social support, neighbourhood cohesion, and sense of community.[3] They may be reluctant to use formal services because of the lack of cultural sensitivity shown by care providers and the barriers related to unmet language needs, transportation issues, racism, social exclusion, accent-based discrimination, and lack of knowledge about the Canadian health care system.[4] Some immigrant caregivers and patients experience poor relationships with health care providers, who may not communicate in a cross-cultural manner or provide adequate care.[5]

Immigrant women often experience caregiving conflicts with work and family expectations, resulting in stress, burnout, guilt, and frustration as they feel overwhelmed by the number of tasks to perform.[6] Caregivers may have chronic illnesses themselves, such as cancer, kidney, arthritis, headaches, and dementia.[7] Moreover, as immigrant caregivers experience resettlement, they frequently must deal with isolation and loneliness, depression, family conflict, economic dependence, and coping.[8] While a strong sense of responsibility prevails in providing care, structural issues such as disadvantaged access to housing, employment, transportation, or health care services often cause distress for immigrant caregivers looking after their family members.[9]

The impact of immigration on access to and use of health care has been examined; however, conventional approaches often homogenize the experience of racialized immigrants, and the intersecting power axes of racialization, immigration, and aging have been overlooked. Our study

revealed that racial minority immigrants' vulnerability in accessing health services is rooted in racial-nativity status and specific markers of power differences in regard to minorities. These multi-level factors are evident in diverse forms of oppression and manifest in socio-economic challenges, cross-cultural differences, labour and capital adequacy in the health sector, organizational accessibility and sensitivity, inter-sectoral policies, and societal values and ideology. Therefore, to counteract prevailing personal and cultural barriers to care, further research is useful to explore structural solutions to address power imbalances and empower racialized immigrants in later life.[10] More specifically, little is known about Filipino family female caregivers, their aging family members' experiences, and their relationship with nurses and health care providers in an unfamiliar context of Canadian health care.

This research presented here addresses this gap by examining Filipino caregivers' and patients' testimonies that call for centering the Indigenous Filipino philosophy of *kapwa* (shared identity) in the relationship between health care providers and patients as a way to achieve positive health outcomes. We argue that *kapwa* can be conceptualized as an Indigenous form of peacebuilding and conflict transformation that can be used in health care settings to achieve oneness and racial justice. *Kapwa* demonstrates *pakikiisa* (oneness), the unity of 'self' and 'others.' In English, 'others' indicates the opposition to the 'self' and implies the recognition of the self as a separate identity. In contrast, *kapwa* recognizes shared identity, an inner self shared with others.[11] The article begins by providing an overview of *kapwa*, linking domains of direct, structural, and cultural violence and microaggressions to health outcomes. We present evidence of health care providers' practices of oppression, described as *ibang tao* (not one of us), and liberation, and *hindi ibang tao* (one of us), supported by the voices of Filipino caregivers and patients. Filipino Indigenous philosophy can form a common ground and inspire creative solutions at the interpersonal level, change power dynamics from the top down to shared power in institutions and policy, embracing core peace testimonies and the values of *kapwa*—respect, mutual help, compassion, sensitivity, and community. Justice requires recognition of truth and moving forward together as a community to practice *kapwa* and oneness at all levels of our diverse society. The efforts described by the Filipino community work together to provide evidence for interventions to reduce racism, a key cause of adverse health outcomes for racial/ethnic

minorities and racial/ethnic inequities in health.

THEORETICAL BACKGROUND

This section introduces the philosophy of *kapwa* (shared identity) and *pakikiisa* (oneness) to show how cultural awareness is crucial for successful conflict analysis and peacebuilding, transcultural nursing, racial justice and quality of health care. Madeleine Leininger, who developed a theory of transcultural nursing, stresses various dimensions of culture such as values, health beliefs, religion, and philosophy as critical in providing culturally competent care to patients.[12] Ethnonursing examines interactions with people and their daily life conditions, and patterns influencing their human care, health, and nursing practices.[13] Although care is universal, its patterns and expressions can take different meanings in different cultures.[14] Leininger also stresses that culturally congruent health care considers broad aspects of social structure, world view, language, and the environmental context of individuals, families, groups, and institutions.[15] Understanding the culture of the patient being cared for is critical in understanding the relationship between health care providers and caregivers and patients, in addressing conflict and its resolution to provide quality care and health outcomes. Culture, identity, transcultural nursing, and transforming oppressive systems are useful concepts to re-theorize peacebuilding, and we find that their potential has not been fully analyzed in peace and conflict studies or in health care disciplines such as nursing and public health. The findings of this study address the gap in the literature by identifying the issues related to the quality of care provided to aging immigrant patients and underlines the importance of *kapwa* as a conflict transformation tool in peacebuilding and racial justice.

The authors use aspects of Indigenous conflict resolution and peacebuilding that can be found in North America, the Middle East, and the South Pacific:

> (1) The goal of peacemaking is to reveal the truth and the cause of conflict by collecting evidence.
>
> (2) The party responsible for the conflict is held accountable; the family and community are critical in establishing the facts and resolving conflicts, unlike in the existing legal system where the individual is a focal point in resolving conflict.

> (3) Stories and parables are vital discourse in mediation.
>
> (4) Connections are made between the individual, family, community, nature, and the supernatural.
>
> (5) Conflict resolution is used to establish unity and in keeping with family and community traditions. The goal of conflict resolution is not based on class and power but on the worth the community places on a person regardless of their power and status.
>
> (6) The goal is to repair damaged relations and not to punish the individual but find the right remedies.
>
> (7) Forgiveness is critical in repairing damaged relations.
>
> (8) Ritual plays a major role in the process of peacemaking and peacebuilding.[16]

Indigenous methods of conflict resolution, peacemaking, and peacebuilding are grounded in peace processes. Peacebuilding is defined here as the development of the constructive individual, group, and political relationships across racial, ethnic, religious, national, and racial identities. The purpose of peacebuilding is to resolve injustices in a nonviolent way and to transform oppressive structures. Peacebuilding becomes strategic when it builds social networks and designs long-term interventions, recognizes and reinforces peace capacities on the ground to increase capacities to respond to and transform conflicts, and also builds communities, institutions, politics, and relationships that are able to sustain peace and justice.[17] Conflict transformation requires enhancing the peacebuilding capacities of stakeholders to handle conflict non-violently and to transform relationships, systems of governance, and oppressive systems embedded in structural violence.[18]

There is a larger effort around the world to witness and collect testimonies through storytelling. A testimony is an account in which the narrator provides a firsthand oral or written statement to speak up against injustice, racism, genocide, or oppression.[19] Testimonies are built on personal experiences and evidence and conveyed through storytelling; they create meaning and knowledge with the aim to mobilize communities and bring

social change. Through stories, individuals define identity, negotiate power relations, construct emotions, and create knowledge. Storytelling can play a central role in bridging the gap between immigrants and communities to create a sense of inclusion and belonging, construct shared meaning, educate, collect knowledge, and exercise agency,[20] all of which are critical in creating *kapwa* and in establishing cultures of peace. Life events, along with memories of oppression, can be communicated through storytelling as an intentional strategy for teaching oppressors, and stories may serve as a rationale for conflict transformation and peacebuilding.

Kapwa

Filipino culture is based on kinship structures and strong family ties that embody values of respect, mutual help, compassion, kin obligation, social sensitivity, and a strong sense of community.[21] Cultural values, norms, and behaviour define how people relate to each other and manifest in verbal and non-verbal expressions.[22] In Filipino culture, social interactions fall under two categories: (1) *ibang tao* (not one of us), which includes levels of social amenity, conformity, and adjustment; and (2) *hindi ibang tao* (one of us), which includes levels of mutual trust and oneness (see Table 1).[23]

Understanding these categories and levels of interpersonal interactions are critical for health care providers in progressing toward *kapwa*, a shared identity that is embodied in how people relate to other people (*pakikiisa,* oneness), and their "being" or *pakikipagkapwa-tao*.[24] This concept refers to the collective nature of community and doing things together. Filipino culture is mainly Confucian and values collective well-being rather than individualism brought by colonialism. Achieving pakikipag*kapwa* tao, going beyond empathy, and establishing positive relationships and actions with others, can lead to satisfactory interactions with patients and understanding their meaning of illness.

The Western health care system tends to conceptualize patients' bodies as universal and appears to ignore the social context or identity of the individual person.[25] In a study on cross-cultural relationships between Canadian nurses from diverse cultures, Filipino Canadian patients identified nurses in terms of *hindi ibang tao* and *ibang tao* and showed their preference for those who performed personal care in a culturally appropriate manner. Filipino patients considered nurses, regardless of their cultural background, to be *hindi ibang tao* if they demonstrated respect, kindness, courtesy, and readiness to accommodate the patients' needs. Patients' readiness to trust and share their *kapwa*-oriented world view involved nurses or other people who understand the language of words, gaze, touch, and food that allow nurses to become *hindi ibang tao*.[26] *Hindi ibang tao* also involves understanding and accepting someone's identity for who they are.

Other strategies that enabled some nurses to become *hindi ibang tao* involved spending time with the patient and family members, communicating health-related issues to family members, providing quality care, and responding in a timely manner. With an increase of trust and mutual comfort, the relationship between the patient and nurse could progress through levels of formality, adjustability, acceptance, mutual comfort, and oneness.[27] From the perspective of Filipino family caregivers and patients, cultural competence and knowledge of *kapwa* in health care practice are needed to address their needs and reduce insensitive communication and unsatisfactory relationships among health care providers, family caregivers, and patients.

Oppression. Oppression refers to interlocking elements in a dynamic process that creates and sustains injustices such as racism, sexism, ableism, elder oppression, and so on.[28] During the last decades, empirical research has shown how racism at the micro, meso, and macro levels results in poor health outcomes. The groundbreaking work by Derald Wing Sue demonstrates how everyday racism in the form of microaggressions (individual biases, interpersonal bigotry, and social prejudice) are embedded in power and social relations at the micro institutional level (health care system) and the macro level (economic and socio-political system).[29] Oppression can be pervasive, restrictive, and cumulative; socially constructed, categorizing, and group-based; hierarchically normalized and hegemonic; intersectional, internalized, and mutable. The pervasive nature of oppression is entrenched in social institutions through laws, policies, social cohesion, and gender norms that justify hierarchies among groups as well as in individual consciousness.[30] The combination of institutional and systemic discrimination creates a complex web of relationships and structures that mutually reinforce all elements of oppressive systems.[31]

Studies have repeatedly identified racial biases of health care providers, and the empirical evidence shows how sexism, racism, and aging are linked to poor mental health among racialized groups.[32] A growing body of research

indicates that racism is demonstrated by inadequate medical care and outcomes such as hypertension, obesity, cardiovascular disease, poor self-rated health, anxiety, and depression.[33] A study of Canadian South Asian, Vietnamese, and First Nations women recorded discriminatory remarks from health care providers regarding their "low pain threshold," "peculiar body odour," and "tendency for substance abuse." Overall, racialized patients are considered "challenging" because of linguistic and cultural barriers.[34]

METHODOLOGY

The principal investigator and lead author used a snowball recruitment technique, asking participants in the study to recommend and identify eligible additional participants from their social network.[35] This type of recruitment helped reach out to the racialized minority community.[36] Interviews were held in participants' homes, in the hospital, or in the lead author's office. The lead author trained two research assistants (RAs) who were fluent in Tagalog to conduct audio-recorded interviews. Between the two RAs and the lead author, ten semi-structured interviews were conducted in English or Tagalog. The RAs who conducted the interviews verified the transcription notes for accurate translation. The lead author then read the English transcripts and discussed any questions that arose with the RAs to re-validate translated transcripts for accuracy.

The lead author conducted data analysis simultaneously with the data collection.[37] Interview data were analyzed using content analysis to code and identify key themes that emerged from transcribed interviews.[38] Informal conversations and observational methods were used and documented in field notes by the lead author and RAs.[39] Check-ins with participants took place over two months after all interviews were completed, where the first author obtained feedback on the identified themes, clarified misunderstandings in the data, and verified information that was captured in the transcripts. Informal conversations and prolonged engagement with participants by the RAs and lead author at cultural events and scheduled visits to participants' homes helped ensure the reliability of information. The lead author also obtained feedback on study findings that were presented to members of the Philippine Heritage Council of Manitoba Inc. Pseudonyms were used to protect the confidentiality of participants. The participants used interviews to testify about the injustices they experienced and call for equity

and inclusion in health care. The testimonies in this study represent the discerning voices of Filipino caregivers and patients to address interlocking systems of oppression based on sexism, ageism, and racism that compels the transformation of the health care system fostering social and economic equity.

RESEARCH FINDINGS

The data reveal three themes in relation to caregivers' and patients' experiences of diverse forms of oppression and their quest for *kapwa*: (1) Restrictive oppression in access to and quality of health care services; (2) health care providers' practices of *ibang tao* and their impact on quality care; (3) health care providers' practices of *hindi ibang tao* that achieved a level of mutual comfort and level of oneness; and 4) Discerning voices of caregivers and patients on how to become *hindi ibang tao* and embrace *kapwa* and peacebuilding.

Study Participants

A sample of five caregiver-patient dyads was recruited. The caregivers identified themselves as a wife, daughter, sister, or granddaughter of the patient who provided care to the patient for three months to sixteen years. All caregivers were Catholic Filipino women (n = 5), had obtained undergraduate education in in the Philippines and/or in Canada, and had an average age of 52.4 years (range: 21 to 77 years old). Four female patients and one male patient (n = 5) were around 70 years old (range: 58 to 83 years old).

Systemic racism in the labour market has led to a disproportionate overrepresentation of racialized groups in precarious and low-income jobs, resulting in income inequality, racialization of poverty, and poor health.[40] The majority of patients were retired and had worked either as a garment worker, a driver, or as a home care provider. Patients had been diagnosed with stroke or kidney disease alone, or a combination of a tumor and stroke, diabetes and schizophrenia, or glaucoma and high blood pressure. All patients received home care services ranging from two to five days per week. Most patients were widows who lived with their children in low-income neighbourhoods. Widows reported yearly income below CAD$20,000, and

one patient depended on social assistance and lived in subsidized housing. Clearly, this research confirms the growing relationship among racial/ethnic immigrant residential segregation, racial segmentation in the labour market, spatial concentration of poverty, and epidemiological evidence and connections to health outcomes.[41]

Restrictive Pang-Aapi

Differential and inequitable patterns of health care services and quality by race/ethnicity are evident in Canada.[42] Consistent with the findings of previous studies,[43] interviewees revealed restrictive *pang-aapi* (oppression), stressing the following factors that reduced access to and quality of care: (1) the minimum number of home care hours for low-income patients; (2) a lack of knowledge about the health care system; and (3) poor provision of care in tertiary care hospitals (providing highly specialized care and technology in areas such as cardiology and intensive care). Many immigrant patients depend heavily on family support; hence, family caregivers' and patients' access to services and the support of patients in the home are critical in maintaining quality of care. Those who lived in low-income neighbourhoods and/or subsidized housing received a minimum number of home care hours. For example, a patient with dementia who had home care support for four hours per week (two visits) spoke of how she did not remember when she gave herself an insulin injection and took medication. Most caregivers reported structural and systemic barriers to obtaining information about the availability of home care services, access to social workers, and access to physiotherapy and occupational therapy for patients. Caregivers also lacked information about the availability of hospital beds for home use and opportunities to take stress leave from work due to caregiving demands. Often caregivers expressed that they did not know about service provider assistance and resources they could rely on to support them in assisting the patient with mobility, medication administration, and transportation. Structural barriers resulted in health inequities when some caregivers experienced delays in timely access to and utilization of home care services.

Earlier studies have documented how racialized patients experience moderate to high classism and everyday racial/ethnic discrimination; these inequities were demonstrated in the denial or delay of health care services to patients.

The health care system is structured around a model of service delivery and policies that ignore unequal power relations and oppression.[44] The majority of caregivers indicated that the quality of services received in two tertiary care hospitals (both located in low-income, racialized neighbourhoods) was worse than services received in community hospitals (offering short-term general or specific care accessible to the general public). Caregivers viewed tertiary care hospitals to be crowded, busy, and in general, found that services were not provided in a timely fashion by nurses. "Kate," a family caregiver, stated,

> You can see that people [visitors] there [in tertiary care hospitals] are all depressed because of the patient's situation compared to ... [community hospital] that it's more quiet and you don't see people crying or you know complaining like "Hey, I need help!" but in … [the community hospital] it is different.

Furthermore, caregivers noted that physiotherapists and occupational therapists were always ready to provide care to their family members in community healthcare hospitals. In comparison to tertiary care hospitals, caregivers described how community hospitals seemed to admit an appropriate ratio of patients to health care providers, who had sufficient time to help each patient. Social workers and nursing supervisors were viewed as being more accommodating to patients' needs and more welcoming of concerns voiced by caregivers in community healthcare hospitals. These health care workers practised levels of adjustment and acceptance, attempting to progress to *kapwa* and *pakikiisa.* Nevertheless, it is also evident that this approach is centred on the physical, while disregarding the emotional and spiritual well-being of the patients.

The findings of the study are congruent with other studies and demonstrate how restrictive oppression creates structural and material barriers, limiting individual life choices and opportunities (self-development). It is also evident that hierarchical oppression grants dominant or privileged groups positions of power and influence, status, privilege, and access to resources, positioning them as dominant or advantaged in relation to other groups that are subordinated and disadvantaged. For example, white-dominated institutions limit the life expectancy, infant mortality, income, housing, employment, and education of people of colour. Complex, multiple, cross-cutting relationships reveal connections between actions, policies,

and practices from the past and their cumulative nature of oppression and outcomes in the present.[45] Power is reproduced through domination and subordination in the forms of rules, roles, institutional norms, and social practices of groups and normalized through language, ideology, cultural and material practices[46] that are often institutionalized in health care settings.

Health Care Providers' Practices of Ibang Tao

Intersectional oppression is an interaction of many forms of oppression, co-creating interlocking systems that overlap and reinforce each other at institutional and individual/interpersonal levels.[47] The way these interlocking systems of power affect the lived experience of people requires an understanding how diverse forms of identity (race, ethnicity, gender) manifest in conflict dynamics.[48] Canadian studies have documented how patients experience racial/ethnic-based discrimination when receiving health care, the high rate of inaccurate assessment by health care providers that ignores and misdiagnoses patients' symptoms, and being belittled or talked down by health care providers.[49] The participants' experiences of *ibang tao* (not one of us) can be categorized under the following themes: (1) implicit bias, microaggressions, and racism; (2) power; (3) judgmentalism; (4) lack of professionalism and expertise; (5) level of formality: strict boundaries and lack of trust; (6) lack of sensitivity to cues.

Implicit bias, microaggressions, and racism. Caregivers strongly voiced their concerns about ill senior patients who often experienced unwarranted language and racism from some health care providers. Caregivers' and patients' negative experiences with nurses were associated with experiences of nurses' othering them based on the intersectionality of race, ethnicity, and citizenship status. Caregivers and patients viewed these negative experiences as a reflection of some nurses' lack of respect for the patient's quality of care and overall quality of life. Most caregivers and patients felt that nurses of some cultural backgrounds did not provide adequate care in comparison to the sensitive care provided by Filipino nurses.

Congruent with other empirical studies exploring intersections of quality care, level of trust, and racism,[50] all caregivers and patients stressed that they had lost trust in their health care providers because they could not receive timely or quality care in tertiary care hospitals. Sometimes patients had to wait thirty to sixty minutes to receive requested assistance. "Grace" described how her mother waited to receive timely assistance from hospital nurses:

> Because at the … [tertiary hospital] it's so hard 'cause sometimes my mom already got poo in her diaper for like, a long time and nobody's ... Yeah, like you know nobody's trying to clean her right away because they are all busy. Like you know they will clean her, but you would have to wait. But because of our culture ... Sometimes she has to wait for one hour.… I said that "Hello, can you, can someone help my mom?" and they will tell us that "Okay, she will be the next." So you're waiting and waiting and waiting, and because of that I, I want to do it on my own.

Caregivers also expressed their concerns about patient safety, noting a high rate of falls while in hospitals. Caregivers described patients that could not wait for the help to arrive. Sometimes patients did not want to wait for a nurse's assistance because they felt that they had enough strength to be independently mobile or did not want to urinate in their incontinent pads, in order to preserve their dignity. In Filipino culture, holding feelings of distress usually has to do with developing or proving one's strength of character.[51]

Power. Filipino caregivers and patients expressed that they often felt powerless when non-Filipino home care providers exercised domination through expressions of power (yelling, blaming, and communicating with judgment). Caregivers in this study also reported that some non-Filipino home care workers did not fulfill their responsibilities adequately. For example, some home care workers engaged in care activities for only five minutes instead of the fifteen to thirty minutes allotted to patients. Caregivers also described that some home care workers did not respect Filipino food rituals as an extension of communication. For example, some health care workers administered medication, heated the food, and then left without ensuring that the patient ate the food. Some non-Filipino home care workers yelled at patients instead of providing help and support to the patient. One caregiver named "Roselyn" witnessed how a home care worker was emotionally abusive to the patient, who wanted to move her chair:

> The home care is there, warming up her supper. They don't cook, they just warm up, and this home care went like this [mimicking yelling voice]: "You shouldn't help her, she has to do it herself!"

> and this and this and that. And she was yelling, and the patient is already upset so I told her, I said: "Don't you see? She's already upset, why are you yelling?" "No, because you can't help her." She needed help.

Filipino caregivers explained that they rarely resorted to an open discussion with health care providers because of experiences of the power differential that were expressed in the tone and body language of health care providers. When caregivers communicated their disagreement, they expected health care providers to be respectful and alter their attitudes and behaviour to accommodate patients' needs. The dominating behaviour of home care workers may stem from denying power and privilege and the lack of anti-racist training, thereby reducing quality care and health outcomes for racialized patients.

Judgmentalism. Health care workers who communicated judgmentally about the caregivers' and patients' standard of living were another source of distress for Filipino caregivers and patients. Caregivers preferred that home care providers not argue with caregivers or patients living on social assistance about their living conditions (e.g., living in an unsafe area or not having air conditioning in their residence). Caregivers felt that home care workers need to understand that discussing social issues can increase patient anxiety and affect patients physiologically (e.g., increased blood sugar levels, increased anxiety, which triggers more phone calls to the caregiver). Caregivers explained that working conditions in home care can affect the demeanour of home care workers in ways that are not conducive to caregivers' and patients' well-being. They suggested policies be developed to disallow disempowering communication by home care workers that can lead to conflicts and anxiety, especially when a patient is dealing with a mental health condition.

Lack of professionalism and expertise. The implicit racial bias of health care providers and their stereotyping of racial/ethnic groups result in under-treatment of pain, poor quality of care, and unequal access and treatment. Some health care providers believe that racial/ethnic groups are less sensitive to pain. Previous studies have disclosed that racialized patients are not treated properly for pain across their lifespan, and they bear the burden of inequality in pain management and systemic racism.[52] In this study, many Filipino patients did not disclose their distress associated with pain to nurses who appeared to be *ibang tao.* Patients testified that they were reluctant to share information with nurses who had given them incorrect medication, mistreated them, or caused them to wait a long time for assistance. Some nurses were formal or did not engage in a friendly dialogue that could build a trusting relationship with the patient. Some did not greet patients when taking their blood pressure. When the trust was lost, the relationship was lost. Caregivers witnessed that while nurses would accompany their family members to the bathroom, they would then leave them unattended without checking on their safety.

When patients did not receive quality care, they complained to a person who was *hindi ibang tao* (one of us) who would intervene to solve a conflict between the patient and health care providers. This third-party intervention was facilitated by a trusted caregiver, usually a daughter, spouse, or child who understands the patient's needs and can serve as a *tagapamagitan* (go-between). This person has *pakiramdam* (knowing through feelings). *Pakiramdam* is often considered an important "shared inner perception" that complements the "shared identity" of *kapwa*. It is an emotional a priori that goes with Filipino personhood, the *kapwa* personality. The role of the mediator is to change unacceptable behaviour, suggest, and teach new cultural norms and proper behaviour.

Level of formality (pakikitungo). Non-Filipino nurses of diverse backgrounds tended to maintain strict boundaries around their engagement with patients and family caregivers. They tended to address patients more formally or authoritatively than did Filipino nurses. One caregiver shared the example of a nurse saying, "Here's your medication Mrs. Leon, you have to take your pill, take this …. " The caregiver recounted that if her mom did not want to take the pill, the nurse would then abruptly ask, "Can I just leave it to you?" These types of interactions show a lack of respect and cultural sensitivity from the perspective of Filipino patients.

Lack of sensitivity (pakiramdam). Some caregivers reported that non-Filipino health care providers lack *pakiramdam* to cultural nuances related to illness and death and have ineffective communication skills. For Filipino caregivers in this study, open dialogue about the patient's impending death in front of the patient was emotionally challenging and culturally inappropriate. Caregivers also wanted doctors and nurses to understand that open communication may lead to increased anxiety and emotional exhaustion for Filipino patients and caregivers. Indiscriminate sharing of facts with patients and caregivers about the disease may also instill hopelessness and

reduce caregivers and patients' abilities to cope with disease or disease prognosis. Furthermore, caregivers and patients may feel disempowered in their relationship with health care providers who divulge information that patients or caregivers are not willing or prepared to deal with as part of their coping approach. In addition, caregivers explained that cultural preferences for privacy or intimate bodily contact are linked to the gender of the nurse and can have an impact on social interactions between the patient and the nurse. Overall, this study has revealed oppression experienced by Filipino patients and added new elements to the understanding of *ibang tao*.

Health Care Providers' Practices of Hindi Ibang Tao

Mutual comfort and pakikiisa. Caregivers shared a common belief that Filipino nurses' cultural values of *kapwa* had positively impacted their relations with patients and caregivers by helping them to build better rapport, extend friendly communication, and achieve positive health outcomes for the patient. A caregiver, "Analyn," shared how a Filipino male nurse provided care to her mother:

> "Nanay! Oh wake up! I'm giving you your medication! Open your eyes! Here's your medication, Nanay! I need to help you to sit up so that you can take your medication because you can't take your medication when you're lying down, you must be elevated!"

The pattern of helping dialogue by Filipino nurses was less formal in tone (e.g., by calling the patient *nanay* [mother or mother figure] rather than Mrs. Leon) and is built on *paggalang* (respect) for familial relationships. Within the Filipino community, people might refer to an elderly woman whom they respect and have built a relationship with as *nanay* even though they are not related. The Filipino nurse not only extended help to the patient by helping her to sit up safely to take her medication, but also encouraged the patient with careful explanation (level of mutual comfort and *pakikiisa*).

According to participants in this study, Filipino nurses often provide care using friendly facial expressions, gestures, and speech intonation when communicating with patients and caregivers. A caregiver, "Grace," said:

> I have a nurse there, she's a Filipino, she's very good. My mom got, uhhh she was done I think two days or three days done for her operation [removal of the tumor on the face]. Then they want my mom to move her hand and to move her feet.… She managed to ask my mom to sit and she managed to ask my mom to stand up. I'm so happy to see that. She's doing that so [said with emphasis] patiently. And then on the next day, there's a different nurse and after that my mom was just sleeping and sleeping and sleeping and not doing anything. And not responding, not responding to anything. She was not like the other nurse who was "Hi Nanay! I'm here again!" like you know talking loud and like "Nanay! Wake up! Don't sleep a lot, it's not good for you!" But the other nurses are just looking at my mom and that's it.

Caregivers explained that Filipino nurses' personal relationships with patients, gazing, touching, smiling, and empathy were key elements in constructive communication with Filipino patients that often led to better health outcomes (*pakikiisa*).

Quality of care. Patients explained that they preferred Filipino home care workers because they can communicate and express their needs and feelings more comfortably to someone who accepts them as they are, understands their cultural background and fosters *kapwa* and *pakikiisa*. Caregivers and patients said that many Filipino home care workers do their job well and were respectful, caring, and empathetic. Filipino home care workers were patient and did not rush through their care tasks. The length and quality of time spent by health care providers with patients were critical in building rapport, comfort, and trust to establish commonalities in the process of *pakikipagkapwa-tao*, acknowledgment of a shared identity and/or experience. Although caregivers explained that they needed to closely supervise Filipino home care workers at the beginning of receiving home care support, they became less guarded over time. The home care worker–patient and caregiver relationship changed in the level of formality, adjustability, acceptance, mutual comfort, and oneness, while trust and understanding increased.

	Ibang tao Not one of us	Type of health care worker–patient relationship				Hindi ibang tao One of us
		Level of health care worker–patient interaction				
	Pang-aapi	*Pakikitungo*	*Pakikibagay*	*Pakikisama*	*Pakikipagpa lagayang-loob*	*Pakikiisa*
	Level of oppression	Level of formalities	Level of adjusting	Level of acceptance	Level of mutual comfort	Level of oneness
Nature of interaction	Top-down Power-driven	Polite, formal, may be friendly	May nod or say "yes" but not necessarily agree	Agree and will compromise and "go along with"	Sympathize each other	Identify with each other
Patients' needs	Rejected and gaslighted	Concealed	Concealed	Articulated through mediators/ family/ relatives	Articulated directly to the nurse	Anticipated by the nurse
Patients' feelings	Disregarded	Concealed	Concealed	Restricted to family/ relatives	Revealed	Revealed
Patients' trust	Broken	Tested	Conditional	Initially given	Mutual	Complete
Patients' response to health care providers	Subdued	Silent and reserved	May express agreement to care but not comply	Agree to care and are willing to comply	Entrust oneself to the care of the health care providers	Patients and health care providers share care goals

Caregivers and Patients on How to Become Hindi Ibang Yao

Caregivers pointed out that communication is critical in enhancing patient health emotional and physical well-being. Communication is an essential precursor to building satisfactory relationships with patients and caregivers. One caregiver shared how a health care provider was constantly acting improperly:

> We had one case, my gosh, he just walks in and he does not even talk to the patient. He says, up (order), then go to the bathroom and then he puts Roldan to bed. And he does not say ok, good night, Roldan. See you tomorrow. And he leaves without talking!!! I told the coordinator. I said you know I do not think he is making Roldan feel good. Instead, he is being depressed because the person that is caring does not communicate well and is a depressing person. I told the coordinator.

In many of their experiences with health care workers, caregivers described their role as that of primary communicator, advocate, cultural broker, bridge builder, and educator. To minimize the power differential and social distance with health care workers, some caregivers made an effort to educate home care workers on how to interact with patients:

> Then I said ok I better change the style I said. When he comes, I would say how are you? How is your day? You know just to keep him going and saying something. Sometimes he answers and sometimes he does not. So here's the thing: I would say that the most important thing to me I think is communication with the patient. And that has to be emphasized even with nursing, whatever profession you are in. I think you know I think to me I would say the way you deal with people I think is very important. People skills is very important. I think that's the basic. Wherever you work.

Many of the study's caregivers recommended having home care workers assigned to them who could communicate in Tagalog. This recommendation was made to help home care workers build rapport with senior patients and have more meaningful social interactions, especially with patients experiencing memory loss and difficulty speaking English. They also wanted health care providers to not only provide personal assistance, serve meals, and give medication, but also to be good social role models. The caregivers and patients wanted to be assigned home care providers who were willing to engage in informal discussions (e.g., discuss soap operas they watched in Tagalog) and hence enhance their quality of life through pleasant social interaction on topics that were of interest to caregivers and patients. In this way, home care providers are not just treating patients as a physical being but as a total person needing social interaction and care at *pakikiisa,* the level of oneness.

Filipino caregivers called upon health care policymakers and administrators to examine health policies, rules, and regulations to better address diversity, equity and inclusion. Health and Senior Care of the Government of Manitoba specifies the responsibilities of provincial home care programs as developing care plans that meet the patient's needs, providing flexible services, and communicating promptly about the changes and replacement services.[53] Quality care should also include respect, a non-discriminatory

attitude, and cultural sensitivity toward clients.

Caregivers also expressed that it is important for nurses to understand the urgency to respond to someone's needs and be aware of cultural cues as an important part of providing optimal culture care. Most Filipino caregivers explained that they did not want to appear demanding when requesting assistance from non-Filipino nurses and preferred to ask for help from a Filipino nurse. Offering health care personnel anti-racist training is key to helping them understand power differentials that impact quality of care. Anti-racist intervention is an action-oriented, educational and/or political strategy for systemic and political change that addresses interlocking systems of oppression. Anti-racist action includes transformation and change within individuals and in organizations and communities, centring on anti-discrimination legislation and racial equity policies in health, social, legal, economic and political institutions.[54] Anti-racist action requires self-reflection, a dismantling of power differences, and demonstration of respect and oneness.

DISCUSSION

Diversity and Quality of Care in Community Care and Tertiary Hospitals

Many studies, including this one, document immigrant-specific unmet health care needs in tertiary and community hospitals and the disconnect between the health care system's operational efficiency, demands, and the needs of caregivers and patients.[55] The availability and accessibility of quality services in community hospitals has enabled patients and their caregivers to exercise better control of patients' physical health, the emotional and spiritual well-being of patients. Whether health care providers in community hospitals are in more control of patient care because lower patient-health care providers ratios mean fewer demands placed on them or whether it is because of other reasons requires further investigation. Given the small sample size of the study, this article does not offer generalized findings on whether health care providers care in community hospitals is inherently unbiased.

Diversity, Quality of Care, and Outcomes

The cultural background of nurses makes a difference in patients' health outcomes. The study's findings suggest that non-Filipino health care providers' stresses and work environments in tertiary hospitals might influence the perception of caregivers and patients on how well health care providers provide culturally appropriate care. According to a theory of power,[56] the power exercised by home care providers can be characterized as positional, stemming from the status and self-discretion they perhaps perceived was ascribed to them by the health care system to determine the level or quality of care to provide to their patients. It is also clear that health care providers in tertiary hospitals made choices on whose care should be diminished on a racialized basis, reducing health outcomes for immigrant patients. Caregivers were attuned to the impact that different types of care settings (tertiary care versus community hospitals) and biases can have on patients' health outcomes.

Health through Kapwa and Peacebuilding

There is long-standing evidence that immigrant caregivers' and patients' needs have not been met.[57] For example, Chinese stroke patients need access to care in their language, adequate support and education for caregivers, traditional Chinese medicine, and traditional food during recovery and rehabilitation.[58] The framework of *kapwa* and *pakikiisa* can provide a holistic understanding of the quality of communication and health care management and improve health care outcomes. It might also minimize hierarchical power relations and bring health care providers and caregivers and patients together to meet health care needs, create a sense of belonging and inclusion, and lead to better health outcomes.

CONCLUSION

This study underscores how structural racism in the labour market and residential segregation is intertwined with poverty, racial/ethnic inequities, and health disparities. Living in low-income neighbourhoods with high rates of poverty, a lack of employment and inadequate health care often lead to chronic illness. Furthermore, these racial/ethnic disparities are deepened by discrimination, as demonstrated by the oppressive behaviour of health care providers toward Filipino immigrant caregivers and patients as *ibang tao*. Empirical evidence shows a power struggle between what caregivers and patients desired for competent care and what was actually offered to them by health care providers.

Filipino caregivers and patients called for racial justice, equity, and inclusion, and expressed their need for health care providers to overcome racism and attitudinal barriers, improve their communication, and engage in more partner-based decision-making when helping immigrant caregivers and patients to receive quality care and health outcomes. Furthermore, chronic illness and symptom assessment, pain prevention, treatment, management, and overall provision of care is a racial justice issue that needs to be addressed to ensure quality care and positive health outcomes. Caregivers and patients observed that health care providers exhibited a lack of professional competence and assessment skills in addressing immigrant caregivers' and patients' care needs. Like other studies, this research recognizes that justice requires an acknowledgement of health disparity issues, including immigrant aging population.

This research brings forward the idea that *kapwa*, an Indigenous community-based peacebuilding and conflict transformation approach, can be used in health care settings to achieve oneness and racial justice. Filipino caregivers' and patients' perspectives on the quality of care they received reflected a complex interplay between their meaning of health and the understanding of professionalism, trust, sensitivity, and communication that empowers them. Indigenous philosophy can shift health care providers' practices of oppression and being *ibang tao* toward being *hindi ibang tao* and reinforce peace testimonies that express values of respect, mutual help, compassion, kinship obligation, social sensitivity, and community. This study's findings demonstrate the importance of basic and continuing education on anti-racism, diversity, and equity. Health care providers must optimize the skilled provision of quality care to immigrant caregivers and patients to achieve health through peace.

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