

# Older African Caribbean Women: the Influence of Migration on Experiences of Health and Well-Being in Later Life

Sharon Wray and Michelle L Bartholomew, School of Human and Health Sciences, University of Huddersfield.

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## Abstract

*The question of what constitutes good health and well-being varies amongst migrant minority ethnic groups and is not necessarily simply linked to the absence of illness, or the physical capability of the body. In 1995, the launch of the World Health Organisation (WHO) programme on ageing and health sought to promote a proactive and positive approach to health in later life. In this, key components included; life course issues, health promotion, cultural diversity, gender, intergenerational relationships, and ethics. Similarly, the National Service Framework for Older People (NSFOP) focuses on the promotion of activity, independence, and choice, as key components of health and well-being in later life. This paper considers the extent to which these underlying themes, about what it means to age successfully and healthily, resonate with the experiences of older African Caribbean women in the United Kingdom. Drawing on qualitative research, the paper highlights the impact of migration and ethnic and cultural diversity, across the life course, on the health and well-being of older African Caribbean women.*

## Keywords

Black and minority ethnic people, African Caribbean women, ageing, migration, health and well-being, social networks.

## Introduction

A central objective of social policy in ageing societies is the promotion of health and social well-being, through the creation of person-centred policies that are sensitive to the needs of individuals and different groups, in society. The concept of active ageing is promoted in policies from the World Health Organisation (WHO, 1998; 2002) and the National Service Framework for Older People (NSFOP) (Department of Health, 2001). The Policy Framework for Active Ageing (WHO, 2002) defines 'active ageing' as participation in 'social economic, cultural, spiritual and civic affairs'. In this document there is a move towards the prevention of illness through 'the adoption of healthy

lifestyles' (WHO, 2002), based on activity, empowerment and prevention. This is also evident in the NSF for Older People launched in 2001 (Department of Health, 2001), with its emphasis on the extension of choice and the promotion of independence in later life. These attempts to move towards a more positive approach to ageing represent a challenge to negative views and stereotypes of growing older. Nevertheless, although these developments promote new perspectives on ageing and mention ethnic difference, they tend to conceal the considerable cultural variation that exists across ethnic groups, relating to perceptions and experiences of health and well-being in later life.

Research has examined the links between migration and family relationships and the health of migrant groups (Bhalla & Blakemore, 1981; Bhachu, 1985; Blakemore & Boneham, 1994; Karlsen & Nazroo, 2002; Nazroo, 1998). However, although an increasing number of older people are international migrants, little attention has been given to the impact of migration on health and well-being from a life course perspective. Instead, there has been a tendency to neglect the relationships between migration, ageing and health in both gerontology and social policy. Arguably, this has led to the development of theories and policies on 'successful ageing' and health in later life, that are western centric (Fox, 2005; Wray, 2004).

A main argument of this paper is that western ideas and priorities underpin current understandings of what health and well-being means to older women. As a consequence, the impact of ethnic and cultural diversity and migratory experiences on health and well-being in later life have not featured highly on the agendas of either social researchers, or policy makers. This diversity is, in itself, an outcome of features that often characterise migration, such as poverty, discrimination, hostility and racism (Bryan *et al.*, 1985; Castles, 1993; Mirza, 1997; Thiara, 2003). Yet, the potential of these to influence health and well-being and shape the experiences and life chances of older people, receives little attention.

This paper will consider the extent to which experiences associated with migration, impact on the health and well-being of older African Caribbean women. It will be argued that a more culturally sensitive approach to research on ageing, which takes into account migratory processes and experiences, is required. The paper is organised into

four sections. The first, evaluates the extent to which notions of 'successful' ageing, health and well-being are culturally bound (Fox, 2005). The second section provides an outline of the methodological approaches used to generate the data for this paper. The third section draws on qualitative accounts from African Caribbean women and examines the links between some of the women's experiences of migration, and their current health and well-being. The final concluding section offers some suggestions for future research and policy on ageing, health and well-being.

#### *Migration, ageing, health and well-being*

Historically, women have actively participated in migration yet the economic and social contributions they have made have often been rendered invisible (Andall, 2003; Kofman *et al.*, 2000; Mirza, 1997). Sociological research on migration has often overlooked women or assumed that they were dependant on husbands for economic and social support (Werbner, 1995). Yet, the majority of first generation women migrating to Britain from the Caribbean were not simply following in their husbands' footsteps, but actively chose to migrate to seek employment (Davison, 1962). Many of these women were unmarried and migration offered opportunities such as a better job and financial security (Bryan *et al.*, 1985). However, there are other reasons that influence the decision to migrate, as Phizacklea notes:

*(...) relieving poverty at home, building a better future for their children and escaping from unsatisfactory marriages are just some of the motivational factors for migrating.*

(2003, p34)

On their arrival to Britain, the majority of migrant women often ended up in unskilled or semi skilled employment with limited opportunities of social mobility (Cohen, 1998). They were also frequently subjected to high levels of gender and racial discrimination which served to define their participation in the work and social spheres, both of which impacted on their life chances (Anthias & Yuval-Davis, 1992; Platt, 2005). Mirza notes how migrant women 'emerged in the official patriarchal, neo-imperialist discourse only as subjects for sexual and racist humiliation' (1997, p7).

Theories on ageing range from those focusing on the quantifiable material conditions of older people and arguing for State intervention through policy making (e.g. Arber & Ginn, 1995; Midwinter, 1997; Walker, 2002), to those that are more focused on the qualitative subjective experience of ageing (e.g. Fox, 2005; Gilleard & Higgs, 2000; Hockey & James, 2003; Wray, 2003, 2004). However, there has been little investigation into the impact of migratory experiences across the life course on health and well-being in later life. This is despite the growing body of evidence that shows a direct link between racism and poor health (Karlsen & Nazroo, 2002; Moriarty & Butt, 2004).

*Constructions of health and 'active' ageing in western (British) society*

Recent policy initiatives (DH, 2001; WHO, 2002) on good health for older people are influenced by notions of 'successful' and 'active ageing' that tend to be based on inherently western (Northern European/North American) conceptualizations of autonomy, independence and quality of life (Harper, 2000; McNay, 1992; Wray, 2004). In these formulations, autonomy,

independence and self-sufficiency are often emphasized above interdependence and collectivity, as indicators of agency and empowerment (Wray, 2004). This commitment to the empowerment of individuals has formed part of what is regarded as a formula for successful ageing in western society. Additionally, it has come to inform programmes and policies on health and ageing. As a consequence, ageing healthily and successfully is often associated with the ability of individuals to be *independent* from rather than *interdependent* with others, as they grow older. Hence the NSF for Older People (DH, 2001) promotes independence rather than interdependence and a central objective of the WHO policy on ageing (2002) is the encouragement of individuals to take 'control' of their health status as they age, through the development of 'healthy active lifestyles'. Although the significance of interdependency is discussed as an 'important tenet' of active ageing, in the WHO (2002) document this is very limited.

In both gerontological and sociological research, the centrality of 'good health' to quality of life for older people has been acknowledged (Afshar *et al.*, 2002; Markides, 1989; Nazroo, 1998; Wray, 2003). Ethnic variations in health and illness, particularly the links between ethnicity, structural inequality and health, have also been examined (e.g. Blakemore & Boneham, 1994; Karlsen & Nazroo, 2002; Keith *et al.*, 1990, 1994; Markides, 1989). Health is, then, regarded as an important ingredient of a 'successful' later life, alongside other variables such as income, activity, independence and self-sufficiency. Thus, in western societies ageing successfully has come to be associated with a range of factors, all of which have the potential to influence happiness and quality of life.

However, these understandings tend to be influenced by ethnocentric notions of what 'success' actually means (Wray, 2004). In western societies, the word 'success' denotes prestige, status and hints at hierarchy, with some types of behaviours, actions and beliefs perceived to be more valuable than others. For instance, the expectation that it is possible to remain 'forever young' through a variety of techniques and products aimed at reducing and disguising the effects of ageing (Biggs, 1997). It is also evident in the way that responsibility for health has shifted from the state to the individual, and the contribution this has made to the creation of a set of moral individualistic imperatives that emphasise the responsibility of individuals to maintain their health, as they grow older (Hockey & James, 2003). This shift to individual responsibility, to manage both health and the ageing process, has produced a tendency to focus on individualistic forms of empowerment and agency that deny the centrality of collective social practices. For example, there is evidence to suggest that religious belief and social practices, such as church attendance, prayer groups and bible classes, impact positively on health outcomes and well-being (e.g. Armstrong & Crowther, 2002; Levin, 1994; Wray, 2004). The impact of such migratory experiences and the effect that living in an inherently racist society may have on both strategies and opportunities for resistance requires further attention.

#### *Components of social well-being*

Understandings of empowerment and disempowerment influence the meanings that are given to health and well-being and are often used as measures of happiness, fulfilment and 'quality of life' (Harper, 2000; Wray, 2004). However, the way empowerment and disempowerment are understood in

British society, tends to lack sensitivity to both ethnic and cultural diversity and the impact of migration on health (Torres, 1999; Wray, 2004). This is partly a consequence of the way that liberalist accounts of self have been taken as the norm in western understandings of agency and empowerment (Grimshaw, 1986). This includes, for example, the association of power with independence and a lack of power with dependency. It is also evident in policies on ageing and health that tend to focus on the promotion of independence, activity and self-care as opposed to inter/dependence, *being* rather than *doing*, and state led health care. Ultimately, it is necessary to question both the theorisation of dis/empowerment and agency and how particular understandings come to influence definitions of well-being and quality of life that often inform policy and practice. Further, it is also important to recognize that significant differences exist between migrants and non-migrants with regard to life trajectory and that these experiences are also gendered (Bryan *et al.*, 1985; Phizacklea, 2003).

Attempts to quantify quality of life and social well-being have led to the emergence of numerous definitions and indicators (Smith, 2000). Key domains include: physical and material well-being, relations with others, social, community and civic activities, personal development and fulfilment, and recreation/leisure (Flanagan, 1978, cited in Smith, 2000). In a useful discussion Marcoen, identifies six components of personal well-being: psychological, physical, social, material, cultural and existential (1994: pp.524-525). Understanding what influences well-being is complex and will differ across and within groups. The consequences of racism and deprivation, often accumulated throughout the life course,

need to be factored into this when examining well-being in later life.

Although there is recognition that these objective and subjective domains are important, there is no agreement on how quality of life and well-being can actually be measured. Western centric perspectives on the significance of indicators of quality of life tend to be universalised to all ethnic groups and, significantly, the effects of migration are not regarded as a possible influence. This is despite evidence to suggest that perceptions and experiences of ageing, health and quality of life are culturally specific (Fox, 2005; Wray, 2004). As such, the extent to which these indicators influence and shape the quality of life and social well-being of older people cannot be generalised across ethnic and cultural diversity. Relationships with others, opportunities for personal development and physical and material aspects of well-being, take on different meanings across culture and ethnicity, and are influenced by shared histories and migratory experiences. In their research, examining the effects of spirituality on physical and mental health of African Americans, Armstrong & Crowther (2002) identify a link between religious and spiritual belief and resistance to social injustices:

*Partly as a result of the social and political injustices, group solidarity, and racial identification, religion and spirituality have been consistent themes in the life course development of older African Americans.*

(2002, p7)

This is an important point and one that resonates with the research findings presented in this paper. For example, the women's views on health and well-being are shaped by factors associated with the processes of migration, including racial discrimination and reduced opportunities. Consequently religious

and spiritual affiliation, offer a potential source of empowerment that can be drawn upon during ill health and difficult times.

### **Methodological approaches**

This paper draws on findings from two qualitative research studies focusing on two key topic areas. The first study examined empowerment, disempowerment and quality of life across ethnic groups of older women between the ages of 60 and 80 (Afshar *et al.*, 2002). It was funded by the Economic and Social Research Council (ESRC) as part of its Growing Older Programme and took place in the North of England over a 14-month period, commencing in September 2000. The participants self-defined as, African or Black, African Caribbean, Dominican, West Indian, Indian, Pakistani, British Muslim, British Irish, British Polish, Bangladeshi and British/English white. The second study is part of ongoing doctorate research, focusing on the perceptions and experiences of health of older women who self defined as West Indian. Five of these women were interviewed during December 2004. Thus, this paper includes the experiences of women who self-defined as African or Black, African Caribbean, Dominican and West Indian, all of whom lived in inner city and suburban areas.

For the first ESRC study, access to the research participants was gained through negotiation with gate-keepers at two local community organisations. At each organization an initial focus group took place and this was followed by semi-structured interviews. The focus group aimed to gain background information on the life histories of the participants, encourage participants to talk about the meanings they attached to ageing and quality of life issues, and to generate further topics and issues for discussion

in the follow up interviews. In both the focus groups and the interviews, the main areas of discussion included the experience of migration, employment, health, family and social networks, racism and inequalities, and religious and spiritual beliefs.

Access to the five research participants for the PhD research was gained through personal contacts. Similar to the ESRC study, the aim of the focus group was to collect in-depth data on the life history and experiences of the participants in relation to their health, health experiences and identity. The data obtained served to enhance the ongoing thesis by identifying issues which were of key importance to the women. These were migration, health, religious and spiritual beliefs, racism, inequalities and employment.

Analysis and interpretation of the data for both studies were ongoing throughout all stages of the research. When analyzing the data the aim was to uncover the relational meanings attached to key concepts used to examine quality of life. These included, empowerment, disempowerment, agency, power, control, in/dependence and inter dependence, and key features of life, such as migration, health, racism and discrimination, employment and material factors, and religious belief.

Participants for the ESRC study were kept informed about the progress of the research through newsletters and were invited to participate in an end of research conference/workshop. The aim of this was threefold; first, to enable the participants to meet and discuss their experiences, second, to enable the research team to feedback the main findings of the research and discuss future dissemination, and third to provide an opportunity for participants to feedback their experiences of

participating in the research. The PhD research is ongoing.

### *Connecting migration, health, and well-being in later life*

This section will consider the links between migratory experiences and health and well-being in later life. It will focus upon four key issues, raised by our participants, and common to both research studies. The first of these concerns the migratory experiences, for example, what motivated our participants to move to England and the greeting they received on arrival. A second significant issue articulated by our participants concerned the relationship between the inequalities they had faced in the employment sphere, which often placed them in physically heavy work with low pay and long hours, and their current health. When asked about their health a third topic emerged that was also linked to migrant identity. This was the use of traditional 'homeland' medicines in the treatment of ill health. A fourth and final theme voiced by our participants, was the importance of religious and spiritual beliefs as sources of empowerment.

### *Migratory experiences: 'sticking together'*

The historical movement of people from the Caribbean and West Indies to Britain is well documented (for example, Bryan *et al.*, 1985; Dodgson, 1984; Mirza, 1997). Migration may be perceived to be a good option for a number of reasons, for example, political, economic or a personal desire to seek out a new life. All our participants moved to England during the 1950s and 1960s and have sporadically returned to their birthplace for varying periods of time. The majority of Caribbean women migrating to England during this time came independently and in similar

numbers to men (Fryer, 1984; Mirza, 1997). A small minority of our participants migrated to be with other family members:

*Yes, I came here when I was sixteen and a half. (...) I came to my brother, he live here so I came and meet my brother.*

(Isadora, West Indian, 58)

*knew how to bring others together...that we join together in a country that not, that wasn't ours. Being a stranger to the country and you don't know that many people, especially the English people and our people the black people join together in force, that make me feel that we was one Nation, one faith, one Love, that how I look at it in the 60's.*

(Ruth, West Indian, 60+)

(As mentioned in the introduction, the way in which participants' ethnicity is recorded is how they defined themselves).

However, economic reasons were the main catalyst for migration to England amongst our participants. They were often promised good jobs and other opportunities, which generally did not materialise. Instead, many had to take on different types of work that did not require the same levels of skill as their previous employment:

*When I were back home I were doing health care with black people. So (I) was there with them and when I come in this country I didn't get the same job I used to do back home.*

(Mrs Luke, Caribbean, 77)

*We came here because they told us England was supposed to be our mother country and they needed workers and we came because we thought we would be welcome. We found we were not all that welcome.*

(Dorothy, West Indian, 60+)

Sharing a house with family and friends or other migrants was a common experience amongst our participants on arrival to Britain. This was not necessarily a positive event as the conditions they lived in were 'really bad'. During a focus group, some of the women also reported on the poor housing and 'feeling like an outsider':

*We hadn't house or anything like that. Sometimes you might have a room and in that room yourself and your husband or whomever and in that room, you have to eat sleep and everything in there, in the same room. And then you share the kitchen and you share the bath. You had to put money in the meter, a shilling in the meter, sometimes you put a shilling in the meter, but because there is so many people in the house, when you ready to cook they use your money out. Some people they just used to wait until you put the money in and then they use it.*

(Mary, West Indian, 60+)

*We had to stick together to survive and nobody told us they had corporation houses. Nobody told us. We struggling in one room. (...) Nobody told us anything...like an outsider*

(Dorothy, West Indian, 60+)

*Well we are still outsider.*

(Hannah, West Indian, 60+)

Our participants noted the importance of family and friendship networks and 'sticking together' to survive material hardship and racial prejudice. They also spoke of 'joining together' in a strange country with other migrants from the West Indies and how this made them feel they were 'one Nation':

*(...) we are Caribbean from the West Indies, we know how to entertain ourselves and other people 'cos, them years I believe everybody was one Nation and I thanks God for that, because we*

### *Connecting earlier inequalities to current health and well-being*

Structural inequalities associated with housing, employment, education and income, have shaped the lives of our participants and made them feel they were 'outsiders'. The women thought they would be 'made welcome' on

arrival to England, but instead some spoke of the hostility and racism they had encountered. This included everyday acts of personal prejudice and encounters with institutional racism. This is apparent in the following joint interview extract where Lucy talks about being made to feel invisible soon after her migration to England:

*(...) When I came here I go to look for a job I went to look for a job, people would make a sign you know like a sign...you don't speak English .You go into the shop for anything, (...) you had to always wait for your turn and they would be looking over your head to the other...the white face. They would be looking over my head at the...because I just came I don't know I didn't know...that they were to get served before me, so you know they looking over my head (...) and they're saying 'who is next here?' That mean they don't see you, you know?*

(Lucy, African Caribbean, 73)

The racist prejudices and stereotypes embedded within British society during this period are evident in this extract (Bryan *et al.*, 1985; Mirza, 1997). Lucy was made to feel invisible and afforded a low social status she was, literally, placed at the back of the queue by the receiving society. The hostility faced by our participants as African Caribbean migrants during this time is also documented by Reynolds who argues, 'support from others, outside the black community, was often not forthcoming in this openly hostile and racist society' (1997: 105). Living with racist hostility, marginalisation and high levels of social isolation, has a negative impact on social well-being and health (Karlsen and Nazroo, 2002; Moriarty and Butt, 2004; Wilkinson, 1996).

'Good health' was thought to be a major component of happiness and well-being by all of our participants. Experiencing 'good health' generated feelings of control over the present and future and

empowerment that transferred into the women's everyday lives, and contributed to their well-being. It was often valued above material factors, such as income:

*That (health) is the most important thing in my life. Good health. If one hasn't got good health, you're nowhere. It is very, very, important to me good health.*

(Lavinia, Dominican, 61)

However, some of the participants did not consider themselves to be in 'good health' and they attributed this to the migrant experiences that had shaped their lives. For example, the majority spoke about the impact of previous employment on their current health. This is evident in the following focus group (FG) extract:

*Mary: Well I forgot what health feels like for the past few years...I don't know what health feels like all that I know what pain feels like because I am feeling so much pain in my shoulders. And the thing is it all arise from lifting at work. You know we lift, had to lift so many patients...Now they have lifts to lift the patients in, but when we started, 20 something years Ruth, myself and Ruth, we lift patient...32 baths and you have to lift them with you hands. If you working different places you could claim when you get poorly like this (group agreement), but with the National Health Service you can't do that. You just have to suffer now. Most people that work in hospital they feeling a lot of pain now in some way or other. I think most of it (the pain) it's the jobs we did.*

*Maria: Yes, poor wage and we as Black get the worst job, worst end of the stick.*

(FG with West Indian women, aged 60+)

For these women, current health experiences are intimately linked to previous inequalities in employment, where they felt they had got the 'worst job'. Mary links the lifting she did in her previous employment as a nurse to the pain she now feels in her shoulder. The fact that this was also badly paid

suggests she also had to contend with socio-economic disadvantages. These findings are similar to those of Bryan *et al.* (1985) who researched the working lives of Black women in Britain, particularly within the National Health Service (NHS). Mary and Ruth had previously been employed as nurses, which involved heavy labour, long hours and anti social shifts (Bryan *et al.*, 1985; Fog-Olwig, 1998; Mama, 1997). As socio-economic factors are important determinants of health and well-being, working in labour intensive poorly paid employment throughout the life course may create an accumulation of disadvantage for migrants, as they grow older (Nazroo, 1998). Consequently, it is worth considering how the health and well-being of migrants as they enter into later life may have been influenced by a lifetime of racial discrimination, personal hostility and a lack of material deprivation.

It is evident that good health is highly valued by our participants, though this has been affected by previous employment disadvantages. Additionally their health has been affected by the racist society and poor socio-economic circumstances they found themselves in, on their arrival to England. Thus, this suggests the women's previous migrant experiences of hostility, inequality and poor work conditions have impacted on their health and well-being, as they have grown older.

*Perceptions of health care: 'Doctors is somebody I don't like to argue with'*

Although the majority of our participants had worked in health related employment and as a consequence had worked closely with medical practitioners, many had doubts about the effectiveness of British medical care generally. This was based on their experiences of the medical care they had

received and is evident in the following focus group extract where three women talk about their experiences of visiting local GPs:

*Ruth: I don't like doctors I hardly talk.*

*Maria: You can see the frustration in their face.*

*Ruth: And you pay for that.*

*Maria: You can't tell them nothing, that's what they want to make people understand, 'you're not telling me my job'...And doctors is somebody I don't like to argue with 'cos they could give you anything, you don't know.*

*Mary: Yes you're sure right.*  
(FG with West Indian women, aged 60+)

In this discussion, it is evident that the women felt that they could not speak openly to doctors. Further, they 'don't want to argue' because as Maria points out, 'they could give you anything'. For our participants this meant choosing an alternative rather than simply opting for the doctors' advice. The majority of our participants described turning to alternative traditional forms of treatment that were closely linked to their culture and 'homeland'. For example, in the same focus group the women spoke of their use of herbal remedies and how they were 'brought up' with them:

*Mary: (...) herb is an ancient thing, tradition, lots of people use herbs.. I think the time will come when everyone will go back to herbs really.*

*Ruth: We believe in herbs, because that's how we brought up.*

*Maria: I am taking lots of tablets for blood pressure and what not, but I'm more spending me own money, going to Holland and Barrett and Dodd's...I don't depend on their (medical doctors') tablets...I mean, once I know what complaint I have, I do my own research and get different herbal tab, its tablets again though, but I more believe in them.*

(FG with West Indian women, aged 60+)

This belief in herbal remedies enables these women to have some control over their health. In particular, their knowledge of culturally embedded traditional alternatives to biomedicine means they are able to exert choice and control, and this is experienced as empowering. Since they have been taught from an early age by their family and friends to use herbs, they are confident they can be used to treat high blood pressure. The decision by migrant women to use traditional remedies is also noted by Patterson (2004) in her research on the lives of ageing international migrant women. She argues that this is partly a consequence of the inequitable health and social care her participants have received. In particular she cites the example of how one Puerto Rican woman's 'opinions about her care were automatically overridden by official decisions' (Patterson, 2004: 31). This suggests that migrant women are likely to distrust Western biomedicine. Instead, they prefer to use traditional culturally embedded remedies that enable them to have control over their bodies and health. Additionally, because these remedies rely on plants and spices that are native to the Caribbean they provide a link to a 'homeland' cultural and ethnic heritage. This is important because cultural artefacts such as these help to maintain transnational collective ethnic and cultural identities. Therefore, it is possible that traditional alternative healthcare may enable our participants to develop and sustain social and cultural relations between their migrant country and 'home'.

#### *Migration, spiritual and religious beliefs and health and well-being*

A number of studies have shown clear evidence that a relationship exists between religious belief and/or spirituality, and health and well-being

(e.g. Black, 1999; Marcoen, 1994; Musick, 1996). This is apparent in Marcoen's (1994) analysis of well-being. He argues existential questioning of the meaning of life and the 'conscious search for meaning', form the 'core elements of a spirituality which influences' how an individual responds to their life (1994:526-527). There is also evidence to suggest that older African Caribbean migrant women are more likely than their non-migrant counterparts to identify as religious (Ferraro & Koch, 1994; Levin *et al.*, 1994). Religious and spiritual beliefs were important to participants in both of the research studies on which this paper is based. They contributed significantly to how they felt about and experienced their health. Religious beliefs in particular were regarded as a source of empowerment enabling the women to deal with constraint and hostility (Armstrong & Crowther, 2002; Bryan *et al.*, 1985; Mama, 1997; Mirza, 1997; Patillo-McCoy, 1998; Wray, 2004). This is evident in the following focus group extract, where five participants discuss how their faith has enabled them to survive hardships:

*Eliza: Well I think is very, very important in my life.*

*Mary: In all our lives.*

*Ruth: Because we brought up in the church and I thank the Lord that I kept it, that I still kept my faith from when I was growing up.*

*Sarah: It never fails me.*

*Others: That's right.*

*Eliza: If you ask for something, you will get it, unless what you ask for is not good for you.*

*Ruth: That's right.*

*Eliza: If you put your heart into it.*

*Ruth: Without the faith, without God I don't think we could...*

*Mary: Survive, that's why we are surviving, on our faith.*

(FG with West Indian women, aged 60+)

This exchange highlights the importance these women attach to their faith, which they have maintained throughout their lives. They gain personal empowerment from their spiritual beliefs which they rely on because it is something 'that never fails' them. Research has shown that spirituality and religious belief increase with age and are influenced by migratory and socio historical life contexts (Armstrong & Crowther, 2002). The personal strength our participants gained from faith is discussed in the following focus group extract where the women talk about how it makes 'you a better person':

*Eliza: It make you stronger, it make you a stronger person you know, it make you a better person, it make you able to forgive, when you think there's no forgiveness at all. It make you able to Love (group agreement) people that sometimes does you something terrible wrong, you can turn round and love that person.*

*Sarah: Strengthens your faith as well (group agreement). Yes it does.*

*Eliza: Makes me able to live from day to day life.*

(FG with West Indian women, aged 60+)

For some of the participants, belief in God and speaking to Him eased their health problems and proved to be a source of empowerment. Sonya, who had migrated to England in 1962, has strong religious beliefs that liberate her from feelings of loneliness and enable her to cope with bad times:

*(...) I can talk to God like how I'm talking to you I don't see Him but I can talk to Him because if I have a problem or if I have the arthritis in me knee I can say 'do God an' ease these two knees, these two legs, not only for myself but for other people'. An' sometimes you know it's not better but you can get a little upliftment from it an' so that's why when I'm uh inside I don't have that big loneliness*

*because I know God is there, you know.*

(Sonya, British Jamaican, 71)

Sonya's life is enhanced by her belief in and relationship with God, and although this may not always 'ease her knees' it is nevertheless consoling to her. Additionally, religious belief contributes to her sense of well-being by enabling her to feel uplifted it is, then, a source of personal empowerment that can be drawn upon at any time (Black, 1999; Marcoen, 1994). Many of our participants said their religious beliefs had enabled them to cope with the difficulties they had encountered, as a consequence of their migrant and ethnic status. This suggests, as sources of empowerment, religion and spirituality are important to migrant women as an influence on health and well-being in later life.

In summary, in this section we have presented empirical evidence to highlight the links between migratory experiences and health and well-being in later life. The findings presented here suggest the racism and hostility, encountered by the majority of our participants, made them feel marginalized and isolated and restricted their opportunities for socio-economic mobility. Further, this was felt to have influenced their health and well-being throughout their lives, but particularly as they had grown older. As a component of happiness and well-being, good health was regarded as highly significant. Yet, a number of our participants felt they did not have good health and that this had been affected by their previous experiences as migrants, for example, their employment opportunities and the type of housing they had lived in. When our participants spoke about their health, it became clear that they distrusted the medical care available to them and often opted for alternative traditional forms of treatment. Herbal remedies which relied

on plants that grew 'back home' and they had been 'brought up with' were important to them. These remedies create a link between their current home in England and the place they viewed as their real homeland, the Caribbean. They also enable the women to feel they have control over their health and are not dependent on western medicine. Their reliance on these traditional remedies therefore contributes to their sense of well-being because it is experienced as empowering.

The final issue raised by our participants related to the influence of religious and spiritual belief on how they perceived their health, and their feelings of well-being. They felt that their beliefs had enabled them to resist the racism and hostility they had experienced as migrants throughout their lives. In later life, these beliefs remained important enabling them to resist loneliness and cope with the pain caused by physical conditions, such as arthritis.

### Conclusions

In conclusion, in this paper we set out to highlight the significant impact of migratory processes on the health and well-being of older African Caribbean women. Our main argument is that although research has examined health variations between minority ethnic groups (e.g. Blakemore & Boneham, 1994; Karlsen & Nazroo, 2002; Nazroo 1998) little attention has been given to the impact of migration on health and well-being in later life. Further this, often uncritical, normalisation of western non-migrant perspectives on ageing, health and well-being, may *exclude* rather than include those migrant experiences and priorities that differ. To illustrate, migrant experiences of racism and discrimination may encourage the development of strong collective inter dependent support

systems, as a form of resistance. Hence, a sense of collective belonging to an ethnic group identity is empowering (Brah, 1996; Mohanty, 1991; Wray, 2004). Clearly, it is important to further examine the strategies of resistance migrant women develop in response to inequalities, and how health and welfare service providers might contribute to the enhancement of these.

Undoubtedly, the hostility and discrimination our participants faced as migrants continued to influence their health and well-being as they grew older. The different types of discrimination, such as poor employment conditions, hostility and prejudice, they have encountered have impacted on both their physical health and agility and their psychological and social well-being. The empirical evidence presented in this paper raises questions about the capacity of current policies, such as the NSFOP, to adequately address the consequences of migratory processes on the life chances, of older people. To illustrate, research has shown that religious and spiritual beliefs are more likely to be important to migrant as opposed to non-migrant groups, in relation to health and well-being. Yet, this is often not recognised by health and welfare services as an important means of improving health and well-being. Consequently, we propose that attempts be made by these services to engage and work with centres of worship in order to improve the lives of older migrant groups. There is also a need for policy makers to recognise that the priorities of older migrant groups, as opposed to older non-migrant groups, may differ due to the discrimination and prejudice that often shape migrant life trajectories.

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#### Notes on contributors

Dr Sharon Wray is currently a Senior Lecturer in the School of Human and Health Sciences at the University of Huddersfield. Her research interests include ageing, ethnicity, gender, health and well being. Michelle L Bartholomew is a Senior Lecturer in the School of Human and Health Sciences at the University of Huddersfield. Her current research interests are health, identity, migration, religion, ethnicity and ageing.

#### Address for correspondence

Sharon Wray  
 School of Human and Health Sciences  
 University of Huddersfield  
 Queensgate  
 Huddersfield  
 HD1 3DH  
 Email: [s.wray@hud.ac.uk](mailto:s.wray@hud.ac.uk)