Resistance and Resilience: The Attributes of Healthy Ageing for Older West Indians Living in the United Kingdom

Danielle Laurie Ward
Centre for Research in Health and Social Care
School for Policy Studies
January 2018

A dissertation submitted to the University of Bristol in accordance with the requirements for award of the degree of Doctor of Philosophy in the Faculty of Social Sciences and Law

Word Count: 63, 527
Abstract

The overarching aim of this thesis was to understand how the processes of migration and associated experiences, placed within social and historical context, have contributed to the definition of healthy ageing among West Indian women and men growing older in the United Kingdom. Specific objectives were (1) to explore the post-migration factors influencing the definition of healthy ageing for older West Indians living in the UK and (2) to examine how these identified factors can be used to understand perceptions of healthy ageing for the aforementioned population. Utilising critical race theory and the resilient ageing concept, the current thesis aimed to contribute to the broader literature on the understandings of healthy ageing within ethnic minority communities and to inform the wider network of individuals working within these communities.

This thesis used qualitative methodologies to achieve its aim and objectives. One focus group (with five participants) and sixteen interviews were conducted with West Indians living in the wider Bristol and Bath areas. Participants were recruited through letters, emails and phone calls. NVivo was used to organise and code the data, which were then analysed thematically.

Findings showed that the participants’ post-migration experiences and construction of healthy ageing can be understood by utilising the concept of resilience, via resilient ageing. Four key factors were identified that can be used to understand perceptions of healthy ageing: social connections, involvement in activities, optimism and belief in a higher power.

The findings of the current thesis can be used in a transformative manner by considering how various structures in society, such as an adaptive and supportive environment or public service policies, can be modified to support the needs of this group, thereby contributing to their overall resilience.
Author’s Declaration

I declare that the work in this dissertation was carried out in accordance with the requirements of the University’s Regulations and Code of Practice for Research Degree Programmes and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate’s own work. Work done in collaboration with, or with the assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

SIGNED: DATE:
Acknowledgements

Thank you to my supervisors, Professor Sarah Payne and Dr. Saffron Karlsen, for their support and advice throughout this process. Thank you for all of the helpful feedback and, especially, the encouragement to keep pressing forward.

I would also like to thank the women and men who kindly agreed to take part in my study. Without you, this thesis would not have been possible.

To the ENHS crew – thank you for ‘adopting’ me and for making my time here at the university enjoyable. Sarah, Ana, Maria, Sahar, Clare and Laura, you have been amazing officemates. You made my days (and nights) in the office bearable. I would like to give a special thank you to Zoi – your friendship means more than you will ever know.

Dr. Debbie Watson, I owe you a huge debt of gratitude. Thank you for recognising when I needed help. Undertaking a PhD can be a lonely and challenging endeavour. Thank you for your support and encouragement.

To my family back home in Antigua – Gran, Aunty Gerda, Aunty Heather, Uncle Dick, Aunty Patty, Carol, Daren, Kayla, Jonathan, Ayden, Rebekah and Sarah-Anne. You have given me a lifetime of encouragement; thank you. To my friends Amanda, Andrea, Shyan, Carina, Sally, Aoife and Rosina – thank you for being amazing cheer leaders! I am truly lucky. To Gryffindor, thank you for making me smile every day.

And finally, to my mother and step-father, Judith and John, I owe you the biggest thank you. This endeavour would never have been possible without both of you. Mum, you are my inspiration and reason. You taught me the meaning of hard work, kindness and perseverance. This is for you.
Table of Contents

Chapter 1  Introduction ............................................................................................................. 1

1.1  Background to the Thesis ......................................................................................... 1

1.1.1  Definition of Key Terms ................................................................. 2

1.1.2  West Indians in the United Kingdom ...................................................... 3

1.1.3  West Indians in Bristol ....................................................................................... 5

1.1.4  Who are ‘Older’ People?.............................................................................. 7

1.1.5  Ageing in the United Kingdom ................................................................. 9

1.1.6  Policy Context of Ageing ........................................................................... 9

1.2  Conceptual Frameworks Influencing the Study ......................................................... 11

1.3  Structure of the Thesis ......................................................................................... 11

Chapter 2  Healthy Ageing in Later Life .......................................................................... 13

2.1  Introduction to Ageing and Health ........................................................................ 13

2.2  Healthy Ageing ..................................................................................................... 14

2.2.1  Successful Ageing, Active Ageing and Healthy Ageing ...................... 14

2.2.2  Why These Concepts May Not Work ...................................................... 17

2.2.3  How Do Older People View Healthy Ageing? ....................................... 18

2.2.4  Are Perceptions of Healthy Ageing Different in Ethnic Minority

          Communities? ...................................................................................... 21

2.2.5  What About Resilient Ageing? ..................................................................... 28

2.3  Chapter Summary ................................................................................................. 32

Chapter 3  Theoretical Frameworks .............................................................................. 34

3.1  West Indians in the United Kingdom ................................................................ 34

3.1.1  Experiences of and Responses to Racism .......................................... 34

3.1.2  Policy Responses to the West Indian Migrants .................................. 36

3.2  Critical Race Theory ........................................................................................... 39

3.2.1  Applicability of Critical Race Theory to the Study ............................. 44

3.3  Ethnic Minorities, Racism and Health ................................................................ 49
3.4 The Life Course Approach to Migration and Health............................52
3.5 Chapter Summary............................................................................54

Chapter 4 Methdology.......................................................................55
4.1 Research Aim and Methodological Considerations.....................55
  4.1.1 Theoretical Underpinnings of the Study.................................56
  4.1.2 Assessing the Quality of the Study.........................................57
  4.1.3 Reflexivity................................................................................57
4.2 Methods.........................................................................................60
  4.2.1 Sampling...................................................................................63
  4.2.2 Gaining Access.........................................................................64
  4.2.3 Recruiting..................................................................................66
  4.2.4 Qualitative Interviews................................................................72
  4.2.5 Data Analysis............................................................................76
4.3 Ethical Considerations.................................................................77

Chapter 5 Post-Migration Life Course Experiences..........................78
5.1 Pre-Migration & Migration Experiences......................................79
  5.1.1 Motivations and Expectations for Migrating............................80
  5.1.2 Pre-Migration and Migration Contributors to Healthy Ageing....90
5.2 Early Post-Migration Experiences...............................................90
5.3 Later Post-Migration Experiences...............................................93
  5.3.1 Experiences of Discrimination...............................................94
5.4 Later in Life Experiences.............................................................101
5.5 Chapter Summary..........................................................................104

Chapter 6 Resilient Ageing..............................................................107
6.1 Introduction....................................................................................107
6.2 Healthy Ageing Means Being Able to Participate........................108
  6.2.1 Doing Things for Themselves and Doing Things for Others......110
  6.2.2 Activities Build Resilience......................................................113
6.3 Healthy Ageing Means Feeling Connected to Others..................113
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.3.1</td>
<td>Social Networks in Childhood</td>
<td>114</td>
</tr>
<tr>
<td>6.3.2</td>
<td>Social Networks in Adulthood</td>
<td>116</td>
</tr>
<tr>
<td>6.3.3</td>
<td>Feeling Connected Builds Resilience</td>
<td>127</td>
</tr>
<tr>
<td>6.4</td>
<td>Healthy Ageing Means Being Optimistic</td>
<td>128</td>
</tr>
<tr>
<td>6.4.1</td>
<td>Having a Positive Outlook Builds Resilience</td>
<td>131</td>
</tr>
<tr>
<td>6.5</td>
<td>Healthy Ageing Means Believing in a Higher Power</td>
<td>131</td>
</tr>
<tr>
<td>6.5.1</td>
<td>Explaining the Unexplainable</td>
<td>134</td>
</tr>
<tr>
<td>6.5.2</td>
<td>Building Social Connections Through the Church</td>
<td>140</td>
</tr>
<tr>
<td>6.5.3</td>
<td>Guiding Actions</td>
<td>142</td>
</tr>
<tr>
<td>6.5.4</td>
<td>Religious Participation Builds Resilience</td>
<td>143</td>
</tr>
<tr>
<td>6.6</td>
<td>Chapter Summary</td>
<td>144</td>
</tr>
<tr>
<td>7.1</td>
<td>Overview of the Study</td>
<td>147</td>
</tr>
<tr>
<td>7.2</td>
<td>Final Discussion and Study Conclusions</td>
<td>150</td>
</tr>
<tr>
<td>7.3</td>
<td>Implications of the Findings</td>
<td>154</td>
</tr>
<tr>
<td>7.3.1</td>
<td>Implications for Gerontology</td>
<td>155</td>
</tr>
<tr>
<td>7.3.2</td>
<td>Implications for Theory, Policy and Practice</td>
<td>156</td>
</tr>
<tr>
<td>7.4</td>
<td>Strengths and Limitations of the Study</td>
<td>160</td>
</tr>
<tr>
<td>7.5</td>
<td>Recommendations for Future Research</td>
<td>162</td>
</tr>
<tr>
<td>References</td>
<td></td>
<td>164</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
<td>207</td>
</tr>
</tbody>
</table>

Appendix 1 – Organisations identified as working within the ethnic minority or elder communities in Bristol and Bath: 207
Appendix 2 – Emailed Study Ad 208
Appendix 3 – Recruiting Letters 209
Appendix 4 – Participant Information Sheet 210
Appendix 5 – Consent Form 212
Appendix 6 – Interview Guide 213
Appendix 7 – Ethics Application 214
Chapter 1  Introduction

1.1 Background to the Thesis

This chapter presents an introduction to the topic of healthy ageing among older Caribbean people living in the United Kingdom (UK). The purpose of this chapter, therefore, is to lay the groundwork for subsequent chapters regarding the way healthy ageing is constructed as individuals get older, especially pertaining to ethnic minority groups. The subject of health as one ages is of particular importance in the UK given that the proportion of the older population is expected to increase not only from those born in the UK but also from those who migrated to the UK decades ago and are now ageing here; Caribbean people are one such group. With this, the overarching aim of this thesis is to understand how the processes of migration and associated experiences have contributed to the definition of healthy aging for older Caribbean women and men living in the United Kingdom.

My motivation for undertaking this PhD was driven by my Caribbean background. I was born and raised on the tiny island of Antigua and like my grandmother, aunts and cousins, I left my home with the goal of improving my economic position and I was going to do so by pursuing education. When I first left Antigua, I assumed that I would return home to live soon after my undergraduate studies but fifteen years later, I am still living in someone else’s country. I am grateful for my journey thus far and I have had many experiences and opportunities that I would not have had if I stayed in or immediately returned to Antigua. My time away from home, however, has not been without its difficulties. Being a migrant and person of colour means that not a day goes by where I am not aware that I am one of those things. And because of this, I used to find myself wondering how those who migrated before me handled their own difficult experiences; I wanted to know about the things that helped them push through their hard times. That was the motivation for pursuing a PhD on this topic.
1.1.1 Definition of Key Terms

Before I go further, I think it is important that I provide definitions for terms used throughout this thesis. I use the terms *West Indians* and *Caribbean people* to refer to my population of interest and, similarly, I use the terms *West Indies* and *Caribbean* to refer to the region where the population of interest was born. Being born and raised in the Caribbean, it is acceptable practice that we use both of these terms frequently and interchangeably.

Throughout this thesis, I also use the term *Black* to refer to individuals who are descendants of the African diaspora. In the UK, this is often African or Afro-Caribbean or African-American as in the case of the United States. Research in the UK that involves different ethnicities or migrant cultures often collapses certain groups together, for example ‘Black/African/Caribbean/Black British’ (Office for National Statistics, 2012a). The argument is that these groupings are necessary for statistical purposes. However, doing so means that the variations between the different populations in the African diaspora are lost and readers are, therefore, left to assume that all the results for this particular category applies to every population within that group (Agyemang et al., 2005), which is not usually the case. I identify as a Black West Indian woman and less so Afro-Caribbean. However, I acknowledge my African ancestry and I am proud of the way the African diaspora has influenced me linguistically through my use of ‘dialect’, my food and my music, for example. However, my identity is that of a West Indian and the legacy of slavery means that, unlike Europeans who can usually quickly trace their ancestry going back for generations and are able to know exactly what countries they are from, I can only trace my ancestors as far back as my great great-grandmother who was a daughter of slave in Antigua of unknown African origin. My viewpoint here is not representative of all West Indians; it is my own.

Occasionally, I refer to the population of interest as *migrants*, whereby I adopt the UNESCO (2017, p. 1) definition,

> any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country.
The population of interest and, therefore, all of the participants in this study were born in the Caribbean and are Caribbean migrants.

I also use the term *racialisation* to refer to the processes whereby ethnic and/or racial identities are attributed to a group. That group, however, did not ascribe itself that identity. The identities created for these groups, therefore, create race and make racism possible. See Barot and Bird (2001) for a history of this concept.

1.1.2 *West Indians in the United Kingdom*

The history of Black people in the United Kingdom, and West Indians in particular, provides important sociohistorical context to the study about Britain’s relationship with and treatment of ethnic minority groups. The history of Black people in the UK is extensive with records dating back to the early 16th century (Fryer, 1984); see also Olusoga (2016) and Shyllon (1977) for comprehensive accounts. Those same records also indicated that, decades later, the first recorded group of Africans were brought to Britain, as personal property, in the middle of the 16th century. The Black population remained small until approximately the middle of the 17th century when Great Britain began to compete with Portugal in the forced commodification of human lives: when Africans were traded for sugar, molasses, rum and cotton in the trans-Atlantic slave trade. The British-West Indian relationship began during this time when Britain was expanding its empire by colonising many of the Caribbean islands in the triangular slave route. As the British slave trade gained momentum and cities such as Bristol, Liverpool and Glasgow became major slave ports, the affluent society in Britain started to possess slaves as personal property for their households. At this time, information about the people of the African continent was scant and misinformed, with most of the British population believing that Africans were “carefree, lazy and lustful” (Fryer, 1984, p. 7). In Great Britain, this ‘knowledge’ and racist rhetoric about Africans pervaded society and the prevailing attitude among the British was that they considered themselves to be morally, mentally and culturally superior to the Africans (Fryer, 1984). Additionally, the supposed inferior qualities of Africans

---

1 The classic triangular slave route was between West Africa, the Caribbean and/or North America and Europe.
were considered to be biological, inhering within them and, as such, was used as the rationale for justification of the slave trade. During the time of slavery, French, Dutch, Spanish and British powers colonised the Caribbean islands with Britain eventually seizing control of most of the islands. British participation in the slave trade lasted over two centuries until the passing of the Slave Trade Act of 1807. Although slave trading was no longer legal, slave ownership was still legal in Britain and its colonies until 1833 when the Act for the Abolition of Slavery was passed (UK Parliament, 2017). This act of emancipation only immediately affected children under the age of six and it was not until August 1st, 1834 when all slaves were freed.

The literature on Caribbean migration to the United Kingdom most often starts the discussion in 1948 with the arrival of the merchant ship, the Empire Windrush, in London with bringing the first large group of West Indians to British shores. However, Caribbean migration began before this, almost right after the emancipation of slavery. Initially, most Caribbean migration occurred between the different Caribbean islands, to Central America (mainly Panama and Costa Rica) and to the United States of America (Phillips and Phillips, 1999; Thomas-Hope, 1986). The social and political unrest in the Caribbean in the immediate post-emancipation years drove many West Indians to seek employment in these other countries. But by the late 1800s, small groups of West Indians migrated to the UK and settled mainly in the port cities and worked on ships (Fryer, 1984; Thomas-Hope, 1986). With the still flagging economy of the Caribbean region and little prospects of advancement, the next wave of West Indians went to the UK to fight in the British Forces during World War I (Phillips and Phillips, 1999). Once the war was over, many West Indians had hopes of being able to stay and continue to work within the British forces but discrimination in hiring practices against Black people prevented this for many (Fryer, 1984). Xenophobia in the UK was on the rise after the war and this resulted in violent racist acts being perpetrated against ethnic minority populations. Racist and discriminatory practices continued into the 1930s, which, thereby, severely limited the social and economic prospects of Blacks living in the UK at the time. Even with these conditions, West Indians, including those already in the UK and those who were recruited from the colonies, still fought in the British forces during World War II (Fryer, 1984). As members
of the empire, West Indians both near and far were encouraged to consider the UK as their “mother country” and, therefore, their cultural and political home and, as such, fought willingly (Fryer, 1984; Paul, 1997). The legacies of slavery and economic exploitation during colonial years meant that once World War II ended, many of the West Indians who fought were repatriated only to be greeted by a life that was poorer and with even less opportunity than before they left (Phillips and Phillips, 1999; Ward and Hickling, 2005). World War II left the UK in a state of disrepair and in need of people to fill labour voids in coal mining, agriculture and other blue-collar industries. To address this shortage of labour in the immediate years after the war, the British government initially recruited labour from the United States and from across Europe (Paul, 1997). Through active recruiting and word-of-mouth, information eventually spread to the colonies that their “mother country” was in need of labour. This call for help along with the lack of economic opportunities in many of the Caribbean islands, spurred many West Indians to migrate to the United Kingdom (mainly England and Wales) (Fryer, 1984; Phillips and Phillips, 1999). To accommodate this, the 1948 British Nationality Act guaranteed entry into the United Kingdom for those within the British empire (Paul, 1997). The arrival of the Empire Windrush is regarded as the start of the mass West Indian migration to the UK (Paul, 1997; Phillips and Phillips, 1999). At this time, Caribbean people from the colonies were British citizens with all rights of citizenship afforded to them and, therefore, considered themselves to be British in every sense of the word. The Empire Windrush docked in Essex, just outside of London, in 1948 carrying almost 500 West Indians (Fryer, 1984; Phillips and Phillips, 1999). Many of the older West Indians living in the UK today arrived after World War II, in part, because of recruitment by the UK for their rebuilding efforts.

1.1.3 West Indians in Bristol

During the 16th century, approximately 100 slaves were estimated to have lived in Bristol (Dresser et al., 2009). The number of Black people in Bristol remained relatively low until the early 1900s when West Indians took up residence, though with difficulty, in several UK cities (including Bristol) after their post-war service with the British forces (Fryer, 1984). These numbers remained steady until the
very early 1950s, after the arrival of the *Empire Windrush* from the Caribbean. The number of West Indians in Bristol were approximated to be between 150-200 in 1952 which then increased to 2000 by 1960 (Dresser et al., 2009). Since the arrival of the *Empire Windrush* in 1948, West Indian settlement in Bristol largely occurred in the city areas of St. Paul’s, Montpelier and St. Werburgh’s (Dresser et al., 2009; Pryce, 1979). Although many West Indians found that living within these areas offered a form of protection against much of the racism and discrimination that occurred in Bristol they were not completely immune to it and had similar experiences as reported in other UK cities (Dresser et al., 2009), discussed further Chapter 3. In addition to the discrimination faced in the housing, education, employment and financial sectors, there were reported incidents of violent acts carried out against ethnic minority groups in Bristol (Dresser, 1986).

The social exclusion of Blacks in Bristol resulted in uprising against racism and discrimination during the 1960s and 1970s. The Bristol Bus Boycott of 1963 occurred as a protest against the obvious discrimination whereby the Black workers of the company were employed as lower paid auxiliary staff and were not allowed to drive the buses (Dresser, 1986). Adding to the tension of the time, manufacturing jobs were on the decline and many who were only able to find employment within these industries found themselves without work and without the necessary skills to transition to working in the other industries. Increased unemployment resulted in an increase in criminal activity and an increase in the policing and harassment of Bristol’s Black residents (Dresser et al., 2009). This eventually came to a head in the early 1980s when this tension erupted into riots across the city. In the following years, post-riot Bristol saw an increase in the number community organisations supporting the West Indian community and promoting inclusivity among all of Bristol’s residents (Dresser et al., 2009). Although this was an important transitional period in Bristol’s race relations history, Bristol’s Black and ethnic minority residents still experienced racism and discrimination in their daily lives, whether at financial institutions, in their places of employment, within the healthcare system, at the hands of law enforcement or going about everyday activities (Pilgrim et al., 1993). Black West Indians in Bristol have endured a complex set of experiences brought about by the city’s social and political history. It is, therefore, important to understand the impact
these experiences may have had over the life course, especially now as they are older.

1.1.4 Who are ‘Older’ People?

This thesis is focused on the health of a specific group of older people and, as such, an understanding of who they are is necessary to situate the study. While doing so, it is important to note that there are technical definitions of old age as well as subjective understandings old age and that these differences bring about tensions in defining whom older people are. With this, the terms ‘old, older, elderly’ are social constructs typically associated with particular life stages, often linked to events such as retirement and becoming a grandparent as well as physical changes which can sometimes include diminishing agility and menopause; see Phillipson (1991) and Vincent (2006) as examples of the socially constructed nature of these terms. Therefore, it is important to acknowledge that becoming a grandparent and physical changes to the body, for example, do not necessarily signify that a person is ‘old’.

Typically, the age range of 60 to 70 years is often linked to retirement and may be used to signify a person entering ‘old age’ or becoming an ‘older person’. Although the origin of this limit is disputed (von Herbay, 2014; Orimo et al., 2006), it has been suggested that this retirement age can be traced back to one of the first pension schemes introduced in Germany in the late 1800s. This was modernised in the early 1900s and saw the retirement age raised to 65 years, thus contributing to what could be considered a technical definition of ‘old age’. In the UK, Old Age Pensions Act was passed in1908, in the first government mandated state pension programme. While there is currently no longer a Default Retirement Age of 65 years, the age at which a person can claim state pension is shifting: the state pension age for women and men will be 66 years by October 2020 with a further increase to 67 years by 2028 (“State Pension Age Timetables”, 2016).

If we consider the retirement age and receipt of benefits as part of the technical definition of ‘old age’ and this continues to be adjusted, the technical definition of old age will also shift accordingly. The shifting nature of what can be considered ‘old age’ is demonstrated in the following examples. Globally, the United Nations
uses 60 years (United Nations Population Fund and HelpAge International, 2012) to identify the older population while the UK uses ages 60 – 65 years (Office for National Statistics, 2017; The Commons Library, 2007). Similarly, public health (Blake et al., 1988; Langlois et al., 2013; Makai et al., 2014; Ngandu et al., 2015; Steffen et al., 2002) and social science (Bergeron et al., 2016; Cornwell and Waite, 2009; Shanas, 1979) research involving older members of society frequently use the 60 – 65 age group as the minimum age of their study population.

As seen in the paragraph above, research involving ‘older people’ typically uses the ages of 60-65 years to denote the desired study population. And while the retirement age in the United Kingdom is currently 65 years, this is shifting upwards. Given these two reasons and that this research is focused on ‘older people’, this study initially sought to recruit participants aged 65 and older. In addition to the desired age of 65 years, participation in this study was also determined by the time period of migration such that I was interested people who migrated anytime between the 1940s through the 1960s. However, during the very early stages of recruitment, I realised that needed to adjust the age of participation in the study and remove the 65-year age threshold. This is because I met a potential pool of participants who although they did not meet the age requirement, they migrated to the United Kingdom during the desired time frame. The decision to include people under the age of 65 years contributes to the discussion regarding the tension between technical definitions and subjective understandings of who ‘older people’ are and what ‘old age’ is. As I will go on to discuss in the Methodology chapter, I recruited most of the study participants through senior centres, including individuals who were under the age of 65 years. My recruitment experience strengthens the notion that ‘old age’ is dependent upon a person’s own perception of their age. With this in mind, the participants of this study ranged in ages of 56 to 84 years and the two people who were under the age of 65 years were recruited through these senior centres. The fact that these participants opted to attend their senior centres could signify that they perceived themselves as ‘older people’ even though they are not yet 65. Thereby, adding to our understanding that ‘old age’ is, indeed, subjective. The definition of ‘old or older’ varies between societies, settings and from one individual to the next and is also
dependent on that person’s life experiences, beliefs and how that person navigates her or his world, hence the socially constructed nature of these terms. All of these, therefore, contribute to a person’s perception of their age and why I decided to include participants under the age of 65 years.

1.1.5 Ageing in the United Kingdom

Advances in medicine and public health have resulted in people living longer. As of 2015, the proportion of people around the world aged 65 and older was approximately 8.5% of the total population and this is expected to increase to 12% in just 15 years (He et al., 2016). Focusing on the UK, people over the age of 65 currently make up about 18% of the total population with 2.4% being older than 85 years (Office for National Statistics, 2017). The proportion of the UK population over the age of 65 years is expected to further increase to 24.7% by the year 2046 (Office for National Statistics, 2017). Black and Minority Ethnic (BME) groups make up 16% of the total UK population and also make up 8% of the population over the age of 60 (Age UK, 2014; Lievesley, 2010). Historically and currently, BME populations in the UK, whether British born or migrant, tend to have worse health outcomes than the White British population (Age UK, 2009; Eaton, 2004; Nazroo, 2003) with these disparities also extending to the ageing population (Borrell et al., 2006; Karlsen and Nazroo, 2002a; Nazroo, 2004; Norton and West, 2014; Soule et al., 2005; Victor, Martin, et al., 2012). Health and social inequalities in the UK were brought to the forefront by the Black Report (Townsend et al., 1982) which concluded that the widespread disparities in health had their roots in economic inequality. Thirty years later, research on health inequalities (Acheson, 1998; Karlsen and Nazroo, 2002a; Marmot, 2010; Williams et al., 2016) have drawn similar conclusions and have gone further to suggest that an individual’s health may be influenced by the interactions between a person’s social and economic position as well as structural processes like racism operating in society, for example.

1.1.6 Policy Context of Ageing

Some of policy discourse surrounding the ageing population in the UK is framed as being costly and complex. The ageing population was identified as a “key
issue” for the UK Parliament in both 2010 and 2015 (The Commons Library, 2007, 2015). Reports produced by the House of Commons Library (2007, 2015), which are used to brief Ministers of Parliament, highlight the public spending, service provision and impact on the National Health Service of the over-65 members of the population, “the ageing population will cause a widening of budget deficits over time, eventually putting public sector debt on an unsustainable upward trajectory” (The Commons Library, 2015). When looking at the economic impact of the ageing population, there are proposals of easing the pressures on services by improving the health status of the older population; reducing welfare payments; and increasing their time in employment (The Commons Library, 2015).

Although policymakers are paying attention to the growing population, these reports (The Commons Library, 2007, 2015) focus on the growth of the older population via individuals who were born in the UK with no mention of those who moved to the UK and often age here. This is a major omission from these reports given that the proportion of the foreign-born population increased from 7% in 1993 to 13.1% as of 2014 (Vargas-Silva and Rienzo, 2016) and slightly more than half of the total population growth in the UK between 1991 and 2014 was due to migration (Cangiano, 2016).

The suggestions in these reports focus on keeping people healthy, defined as being free from disability as they move into their retirement years. However, utilising such an economically driven definition of healthy ageing aids in creating a culture that is more focussed on active ageing via inclusion in the labour market. Health is an important aspect of ageing but has different meanings for people. Health and ageing, especially when considered together, are multifaceted topics and go beyond physical and mental attributes. They are also more complex than merely remaining active and delaying disability for as long as possible and should be explored further.
1.2 Conceptual Frameworks Influencing the Study

Within the last seventy years, ethnic diversity in United Kingdom has increased and with older migrants ageing here, there is even more of a need to raise awareness about how they may conceptualise healthy ageing. Although the policy focus is currently to keep people active and physically healthy for as long as possible, everyone may not consider this important. This is significant because these prescriptions for how people should age may not apply across the board to all sects of the community and, therefore, any recommendations for ageing ought to consider the diverse lived experiences that individuals may have had including, and especially, migrant and ethnic minority groups. This study draws on elements of critical theory, discussed further in Chapter 3, and recognises that there are social and political processes operating in society that give rise to complex and varied experiences across the life course and that these experiences can impact an individual’s perception of healthy ageing, thus adding to the body of knowledge in both ethnicity and gerontology scholarship.

Torres (2015) suggests that the field of gerontology has not adequately considered and incorporated the multifaceted understanding of ethnicity. Doing so shifts the understanding of ethnicity and “problems of ethnicity” away from one that is individualistic to an understanding that, instead, acknowledges the roles that of the aforementioned social and political processes in influencing health and the perspective of healthy ageing. In addition to offering a more inclusive picture of ageing, i.e. one that considers the impact of wider society, viewing ethnicity in this way also means that the power structures operating in society are acknowledged when looking at the general well-being of ethnic minority groups.

1.3 Structure of the Thesis

This first chapter of the thesis provided contextual background as well as motivation for the study. Chapter 2 reviews the discourse surrounding healthy ageing. The focus of this chapter is to highlight current concepts related to healthy ageing and to present current debates within this field. Chapter 3 discusses the theoretical position of this study. These chapters together form the literature
review which highlights the gaps in knowledge and influenced the construction of the research questions. Chapter 4 details the methodological approach to the study. Chapters 5 and 6 form the findings and discussion chapters. Chapter 5 explores the experiences of migration by utilising critical race theory and the life course framework. And following from this, Chapter 6 examines these experiences with a view to present the attributes of healthy ageing. Chapter 7 presents the overall conclusions for the study, the implications of the findings and will consider the limitations of the study.
Chapter 2    Healthy Ageing in Later Life

2.1 Introduction to Ageing and Health

One of the main aims of this thesis is to explore how the processes of migration have impacted on the health of older West Indians in the United Kingdom. With this, the current study examined the attributes of healthy ageing among older West Indian women and men living in Bristol and Bath. This chapter reviews the literature about concepts linked to the term ‘healthy ageing’ and then focuses on the meaning of healthy ageing for Black and ethnic minority groups. The review begins with a discussion on healthy ageing, specifically looking at how concepts like ‘successful ageing’, ‘active ageing’ and ‘healthy ageing’ are used to construct the supposedly ideal ways in which individuals should age, especially regarding their health. This review will present a critique of such concepts before considering the research that looks at the perspectives of older people on what it means to age healthily and why it is important to understand their perceptions on healthy ageing. These perspectives highlight a disconnect between lay views of healthy ageing and concepts that fall under the umbrella of healthy aging. This chapter will then go on to examine studies of the perception of healthy ageing in minority ethnic communities. Finally, the chapter will explain how use of the ‘resilience’ concept can help us understand these lay perspectives.

Although the topic of ageing has been widely studied, few studies have included health and migration factors. What is known about the health of migrants is that members of this group are more likely to exhibit risk factors for poor health and/or have worse health than the native populations (Bollini and Siem, 1995; Jayaweera and Quigley, 2010; Malmusi et al., 2010; McKay et al., 2003; Newbold and Danforth, 2003; Nielsen and Krasnik, 2010). They also face socioeconomic and health inequalities (Eaton, 2004; Nazroo, 2001, 2003; Soule et al., 2005). Within the last twenty years, research has been consistent in demonstrating that societal influences, like experiences and processes of racism and discrimination, have a negative impact on an individual’s socioeconomic conditions, overall well-
being and both physical and mental health (Borrell et al., 2006; Curtis and Lawson, 2000; Karlsen and Nazroo, 2002a; Nazroo, 2003; Williams et al., 2016).

Looking at the literature on the health of older migrants, complex details are often missing about their lives across the life course after migration. This is due, in part, to the knowledge about the health of older migrants usually being based on the proxy of ethnicity, which not only can ignore multiple identities (Bradby, 2003), but is also means that the effects of migration histories and experiences are ignored (Blakemore and Boneham, 1994; Moriarty and Butt, 2004; Victor, 2010; Wray, 2003), see the earlier example of ‘Black/African/Caribbean/Black British’ or ‘Asian/Asian British’ (Office for National Statistics, 2012a).

2.2 Healthy Ageing

Taking experiences of migration into context, this thesis is concerned with the influences on and attributes of healthy ageing for older Caribbean women and men living in the UK. To achieve this, I began by looking at the literature concerning the health of the older people and realised that their health is often discussed in relation to various concepts under the umbrella of healthy ageing, such as successful ageing and active ageing. There is, however, evidence to suggest, explored in Section 2.2.2, that perhaps these concepts are not relevant to all members of society and different people place emphasis on different things in their lives. Additionally, this importance can be dependent on a number of factors such as life experiences, culture and the structures in place that have given rise to a person’s socioeconomic circumstances.

A brief discussion of these concepts follows and, moving forward, this study will use the term ‘healthy ageing’ to refer to the different linked concepts like successful ageing and active ageing. Additionally, further sections will highlight the potential issues with the use of these terms.

2.2.1 Successful Ageing, Active Ageing and Healthy Ageing

Over the last 30 years, healthy ageing has emerged as an influential term, especially within the medical field, used to describe the ways in which people
should think about their health during their later years. It is, therefore, important to understand these concepts and compare their meanings with the beliefs of older people, as will be demonstrated in later sections. Doing so will, therefore, highlight any similarities and/or differences in meaning which could then impact the ways in which needs are assessed, policies are made and programs are planned.

Successful Ageing

Successful ageing is one of the key concepts within healthy ageing terminology. As defined by Rowe and Kahn (1997, p. 439), the concept of successful ageing, is

...multidimensional, encompassing three distinct domains: avoidance of disease and disability, maintenance of high physical and cognitive function, and sustained engagement in social and productive activities.

Bowling’s review of successful ageing found that the development of the concept has its beginnings in early research in the United States and had the goal of measuring well-being and life satisfaction in older members of society (Bowling, 1993). In addition to Bowling’s work, there are other reviews and critiques of successful ageing (Cosco et al., 2014; Depp and Jeste, 2006; Martinson and Beridge, 2014) and, as such, an extensive review of this literature beyond the scope of this thesis. Briefly, due to growing interest in gerontology on positive ageing and successful ageing, the 1980s saw the formation of the MacArthur Network on Successful Aging (Martin et al., 2015). The ensuing paper from MacArthur Network (now known as the Research Network on an Aging Society, part of the MacArthur Foundation), led by Rowe and Khan, compared ‘usual ageing’ with ‘successful ageing’, whereby successful ageing meant living longer and free of disease and disability (cognitively and physically) (Rowe and Kahn, 1987). This initial work laid the foundation for other research on successful ageing that followed (Martin et al., 2015). A decade later, successful ageing and its ties with health continued to gain popularity, mainly within academia, in the United States (Martin et al., 2015) when Rowe and Kahn modified the initial concept and introduced its three main components, namely maintaining physical and cognitive functioning, avoiding disease and disability and remaining socially engaged (Rowe and Kahn, 1997).
Researchers, however, have since adapted this concept, leading to varied interpretations as well as a lack of an agreed-upon definition (Cosco et al., 2014; Depp and Jeste, 2006; Reichstadt et al., 2010). Despite the lack of consensus on a definition, successful ageing has remained popular in gerontology over the last two decades and continues to be used today (Bowling, 2005; Martinson and Berridge, 2014).

**Active Ageing**

While successful ageing focuses on the avoidance of disease and disability, active ageing places value on keeping people involved in activities of their choosing while also maintaining good health. The concept of active ageing is utilised by the World Health Organization (WHO) in their work on ageing, health and the life course (World Health Organization, 2002). Here, importance is placed on improving the lives of older people by facilitating their involvement in activities important to them, whether social, economic or spiritual (World Health Organization, 2002). The WHO adds that “Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (World Health Organization, 2002, p. 12). The focus is on enabling healthy lives as people age, regardless of their dis/abilities, such that they can remain active participants in their families’ and friends’ lives, and as well as within their neighbourhoods. Active ageing is also frequently used within Europe in policy and academia (Foster and Walker, 2015). Active ageing first became part of European policy in the early 1990s and has continued to remain part of the policy landscape (Walker and Maltby, 2012). At present and as still a member of the European Union, the UK (and other member states) are encouraged to follow their guidelines in developing their own active ageing policies based on the following statement (Council of the European Union, 2010, p. 5):

…active ageing means creating opportunities for staying longer on the labour market, for contributing to society through unpaid work in the community as volunteers or passing on their skills to younger people, and in their extended families, and for living autonomously and in dignity for as much and as long as possible; that the continued participation of older workers, both women and men, in employment can make a valuable contribution to improving the performance and productivity of the economy which in turn is of benefit to all parts of society…
Research utilises active ageing as a way to help older people remain as healthy as possible, to enable them to stay employed for longer and to support them in staying active members of their communities (Foster and Walker, 2015). There are studies based in the Caribbean which also tend to use the active ageing framework when investigating healthy ageing and setting policy recommendations for older members of society; see Cloos et al. (2010) and Eldemire-Shearer et al. (2014) as examples.

**Healthy Ageing**

Healthy ageing is very similar to both successful ageing and active ageing in that it is also focused on the maintenance of optimal health and the ability of older people to continue their participation in society (Naaldenberg et al., 2012). Healthy ageing is often used interchangeably with successful ageing in research seeking a definition of successful aging and/or measuring successful aging in older people (Cosco et al., 2014). At the global policy level, WHO defines healthy ageing as “process of developing and maintaining the functional ability that enables well-being in older age (World Health Organization, 2015, p. 28) while regionally, the European Union defines it “optimising opportunities for good health, so that older people can take an active part in society and enjoy an independent and high quality of life” (European Union, 2016). Given its similarities with successful ageing and active ageing, healthy ageing will not be discussed further.

### 2.2.2 Why These Concepts May Not Work

Arguing that concepts like successful ageing and active ageing can be too limiting, there have been calls to rethink their usage in guidance for how people should age (Martinson and Berridge, 2014; Romo et al., 2013). These terms can be restrictive in that they do not reflect the complexities of life experiences, cultural differences and the structural inequalities experienced by people, or different groups, which can then affect the health of a person as they age.

One of the main arguments given by critics of successful ageing (Bowling, 2005; Cho et al., 2012; Minkler and Fadem, 2002; Young et al., 2009) is that the
emphasis on remaining disability-free for as long as possible is unrealistic and are not inclusive enough in that they do not take into consideration the multiple realities of people such as those with disabilities. Additionally, when the definition of successful ageing is applied to older members of society, many people do not fit the criteria even though they consider themselves to have aged successfully. Studies such as these suggest the need for an expanded, multidimensional definition of successful ageing which acknowledges that successful ageing is more than just maintaining optimum mental, physical and social health. The concepts associated with healthy ageing should be able to recognise that not everyone ages without a decline in health. Moreover, the use of successful ageing as a measure of healthy or ideal ageing excludes adults who have physical disabilities and those with chronic illnesses even though individuals with these ‘conditions’ are often able to adjust their lives accordingly to accommodate these changes and, thus, remain fully engaged with life.

Additionally, any definition for a model of healthy ageing should recognise that there are multiple paths to ageing and that success should be partially based on how that person and their environment adapt and co-exist and, further, the concept should also consider the individual’s sense of well-being and personal fulfilment (Young et al., 2009). Along with investigating healthy ageing from the perspectives of older people, qualitative studies help to highlight the kind of contextual information necessary for researchers to understand the different meanings ascribed to healthy ageing. This will be explored in subsequent sections.

2.2.3 How Do Older People View Healthy Ageing?

The studies above demonstrated some of the limitations of concepts under the umbrella of healthy ageing and the idea that unless you have near perfect physical and cognitive health and still remain active in socially well into your later years, you have not aged successfully. What then do older people consider as being successfully aged or what does healthy ageing mean to them? The sections that follow attempt to answer these questions.
Personal Resources

Concepts such as successful ageing or active ageing do not take into account the importance that psychosocial factors play in determining what healthy ageing means to others. For example, personal growth, happiness and acceptance were elements of healthy ageing found in studies by Knight and Ricciardelli (2003) and Reichstadt et al. (2010). Knight and Ricciardelli explored ideas of successful ageing among older adults (aged 70 years and older) in Australia and found that participants rated health and activity as important which, indeed, reflects the traditional definition of successful ageing. However, these adults also placed importance on personal growth and happiness; elements not included in the traditional definition of the concept. Reichstadt et al. (2010) conducted interviews with participants with a mean age of 80 years in the United States and found that successful ageing meant being happy and enjoying life while personal growth meant being able to participate in activities of their choosing, volunteering and having a positive attitude. The authors also found that acceptance, which was defined as being comfortable with oneself and one’s past experiences, were key for constructing their participants’ definition of successful ageing (Reichstadt et al., 2010).

Agency and Activities

In other studies exploring healthy ageing, activities were revealed to be important and were found to be linked with ability to act of their own free will and to make their own decisions, also known as agency. Bryant et al. (2001) asked 22 people over the age of 60 about their perceptions of healthy ageing. For these participants, healthy ageing meant “going and doing”, emphasising the importance of having something worthwhile and enjoyable to do and also the will (which was indicated by having a positive attitude) alongside the physical ability to participate in these activities. In addition to activities, the British study by Stenner et al. (2011) also found agency to be a significant component of their participants’ perceptions of active ageing. Participants also felt that having agency was important in terms of being able to do what they wanted and when they wanted and not to be dictated to by others (Stenner et al., 2011). The authors also found that the subjective meaning of active ageing consisted of a combination of
social, mental and physical elements that manifested into activities like volunteering, pursuing hobbies and looking after family.

**Adaptation**

As discussed already, the processes of acknowledging limitations and then adapting to the new circumstances was very important in subjective definitions of successful ageing, especially in those with disabilities and chronic illnesses (Minkler and Fadem, 2002; Romo et al., 2013; Young et al., 2009). For example, Minkler’s and Fadem’s review described adaptation as a collaborative process whereby the individual acknowledges their need for assistance and the environment adapts to these changes in order to accommodate these changes. Similarly, in Romo et al.’s (2013) study, adaptation is also psychological process whereby the participants accept their age-related declines in health and adapt their outlook to one that focuses more on positive aspects of their lives.

**Feeling Connected**

One of the components of the Rowe and Kahn definition of successful ageing is “sustained engagement in social and productive activities” (Rowe and Kahn, 1997, p. 439). For many older people, feeling connected embodies this part of the definition. Stephens et al. (2015), for example, in a study of people over the age of 63 years in New Zealand, found that having social connections and being able to give their time and assistance to others was valued as significant. Participants also emphasised the importance of being financially secure and being comfortable, indicated by warm clothing and housing and healthy food, on a daily basis. Valuing social connections and emphasising financial security could also be linked to the finding that many participants strove to preserve their identity as a normal member of society and maintain their connections, despite being ill and having physical limitations. With similar findings, a recent systematic review (including papers across several countries) by Song and Kong (2015) also determined that connectedness to others is important to ageing healthily. This feeling of connectedness also extends to the desire to be connected to a higher power, which often meant having faith in God.
The sections above explored healthy ageing concepts such as successful aging and active ageing; concepts that are often used as guidelines for idealised ageing. Though they remain popular in academic discourse, these concepts might not go far enough to address actual the needs of older people regarding their health. The studies presented above demonstrate a divide between the meaning of these concepts and the perspectives of older adults. It should be noted that the evidence does indicate that traditional definitions of healthy ageing and the views of older adults do have some common ground on what healthy ageing should entail: being able to participate in activities of one’s choosing, being pain free or able to manage pain and feeling socially connected. There is, however, a range of subjective elements missing from these traditional definitions, including personal growth, happiness, acceptance, adaptation, feeling connected, and agency, which are important to older people.

Why, then, is it important to understand how older people view their health as they age? Self-rated health is a predictor of mortality (Alfonso et al., 2012; Benyamini et al., 2003; Inchingolo, 1997; af Sillén et al., 2005), which is very important. But the real issue is the need to understand the meaning of ageing healthily from the perspective of older people.

2.2.4 Are Perceptions of Healthy Ageing Different in Ethnic Minority Communities?

The sections above demonstrate a disconnect between academic definitions of healthy ageing and the views of older people themselves. Significantly, much of this body of research focuses on a majority white and non-migrant population and does not reflect on whether their attitudes might vary between different groups of older people. This work, therefore, aims to examine whether people from ethnic minority communities hold different views of healthy ageing than the general population. Within the fields of health care and medicine, there is considerable agreement that there are cultural differences in understandings of health and illness. Betancourt et al. (2003), for example, explored the ways in which culture can affect understandings of health and illness and expectations of care and,
ultimately, health care decision-making. And, similarly, research on dignity in care in later life contends that culture can affect a person’s values and beliefs and, thus, should be taken into consideration when providing care (Saltus and Folkes, 2013). There is also evidence demonstrating the ways in which culture can affect the perception and discussion of pain (Callister, 2003) as well as how culture can impact perceptions and attitudes about disability (Ravindran and Myers, 2012). Indeed, having an understanding of an individual’s cultural values regarding health and illness can help prevent generalisation and stereotyping and can ensure that health messages and recommendations for care are communicated appropriately and understood effectively (Betancourt et al., 2003; Galanti, 2000).

As was discussed in the previous chapter, many of the people who moved to the UK during the early to mid-20th century from the different ex-colonies are growing older here. The increase in the numbers of older ethnic minority groups warrants an examination of their perceptions of healthy ageing as there is still limited research on minority ethnic ageing in the UK (Nazroo, 2004; Phillipson, 2015). Wray (2003) argues that studies examining the ageing of ethnic minority groups continue to use the same concepts of healthy ageing, i.e. successful and active ageing, across all populations without regard for the different interpretations that healthy ageing may hold. In agreement with other researchers, this thesis argues that research and policy should not present minority ethnic ageing as a problem but ageing, instead, should be contextualised by the social and political processes affecting their lives (Katz and Calasanti, 2015; Torres, 2015). This problematisation of minority ethnic ageing was noted, for example, by ethnic elders in London who felt that their values regarding health and overall well-being were not seen as important and were ignored by health care and service providers (Butt and O’Neil, 2004). Drawing similar conclusions, Phillipson’s recent review of ageing in ethnic minority communities argues for research examining the ways in which elders from minority ethnic groups experience “cultural, economic and social disadvantage” (Phillipson, 2015, p. 920) but notes that it is important to understand that not only are there differences between ethnic groups but that there are also differences within ethnic groups, thereby avoiding essentialising. While ethnic minority communities are not the only members of the population to experience socioeconomic disadvantage, it is the complex
processes of racialisation that occur and the resulting experiences that help to shape their perceptions, which may then differ from the majority population. The ways in which culture could possibly affect understandings of health and illness could also be extended to perceptions of healthy ageing, as will be demonstrated in the following sub-sections.

**Accepting and Being Realistic About Physical Abilities**

Similar to the traditional domains of healthy and successful ageing, physical aspects of health are emphasised as important within ethnic minority communities. The attributes of physical health, however, differed from the aforementioned traditional definitions as described by Rowe and Kahn (1997). For example, in one study of older Black Americans, when participants discussed their physical health, the focus was not on being free of illness nor was it about having perfect health, instead the emphasis was on being realistic about their physical abilities as well as doing what they can to maintain their health, such as eating well (Troutman et al., 2011). In the similar vein of being realistic, a study of healthy ageing in older Puerto Ricans living in mainland United States found that participants stressed the importance of accepting declining health as a normal part of the ageing process (Todorova et al., 2015). Acceptance and being realistic was also discussed by most of the participants in Romo et al.’s (2013) study of ethnically diverse older Americans. This kind of acceptance shifts the focus from the things they are physically unable to accomplish onto the things they are still able to partake in and enjoy.

In a comparative multi-ethnic study by Laditka et al. (2009) participants of all ethnicities (except Vietnamese) highlighted the necessity of staying active and keeping busy for ageing well. Physical health was discussed as independence and interdependence and cultural variations were seen in these concepts. The participants (all Black Americans) in Troutman et al.’s (2011) study emphasised their independence and autonomy as important to healthy ageing which was also echoed by the Black Americans in Laditka et al.’s study. However, in Laditka et

---

2 This study included the following ethnicities: Black/African American, Chinese, White, and Latino.
3 This study included the following ethnicities: Black/African American, American Indian, Hispanic, Chinese, Vietnamese and White.
al.’s study (2009), Vietnamese people placed importance on interdependence as their culture tends to value caring for family members, especially in older ages. Other variations included differences in importance attributed to diet and health, as seen in the case of Black Americans whereby they emphasised eating well as important for maintaining good health (Troutman et al., 2011). Conversely, American Indians did not link diet (or physical activity) with ageing well which, the authors stated, could potentially impact health promotion messages across various groups (Laditka et al., 2009).

Social Connections

Social connections, whether via community engagement, volunteering or spending time with family and friends is another important part of ageing healthily. Lewis’ (2011) research among Elder⁴ Alaskan Natives, for example, highlighted the importance of community engagement and the way it was connected to having a good quality of life in older ages. It is through sharing their experiences and lessons learned throughout their lives that helped to give the Elders a continued role in society as well as a sense of purpose. Another study with older Black adults described the social well-being component of active ageing as the ability to give their time to others through spending time with and helping their families (e.g. with child care), by helping friends in need (e.g. by cooking meals) or by participating in community service activities (Troutman et al., 2011). The role of charity via giving back to their community was also an important component of ageing successfully in older Japanese Americans (Iwamasa and Iwasaki, 2011). As we have seen, maintaining social connections keeps communities bonded together as it allows for the transmission of customs through the generations. And from a personal perspective, it means that the older adults can remain active and engaged.

Spirituality

Having faith in a higher power was particularly important to ageing successfully among elders in ethnic minority communities (Iwamasa and Iwasaki, 2011;

⁴ In this study, ‘Elder’ is capitalised to indicate the older community members whom are regarded as respected and as role models.
Laditka et al., 2009; Lewis, 2011; Todorova et al., 2015; Troutman et al., 2011). For some, spirituality was linked with gratitude for life and health; that it was God’s will that they have lived as long as they had and that, in turn, they should be giving back to the church community (Troutman et al., 2011). Among Elder Alaskan Natives, having faith in a higher power was identified as an especially critical element for ageing successfully (Lewis, 2011). The Elders credited a higher power for their positive attitudes and for overcoming various hardships in life. Drug and alcohol abuse can be a problem, especially among the youth, in this community and, as such, the Elders also credited their religious beliefs in giving them the strength for maintaining their sobriety and making it to older ages (Lewis, 2011).

For older Japanese Americans, spirituality, expressed as faith, religion, charity and appreciation, was also considered to be an important component of healthy ageing (Iwamasa and Iwasaki, 2011). The participants described how going to church or praying helped them find inner peace or, sometimes, connected them further with their culture. Participants also discussed how having faith enabled an appreciation for being alive, thus improving their mental and emotional well-being. Spirituality was found to be key in ageing successfully as the participants discussed its benefit for coping during stressful periods of their lives (Iwamasa and Iwasaki, 2011).

Spirituality, for older Puerto Ricans, was linked with their ability to accept their declining health as they felt that it was through God that they were able to tolerate their pains and, therefore, keep living their best lives possible (Todorova et al., 2015). Linking positive attitude with spirituality, older Puerto Ricans expressed their gratitude through their spirituality by thanking God for life and the health that they did have; these findings were echoed by Black and Latino participants Romo et al.’s (2013) study. Gratitude and appreciation were identified as important to ageing and health as participants, regardless of health status, were thankful for their health, life and family (Todorova et al., 2015).

Spirituality serves multiple purposes among older ethnic minority groups. For the Japanese, for example, spirituality helped them remain connected to their culture.
while for Elder Alaskans, a higher power was called upon during personal hardships. Common amongst the different ethnicities discussed, was that spirituality or belief in a higher power was linked with feelings of gratitude, happiness and inner peace, which then go on to positively affect mental well-being.

**Personal Resources**

Studies that examined successful ageing among older ethnic minority groups found that having a positive attitude was key to healthy ageing and was less about cognitive abilities and more about enjoying life through having a positive mindset (Troutman et al., 2011). Having an overall positive outlook enabled the individual to accept the ageing process and the associated changes in the body and resulting limitations (Laditka et al., 2009) and having a positive outlook on life, linked with spirituality, increased the ability of the person to cope with difficult situations, especially in their later years (Iwamasa and Iwasaki, 2011). In older Puerto Rican’s, the participants tended to have a positive outlook concerning their health, regardless of their conditions (Todorova et al., 2015). For some of the participants, despite having chronic health conditions, they focused on the fact they were still able to be active and continued to be mobile. Additionally, even though some of the participants had poor health, they still said that they felt good (Todorova et al., 2015). Normalising their illness seemed to be a central part of acceptance. The authors also found that this acceptance of their current health manifested itself as resignation as participants felt that the barriers facing them, due to their lower socioeconomic status and resulting inequalities, were immovable. As such, they chose not to complain about their health and, instead, focused on adapting (Todorova et al., 2015). Additionally, gratitude (through spirituality) for their life and health was found to be an important part of acceptance. Positive attitude and emotional well-being, also linked to spiritually, is a very important factor for successful ageing in Alaskan Native Elders (Lewis, 2011) in that members of this community credited a higher power for their positive attitudes.
Financial Security

Although discussed less in the literature, having financial security was an important component of successful ageing in some cultures. Iwamasa and Iwasaki (2011) found this to be true in their study of Older Japanese Americans. The authors theorised that their focus on financial stability could have been due to their experienced discrimination and racism especially during their earlier years when many members of the Japanese American community were interned during the war and, thus, lost much of everything. These past experiences, therefore, impacted on their views about what was important for them to have, i.e. financial security, in their later years. Thus, this study also showed that having this contextual information highlighted the role that past experience can play in shaping our values and perceptions as we get older.

In summary, the sections above highlighted healthy ageing from the perspective of ethnic minority communities. The research showed that there were similarities between general lay perspectives of healthy ageing and ethnic minority perspectives of healthy ageing. Indeed, the social aspect of health is one of the traditional components of successful ageing but there are subtle differences in meaning of ‘socially engaged’. For example, most of the participants in the studies above that discussed social engagement focused on volunteering in the community or helping family members. While Lewis’ (2011) study showed that remaining connected to others, specifically through knowledge sharing, meant preserving their ‘normal’ identity within the community of Elder Alaskan Natives. Another cross-cultural aspect of healthy ageing demonstrated by these studies was that of having a positive mind-set. The positive mind-set was clearly linked to accepting changes in the body which, in turn, prepared the person to be ready to make adaptations in life, particularly noted in older Puerto Ricans living in the mainland United States. Spirituality is another component of healthy ageing particularly noted among ethnic minority populations. In these studies, spirituality was linked to social engagement, a positive mind-set and coping through hard times.
It is important to note that although some of the studies above take place within specific ethnic minority communities, e.g. the study by Todorova et al. (2015), it is important not to ascribe these meanings to all Puerto Ricans, for example. Sandra Torres similarly warns against such essentialising for all ethnic groups and urges those studying older members of ethnic minority communities to (Torres, 2015, p. 950),

expand their focus from the what of ethnicity which is what the essentialist perspective brings attention to (i.e. what ethnic backgrounds mean to different old age and ageing-related issues) to the when and how of ethnicity which is what the social constructionist perspective brings to the fore (i.e. under which circumstances and within which contexts these backgrounds are expected to mean something and how).

In the text above, Torres maintained that ethnicity is not something that is inherent and unmovable within a person and, instead, is a negotiable process between ‘what we claim to be’ and ‘who others claim we are’. Hence, there are no fixed meanings or definitions attributed to particular ethnic groups and, thus, there is no one perspective that a particular ethnicity brings. Instead, researchers need to focus on the ways in which ethnicity interacts with varying contextual backgrounds when designing research and analysing findings among ethnic minority groups. With this, how then can researchers incorporate the views of older people, especially those from ethnic minority groups, while emphasising their experiences and backgrounds? The following sections on resilient ageing propose an answer to this.

2.2.5 What About Resilient Ageing?

As discussed in previous sections, concepts such as successful ageing and active ageing present an unattainable and idealised view of ageing. Numerous critiques of these concepts called for a more achievable and inclusive view of ageing (Bowling, 2005; Cho et al., 2012; Romo et al., 2013). The differences between lay views and academic views of healthy ageing tell us that perhaps another, more inclusive, way to look at ageing and health is needed; one that considers the components elucidated by older individuals while simultaneously taking into account the context of people’s lives past and present. Additionally, with the gap in research about healthy ageing in ethnic minority elders, this thesis proposes to
utilise the resilience concept, via resilient ageing, to add to the body of knowledge regarding how ethnic minority elders perceive what it means to age healthily especially at it places value on the context within which people live their lives.

In an effort to bring to the fore a more inclusive and realistic model of ageing, the concept of resilience has been used to understand healthy ageing in older populations, as will be discussed below. Further, this concept can be used to understand the ageing perspectives of ethnic minority populations as it takes into account their viewpoint as well as considers how that may be shaped by their background and experiences, including processes of migration.

When applied to older populations, resilience can be defined as “the ability to bounce back and recover physical and psychological health in the face of adversity” (van Kessel, 2013, p. 127). And Braudy Harris (2008, p. 59), advocating for the use of resilience in understanding how people age says,

All older adults have the possibility of achieving it. We can be inclusive, not exclusive. For having the goal of resilience as we age, and not successful aging, does not preclude or marginalize people with disabilities.... It can also acknowledge the positive or negative influences of gender, race/ethnicity, or social class.

The concept of resilience has its beginnings in developmental psychology with research in children, specifically those who experienced hardship in their lives and went on to achieve positive outcomes (Wild et al., 2013). Part of resilience research involves the identification of ‘risks’, ‘assets’ or ‘protective factors’ and ‘vulnerabilities’ in people’s lives. With ‘risk’ being identified as an occurrence or process that poses a “serious threat” to development (Masten, 2001) or in the case of older populations, can be identified as issues with health (Braudy Harris, 2008), for example. ‘Assets’ are generally identified as things that help a person moderate or avoid the consequences of a risk, e.g. supportive social networks or high self-efficacy while ‘vulnerabilities’ are considered factors that can amplify a person’s susceptibility to a particular risk (Luthar and Cicchetti, 2000). Proponents of resilient ageing argue that the concept allows for acknowledgement of the different ways in which older people thrive in spite of, or due to, the hardships they have experienced (Wild et al., 2013).
Wild et al. (2013) and Browne-Yung et al. (2015) both examine resilience in adults and find that researchers of ageing either consider resilience a trait, occurring within the individual, that can be measured with the use of quantitative instruments or they consider resilience a process consisting of both individual and environmental factors. The individual approach focuses on the internal mechanisms and strategies older people use in response to the awareness of limited time left and also their response to challenges faced in their lives (Browne-Yung et al., 2015). The process approach to resilience is not just about individual coping and adaptation strategies and, instead, also includes the influence of socioeconomics, cultural factors, social networks as well as wider societal structures (Browne-Yung et al., 2015). This process of building resilience is demonstrated in Gattuso’s narrative study of older women where she “highlighted the strategic use of memories of loss and coping in the construction of reaffirmation of a resilient self” (Gattuso, 2003, p. 176). Through this work, Gattuso found that resilience was built up over time as a cumulative process and aided in developing a person who has a sense of well-being and who embraces acceptance.

As with successful ageing, one of the critiques of resilience is that the components of the concept can be difficult to operationalise thus giving rise to varying methods of measurement (Wild et al., 2013). Additionally, others argue that using resilience places too much emphasis on the individual and not enough weight is given to the influence of a lifetime of positive and negative experiences or social inequalities on the life of an individual (Seccombe, 2002); the process approach addresses this criticism.

There are studies, specifically within older populations, that have utilised resilience as a way to understand and explain study findings. Demonstrating how resilience can be understood within the context of culture, gender and socioeconomics, Aléx (2016) explored the meaning of well-being from the perspective of older Swedish Sami women, an indigenous minority group. Using resilience to analyse the data, Aléx found that resilience was a process that was reinforced by feeling a deep connection to their culture, specifically their connection with their mountainous surroundings and the socioeconomic role that
reindeer play in their culture. Feeling connected to and a sense of dependence with their family and community was also linked with building resilience. In contrast, resilience seemed to be weakened most by feeling disconnected from mainstream Swedish society through having experienced discrimination.

With a view to expand the understanding of resilient ageing, Wiles et al. (2012) examined the ways in which older people experienced and ascribed meaning to the concept of resilience. Similar to other studies (Aléx, 2016; Browne-Yung et al., 2015; Gattuso, 2003), the authors of this study found that “resilience was not merely a trait or behaviour, but a multidimensional, contextual and ongoing process (Wiles et al., 2012, p. 423). For these participants, resilience was about keeping a positive outlook on life, maintaining social connections and having available resources within the community and the linkages between these.

Looking at successful ageing, Braudy Harris (2008) examined resilience in two older adults with early-stage dementia and, specifically, how this information can contribute to the wider body of knowledge on successful ageing. The resulting case studies were organised around the core components of the resilience framework: assets and protective factors, risks and vulnerabilities. The author found that for both participants, having a positive attitude, a good network of social support and having access to community resources were assets in strengthening resilience. Additionally, maintaining good self-esteem, believing in a higher power and accepting the inevitable also added to the process of building resilience for the study participants. Risks among these participants were other long-term health issues that could potentially increase the risk of complications. While vulnerabilities, for one participant, included living alone and his increasing withdrawal from social life, while the vulnerability for the other participant was financial instability. These vulnerabilities had the potential to interact with their risks and, thus, weaken resilience. Overall, Braudy Harris found that, through developing resilience, both participants remain fully involved with life. Although not characterised as successful agers according to the traditional definition, the resilience framework recognises the ability of people to successfully age given their constraints and, therefore, showcases the factors that are important for them to adapt and continue to lead meaningful lives.
2.3 Chapter Summary

The proportion of older people is increasing in the United Kingdom due both to
the extension of life expectancy and from inward migration. Britain’s past
colonial ties meant that many of those who moved here in the post-World War II
years are now ageing here thereby increasing the ethnic diversity of older people
in the UK. Although there is extensive research on ageing in general, there is a
paucity of research on the healthy ageing of ethnic minority groups (Phillipson,
2015). My research, therefore, seeks to fill this gap in the literature by exploring
the meaning of healthy ageing for older Black West Indians now living in the UK.

There is an extensive body of literature regarding the different concepts related to
healthy ageing, such as successful ageing and active ageing. Generally, this
research presents an idealised view of ageing as these terms are mainly focused on
extending the life span as well as maintaining optimum physical and mental
health. Critics, however, argue that these goals are unrealistic for many to achieve
(Martinson and Berridge, 2014; Romo et al., 2013). These concepts privilege
unattainable ageing ideals without consideration of how different experiences
over the life course can impact health and the perspective of health as a person
gets older. Recognising the inadequacies of successful ageing and active ageing,
there exists research that examines what healthy ageing means to older people.
These studies often conclude that older peoples’ perspectives do not coincide with
definition of traditional healthy ageing concepts, like successful ageing and active
ageing (Bowling, 2005; Cho et al., 2012; von Faber et al., 2001; Romo et al.,
2013; Strawbridge et al., 2002). The evidence suggests that, in general, when
looking at healthy ageing older people do not focus on what they are unable to do.
Instead, they focus on what they are still able to do.

In reviewing some of the dominant discourse around healthy ageing, this chapter
also sought to consider the perceptions of healthy ageing by the older ethnic
minority community. It was argued (by others and this thesis) that social and
cultural context that shape the lives of ethnic minority groups may shape the
perceptions of healthy ageing and as such warrants special consideration. This
study argues that the concept of resilient ageing is well positioned to contribute to
the body of knowledge on the healthy ageing in ethnic minority communities. By utilising resilient ageing, my research therefore seeks forefront the perspectives of my study participants while taking their life course experiences into consideration, thus shaping a more inclusive view of healthy ageing.

This chapter backgrounds my own research through a review of the dialogue surrounding healthy ageing, which will then assist me in understanding my participants’ perspective of healthy ageing; accomplished in later chapters. This work will contribute to the body of literature regarding healthy ageing minority ethnic groups, specifically, West Indians, in the United Kingdom. As mentioned earlier, this thesis attempts to explore some of the historical social and political processes that have shaped the lives of the participants of this study; these are considered in the next chapter.
Chapter 3    Theoretical Frameworks

In this study, I draw on ideas associated with critical race theory (CRT) and the life course concept as guiding frameworks to examine the experiences of West Indian women and men who migrated to the United Kingdom in the “Windrush years”. The strength of the life course concept lies in its ability to help us uncover the different factors throughout the stages of life that can contribute to an individual’s definition of healthy ageing. Complementing this, CRT allows for further examination and, therefore, understanding of these aforementioned factors. Together, I propose that using perspectives associated with both CRT and the life course will allow me to explore participant narratives and highlight how some of the social and structural aspects of society shaped their lives and the resulting impact on their perceptions of healthy ageing.

3.1 West Indians in the United Kingdom

The early history of Black people, including West Indians, in the United Kingdom was discussed in the introduction to this thesis. Shifting the timeframe of the discussion to the mid-20th century, the late 1940s ushered in a new era of immigration in Great Britain and although the new arrivals were British citizens, the historic xenophobic attitudes exhibited by some members of the British public did not die out (Paul, 1997; Phillips and Phillips, 1999). Upon arrival, many West Indians experienced shock and dismay at their treatment in their “mother country” (Fryer, 1984). Black people in Britain were seen as aliens and outsiders (Phillips and Phillips, 1999) and a disruption to British way of life (Sutherland, 2006). They were also viewed as an economic burden, only fit to work in certain industries (Paul, 1997) and many considered them as being inferior to Europeans (Fryer, 1984).

3.1.1 Experiences of and Responses to Racism

Any expectations of creating a better life were quickly diminished as the new migrants found it difficult to begin the process of building their lives. Their visible
‘otherness’ along with British colonial attitudes meant that Black West Indians, and other people of colour, experienced racial violence and discrimination in many aspects of life including when looking for work and housing and when trying to enrol their children into schools (Blakemore and Boneham, 1994; Sutherland, 2006). Not all of British society was racist and, in fact, there were many who were welcoming and accommodating to the West Indians (Glass, 1960) but the negative stereotypes of West Indians being lazy, suspicious and violent continued to be perpetuated throughout much of British society thereby making it an unfriendly place for the new migrants (Chamberlain, 1999; Paul, 1997). In addition to violent racist acts perpetrated against the West Indians at this time (Fryer, 1984; Paul, 1997), they also endured structural racism which resulted in their continuous differential treatment that, therefore, led to their socioeconomic mobility being severely restricted. Structural racism operating at this time meant that the Caribbean migrants were often only able to find poor quality and crowded housing (Fryer, 1984; Sivanandan, 1981). Additionally, any skills that they may have had upon arrival were often not recognised as many, without regards to qualifications, were only offered work in lower paying manual occupations (Fryer, 1984; Patterson, 1963; Sivanandan, 1981). Even though the industrial sectors willingly employed the new migrants, they were paid some of the lowest wages. Further, discriminatory hiring practices meant that the West Indians stayed in these jobs for many years, even decades (Paul, 1997). Twenty-five years after the arrival of the Empire Windrush marked a period where structural and personally-mediated racism were common place (Cross, 1986; Sutherland, 2006). This resulted in the systematic exclusion of people of colour, including Black West Indians, in the United Kingdom from the housing, employment and even educational sectors which had long-lasting repercussions on their social and economic standing in society (Fryer, 1984).

Drawing on their extensive interviews with West Indian migrants, Phillips and Phillips (1999) reported on West Indians being surprised and dismayed at the treatment they received in their ‘mother country’. These accounts highlight how people facing harassment and social exclusion form communities for survival and camaraderie and as we saw in the previous chapter, social connections such as these helps to build resilience. Being rejected from churches, bars and pubs, and
with limited employment opportunities, the new migrants sought the company and support of fellow West Indians. In attempting to fight workplace discrimination, the new migrants organised secret meetings at their place of employment. These in-house meetings continued to develop and soon expanded into community-wide efforts (Sivanandan, 1981). These efforts allowed for the development of new social connections that many West Indians identified as a precious commodity due to their experiences of social exclusion. Being denied equal access to, for example housing and finances, the West Indian migrants often had to live in shared housing and sometimes pooled their resources to create informal savings clubs, which also ensured that money was kept within their communities and enabled them to eventually become homeowners (Phillips and Phillips, 1999; Sivanandan, 1981). In addition to financial exclusion they faced, West Indians were sometimes prevented from worshipping at certain churches,

It was a common experience, more so with the Anglican Church and other mainstream churches too, but most of all with the Anglican. A sense of isolation. Nobody really cared. And therefore people soon had to form partnerships and groupings to survive, offering support in every shape or form, and the black churches, Pentecostal churches emerged, and that support was beginning to come forward (Phillips and Phillips, 1999, p. 149).

Because of this exclusion, the Black-majority churches that formed during this time became important not only as places of worship, but also as spaces where social interaction was possible. In a similar way, being barred from places of entertainment meant that West Indians socialised at each other’s homes. The lack of spaces to socialise in their communities saw the eventual formation of their own social clubs and organisations (Augoustinos and Reynolds, 2001). The church, community organisations and other social groups that formed during this time became important places to build and preserve these very important connections with other West Indians.

3.1.2 Policy Responses to the West Indian Migrants

As discussed in the introduction to this thesis, the relationship between the West Indies and the United Kingdom stretches back to the middle of the 17th century when Great Britain began to participate in the Atlantic slave trade and subsequently colonised many of the Caribbean islands. The UK participated in
two world wars in the early part of the 20th century and called upon its citizens, including those from the colonies to join their military, which many West Indians did. Post-war Britain needed assistance with rebuilding the nation and initially ‘imported’ prisoners from the United States and Canada and then extended their search for labour by recruiting women and men from across the majority White continental Europe (Paul, 1997; Small and Solomos, 2006). In need of further assistance, the UK, once again, called upon colonial citizens to help with the effort. To facilitate this, the British Nationality Act of 1948 granted citizenship to citizens of British colonies and former colonies (Fryer, 1984). Once the 1948 Act was passed, the UK saw colonial migration from the Caribbean hover between 1,000 to 2,000 annually until the early 1950s. During the 1950s and 1960s, the UK population began to increase due to immigration not only from the West Indies, but also from European countries. The difference in treatment, however, between the White European migrants and Black West Indian migrants was different as it was the Black migrants who were deemed the issue (Paul, 1997; Small and Solomos, 2006). The White migrants were better able blend in with the White British population while the blatant racism at the time meant that the more visible Black migrants were considered a threat to British society. The rest of the decade saw annual migration numbers ranging in the tens of thousands. The largest numbers of migration from the Caribbean at this time occurred during 1960 and 1961 when migration numbers swelled to 50,000 and 130,000, respectively (Paul, 1997).

The Black population in the UK steadily increased but the ideology that Black people were inferior to Whites was still prevalent in society at that time. The 1940s through the 1970s is widely regarded as a racially politicised time in British history. Acting on the public’s racist anti-Black sentiments and fearing further increases in migration numbers, the British government sought to modify the 1948 Act (Fryer, 1984; Paul, 1997). As a result, the Commonwealth Immigrants Act 1962 was enacted to drastically slow the flow of migrants with Commonwealth passports and only allowed entry to those who were granted employment vouchers (Sivanandan, 1982). The voucher system created under the 1962 Act introduced employment categories with numbers for each category subject to annual limits, which were reduced. For public perception, the 1962 Act was
presented as being colour-blind and non-discriminatory (Sivanandan, 1982). This, however, was not the case as it did not affect citizens of the former colonies of Australia, New Zealand or Canada and, in fact, special provisions were made to ensure the citizens of these majority White nations were allowed continued entry, without controls, into Great Britain (Fryer, 1984; Paul, 1997). The 1962 Act, therefore, initiated the separation of White British Commonwealth citizens and British Commonwealth citizens of colour.

Consequently, the 1962 Act emboldened racist groups as racism was now part of national policy and with this, there came an increase in violent acts perpetrated against people of colour in the United Kingdom (Fryer, 1984; Paul, 1997; Sivanandan, 1981). The increasing numbers of overtly racist incidents happening during the late 1950s and early 1960s led to the passing of the Race Relations Act of 1965, the first of its kind in the UK, which was meant to halt public acts of racism. Analysts, however, described the passing of the 1965 Act as futile as it did not address the discrimination that took place out of the public view, like in the employment and housing sectors (Paul, 1997; Sivanandan, 1982). While the Race Relations Act of 1965 did acknowledge widespread acts of discrimination and racism, Black people in the UK were still considered “an issue” and, with this, the 1965 White Paper openly stated that additional immigration controls were needed to stem the flow of migrants from the colonies and resulting legislation further reduced the number of employment vouchers issued annually (Sivanandan, 1982). This paved the way for the Commonwealth Immigrants Act of 1968 which added further restrictions on entry to the UK by targeting Kenyans of Asian descent and redefining UK citizens as having either a British parent or grandparent (Fryer, 1984). As noted earlier, the rights of entry for Canadians, Australians and New Zealanders continued to be protected by provisions in this latest immigration act and went further to include White Kenyans and Irish citizens as well (Paul, 1997).

Immigration controls continued to be tightened into the 1970s, “The immigrant was finally a migrant, the citizen an alien. There is no such thing as a ‘Commonwealth immigrant’ anymore” (Sivanandan, 1982, p. 111). With the passing of the Commonwealth Immigration Act of 1971, former Commonwealth citizens were now known as either settlers or migrant workers and the only
immigrants who were allowed into the UK to settle were those who were dependents of settlers (Sivanandan, 1982), thereby removing any British citizenship they once had. Although West Indians were actively recruited to Great Britain, their presence was not widely appreciated. Responses to the West Indian migrants reflected part of a society that embraced racist ideology, both interpersonally and systemically. The resulting power dynamic created and perpetuated social and economic inequalities that disproportionately negatively affected ethnic minority groups. The section that follows will provide a lens through which these processes can be examined.

3.2 Critical Race Theory

Critical race theory is interested in “studying and transforming the relationship among race, racism, and power” (Delgado and Stefancic, 2012, p. 2) and does this by bringing to the fore history, the socioeconomic context and the interests of different minority groups as well as highlighting the narratives of people of colour and considering the multiple social locations that people occupy (e.g. gender, immigrant status, ethnicity, class, sexuality, etc.). Critical race theory has three main objectives: (1) to validate storytelling and the narratives of people of colour and other oppressed groups as a way to examine how racism and racialisation processes permeate society, (2) to recognise that race is a social construct and that any form of oppression should, therefore, be eliminated and (3) to highlight the multiple social locations of individuals, such as gender and class, and to acknowledge that their intersections can result in multiple axes of subordination (Parker and Lynn, 2002).

Some scholars credit W.E.B Du Bois’ (1993) *The Souls of Black Folk* as being the foundation for race-based theories, especially critical race theory (Solorzano and Yosso, 2001; Treviño et al., 2008; Wilson, 1999). Wilson (1999), for example, interprets *The Souls of Black Folk*, originally published in 1903, as being in direct opposition to the prevailing explanation of differences between races at the time: the biological hierarchy of humans based on genetics. In *The Souls of Black Folk*, Du Bois introduces the reader to subjective aspects of racism he calls ‘double
consciousness’\textsuperscript{5} and ‘veil of race’\textsuperscript{6}. Wilson (1999, p. 204) explains [of the book], “Its concept of the veil of race counters the idea that biological criteria reveal the essence of race, and its notion of double consciousness reveals the power of social norms in constructing black subjectivity.” Du Bois argues that it is through these concepts, and not biology, that race is constructed through social interactions and their meanings (Wilson, 1999). Several decades after the publication of Du Bois’ seminal work, the American civil rights movement of the 1960s made important advances to the lives of people of colour by fighting segregation, disenfranchisement and multiple forms of oppression. The Civil Rights leaders of this era, including Martin Luther King, Jr. and Rosa Parks, fought for equal social and political rights and justice for Black Americans. Even with this progress, there was impetus to keep the momentum going (Delgado and Stefancic, 2012). As such, springing from critical legal studies\textsuperscript{7} in the 1980s (Solorzano and Yosso, 2001), critical race theory began to gain traction when CRT scholars in the United States questioned the power of the legal system to analyse racial injustice, to highlight the narratives of those affected by institutional racism and, thus, to bring about the desired social transformation.

To carry out the goal of “transforming the relationship among race, racism and power”, critical race theory consists of five main principles (Delgado and Stefancic, 2012, pp. 2, 6–9), some of which are applicable to this thesis: (1) ordinariness, (2) interest convergence, (3) social construction of race, (4) intersectionality and anti-essentialism and (5) the unique voice of colour. Using CRT in this thesis will offer understanding about the ways in which racist systems have marginalised the Black population, including West Indians, in the United Kingdom.

\textsuperscript{5} Double consciousness refers to the ability of the black person to have their own perception of themselves but then to be able to perceive how others see that black person, their social knowledge or communal beliefs about one’s race that others have.

\textsuperscript{6} In this instance, Du Bois’ veil is part of the subjective experience of racism whereby He (the black person) understands the meaning of a racist interaction but that others, white people, do not share this perception and, thus, a veil develops between himself and his whites.

\textsuperscript{7} Born out of the belief “that logic and structure attributed to the law grow out of the power relationships of the society”, critical legal studies is “a theory that challenges and overturns accepted norms and standards in legal theory and practice” (Cornell University Law School, 2007).
Beginning with ordinariness, this tenet holds that experiences of some form of racism, especially the subtle forms like structural racism, are a normal part of daily life for most people belonging to visible minority groups. This ordinariness explains why those who experience racism on a daily basis either ignore these instances or they become keenly aware of them and go on to identify any unfair treatment, including treatment which may not be racist, as racist (Ford and Airhihenbuwa, 2010). This suggests that racism is difficult to eliminate because racist practices are not often acknowledged by those experiencing them as well as those perpetrating them. For example, this can be seen with some of the policies that were designed to prevent racism in the UK, like Race Relations Act of 1965 as an example, which chiefly pertains to overt instances of racism and do not always address the more subtle forms like structural racism (Paul, 1997), thereby making many forms of discrimination difficult to address.

Closely related to this, the second tenet of CRT, interest convergence, explains that racism can be difficult to address because of the racial hierarchy in place in many societies which gives precedence to the white population over visible minority groups and, as such, unless the dominant white population sees some form of benefit to them, there is little incentive to reform racist and discriminatory practices (Delgado and Stefancic, 2012). As discussed above, the Race Relations Act of 1965 was largely viewed as being ineffective as it only addressed racist acts that took place within public spaces. The Race Relations Act of 1976 sought to rectify this and tackled discrimination in initially neglected areas of society like education, employment, housing and finance. While the 1976 Act was considered to be more comprehensive and impactful than its predecessors (Sooben, 1990), it was also judged to be born out of financial interest. Here, Sivanandan (1976, p. 367) argued that it was “more profitable to abandon the idea of superiority of race in order to promote the idea of the superiority of capital. Racism dies in order that capital might survive.” Sivanandan, therefore, suggested that the earlier Race Relations Act was only modified because the majority white population realised it was financially advantageous and in their best interest to attempt a more equal society. Thus, demonstrating a convergence of interest between the demand for equal rights among the population of colour and the capital interests of the ruling majority white population. However, it is important to note that there is enduring
racism beneath this veneer of equality consequently making racism even harder to detect and challenge, thus contributing to the ordinariness or ‘everydayness’ of racism.

Drawing from Du Bois (1993), the third principle of CRT maintains that the ‘race’ of a person or ‘racial groupings’ of individuals are not biologically inhering qualities of people (Delgado and Stefancic, 2012). They are, instead, shifting and negotiable and are, thus, socially constructed. The construction of racial groupings can be dated back to the beginnings of scientific fascination of physical differences of people from different communities in the late 1700s and early 1800s. Then, the 19th century saw the rise of ‘social Darwinism’, mass support for the eugenics movement and the subsequent rise of the popular biologistic understandings of race (Wilson, 1999; Winant, 2000). This movement provided justification for hierarchies in humankind based on phenotypic differences, where white skin and “white features” were the norm and the preference (Omi and Winant, 2015). Hence, any physical features that deviated from this norm were always compared to the white standard and were ultimately deemed undesirable. This biological determinism provided the foundations for the differential treatment of people based on skin colour, as was seen in the way Black and other visible ethnic minorities were treated in the United Kingdom, for example. During the 1950s and 1960s in particular, Black West Indians sometimes encountered instances of physical violence and often had their access to employment, educational and financial resources restricted because of the colour of their skin (Fryer, 1984). This third principle of critical race theory argues that there is neither rationale nor evidence-base for differential treatment of people based on skin colour or other phenotypic variances. And, as such, because races and racial differences are socially constructed, all ethnic groups should be considered equal and treated accordingly.

Closely related to this, the fourth tenet of CRT, intersectionality and anti-essentialism, explains that individuals have several overlapping and shifting identities which characterise them and, as such, a person does not hold a singular

---

8 The concept of intersectionality was originally developed by Kimberle Crenshaw to highlight overlapping oppressions; see Crenshaw (2017).
identity and no singular characteristic can be ascribed to a particular group (Delgado and Stefancic, 2012). For example, in exploring the health of migrant and ethnic minority groups in the West, culture has previously been used to explain variations in health between ethnic groups with the dominant White culture being considered the norm from which others deviate (Smaje, 1996). Using culture in this way engages in the unhelpful practice of “victim blaming” which asserts that health behaviour is due to an individual’s culture (Viruell-Fuentes et al., 2012). This then results in essentialising all particular behaviours to immigrants from a particular country or to specific ethnic minority groups. This is problematic because not only does it place sole responsibility for health upon the individual, it also perpetuates ethnicity-based stereotypes and can also result in differential medical treatment, all of which are done without critical regard for the effects of social and political processes in society (Hunt et al., 2013; Viruell-Fuentes, 2007). However, similar to the discussion above on the social construction of race, culture is also not inherent. Instead, it is negotiable and context-dependent and a truer understanding of the health of diverse communities and their views of healthy ageing can, therefore, be gained by considering the multiple and intersecting social locations that people occupy, such as gender, class, immigrant status, and ethnicity.

In the fifth tenet of CRT, Delgado and Stefancic (2012) maintain that storytelling provides a way for the discriminatory experiences of people to be heard. People of colour are able to speak about their knowledge of and experiences with race and racism and are, therefore, encouraged to share their experiences with legal and political systems, advocating for social justice and transformation. Solorzano and Yosso (2002) agree and refer to this ‘counter-storytelling’ also as a way for the voices of the marginalised to be heard, with the purpose of challenging dominant discourses. In agreement with Delgado and Stefancic (2012) and Solorzano and Yosso (2002), I have foregrounded the narratives of the participants of this PhD study who are part of a wider marginalised community. In doing so and in line with the social justice agenda of CRT, their voices are heard and, crucially, we are able to gain understanding into the structures and processes that help this group remain resilient in light of their racialising experiences, the overarching goal of this thesis.
3.2.1 Applicability of Critical Race Theory to the Study

Critical race theory enables its users to understand the ways in which discriminatory processes and the resulting inequities can impact the lives of individuals belonging to minority groups or ‘other’ groups, which is one of the goals of this thesis. Critical race theory also encourages change by advocating for social justice. A significant aspect of CRT is its ability to examine the subordination of ‘other’ groups by looking at the social, political and structural features in place that allow for the perpetuation of racialising processes. As such, CRT has become a multidisciplinary framework with capabilities in numerous settings. In education, for example, CRT has been used to examine inequities in primary and secondary educational research and practice (Ladson-Billings, 2005; Ladson-Billings and Tate, 1995). Specifically, it was used as a framework to examine how racism continued to propagate through the education systems in the United States. Critical race theory was also then used to support educational institutions in becoming more inclusive and diverse places for ethnic minority groups (Hiraldo, 2010). Turning to sports, Hylton (2010) maintained that just as there are racialising processes that occur in everyday society that give rise to unequal access and outcomes, the same is true for sports. He used the example of the exclusion of British Asians from Premier League football and advocated for the use of CRT in considering how race, racism and racial equality could be used in policy and decision-making, thereby seeking to eliminate racialising processes within sports (Hylton, 2005). The examples above showcase the utility and flexibility of critical race theory. In both instances, CRT was used to understand how racism operated within these spheres and was also used to facilitate the desired goals of increasing inclusivity and diversity in these fields. In a similar manner, one of the goals of this study was to explore the socio-historical context of the lives of a group of West Indian women and men and the resulting impact some of these experiences may have had on their lives. The approach throughout this thesis is, therefore, to examine the participants’ narratives with the CRT lens. Going further, and in keeping with the social justice agenda of critical race theory, this study will highlight the features in place that contribute to the healthy ageing of these individuals.
Storytelling is an significant component of CRT because it acts as a vehicle for the transmission of stories, important accounts that are often side-lined (Solorzano and Yosso, 2001). Stories examined with the CRT lens have multiple important purposes of particular relevance to this thesis. As such, the interviews were designed to highlight participant knowledge about particular experiences. For visible minorities, the unity that stories bring is part of the strength of the marginalised groups and, as such, these stories challenge the narrative of the dominant group (Delgado and Stefancic, 2012). For this thesis, I did not want to present an account of a down-trodden group living with the consequences of a lifetime of racism and discrimination. While this may be the story for some older West Indians living in the UK, it is not the whole story and, instead, I wanted to examine their perspectives on the important influences in their lives. There is agreement among some critical race theorists that storytelling provides a crucial method for forefronting voices of the marginalised (Delgado and Stefancic, 2012; Ford and Airhihenbuwa, 2010; Solorzano and Yosso, 2002). Jaeger and Haley’s (2016) study is a good illustration of storytelling in CRT where they sought to understand and explain how doctoral students of colour decided whether or not to pursue a career in academia. The authors found that the decision-making process was heavily influenced by participant experiences with racialising processes as well as both individual agency and consideration for their own communities.

Some student stories reflected an internal tension of constantly feeling the need to excel in their course work just so that they can be seen as being equal or deserving of place as much as their White classmates. These same stories showed a persistent self-questioning of whether they were accepted to their university because of their abilities or because they filled a diversity quota. Other participant stories indicated the contention of not having ‘people who look like you’ in faculty positions or other positions of authority and the ways in which this can affect how you perceive yourself and how others may perceive you (refer to Du Bois’ ‘double consciousness’) (Jaeger and Haley, 2016). Consequently, this then can lessen the likelihood of the student’s ability to envision themselves in such positions if there are no examples around them. In addition to examining some of the meaning attached to being a doctoral student of colour at a predominantly white institution, the authors found that part of the decision-making process in deciding to pursue particular research topics and subsequent career choices was
two-fold and stemmed from the desire to ‘move ahead’ and better themselves as well as wanting to help their communities (of people with similar backgrounds or ethnicity). Through the narratives and with a critical race lens, the authors found that some of the participants identified and intentionally resisted “oppressive behaviours” by refusing to be part of the stories of the dominant racial group. By refusing to believe, for example, that many ethnic minority students (specifically Black, in this case) will not finish their educational pursuits, participants sought to re-write that narrative and, thus, challenge that dominant claim to not become an unsuccessful statistic. Just as storytelling with a CRT lens was used above to highlight the processes behind career decision-making among Black students, this study used storytelling to examine how West Indians living in the UK framed their experiences which, therefore, helped us understand the components of healthy ageing of this group.

Critical race theory, however, is not without its critics. Treviño et al. (2008), for example, judges CRT as being atheoretical, stating that there is no formal approach in the way the different concepts of CRT are used whether methodologically or analytically. However, it could be argued that citing a lack of a rigorous framework or structure with which to operationalise CRT, is a positivist way of thinking and does not fit into the foundations of CRT; a foundation that argues that race is socially constructed and as such, processes seeking to eliminate racism cannot solely be objective. Along similar lines, other authors have criticised the subjective elements of CRT. For example, Litowitz (1997) questions the ability of storytelling, one of the tenets of CRT, to be used as a method for the basis of analysis, particularly within the legal profession. He contends that the subjective nature of stories yields information that is too personalised and individualistic, has no systematic means of analysis, contributes to identity politics and, therefore, should not be used in the field of law (Litowitz, 1997). While Kennedy (1989) challenges the ‘unique voice of colour’ tenet, by arguing that not all scholars of colour and other visible minorities desire or are adept at offering an expert opinion on matters of race and racial injustice. He continues that not just people of colour, but that also White scholars, may have a similar genuine desire to right the wrongs of racial injustices (Kennedy, 1989). But as advocates of CRT maintain, White and other dominant scholars should,
indeed, be included in the sharing of experiences of people of colour but that the people of colour, themselves, are in a better position to speak to the experiences of oppression at hand (Delgado and Stefancic, 2012).

These claims against the subjective and the so-called atheoretical nature of CRT have been challenged (Bernal, 2002; Delgado and Stefancic, 2012). Delgado and Stefancic (2012) counter these arguments and maintain that substantive, effective and transformative investigation and analysis are possible with CRT and explain that there are generally two perspectives of how to challenge racism. The realist perspective argues that the way to change racist behaviour and outcomes is through making changes in the physical circumstances, like access quality education, of ethnic minority groups who have been stigmatised (Delgado and Stefancic, 2012). On the other hand, the idealist perspective is one that recognises race as a social construct that is not made of immovable categories and, as such, the way to then get rid of racism is to change the mind-set and attitudes of those perpetuating racist and discriminatory acts (Delgado and Stefancic, 2012). The earlier discussion on the policy responses (Section 1.1.2), especially the Race Relations Act of 1965 is an example of the importance of both the idealist and realist perspectives in the pursuit of the elimination of racism. The stated goal of the 1965 Act was to prevent acts of racism however the underlying ideologies that informed systemic and interpersonal racism still existed in British society and this, therefore, rendered the 1965 Act futile in helping to change racist behaviour. Bernal (2002) argues that it is the subjective nature of CRT that allows stories from the “Other” to be heard. Storytelling challenges the dominant narrative of the majority in power and, instead, recognises that all histories, cultures, sexualities and experiences are valid, should be brought to the fore and used in seeking to bring about social transformation (Bernal, 2002).

Offering a different perspective to the critique, CRT has been criticised for prioritising ‘race’ as the only explanation for understanding racism in the modern world. Cole (2009) and Darder and Torres (2004) argue instead that class should be the primary consideration in seeking to explain the cause of racism and its continued existence. Specifically, Cole (2009, 2015) refutes the assertion that it is
the political system of white supremacy, which appoints Europeans as the superior or preferred ‘race’ and that this has shaped the way that the balance of politics, power and privilege today is swayed towards whites. Cole’s case for focusing on class is that production and capitalism are the reasons for racism’s continuity. Racism and the existing oppressive structures, he continues, was born out of economic interest of the state and not due to the supposed racial superiority of whites as argued for critical race scholars. Cole goes on to say that CRT ignores that there is a white working class and that it is unable to explain xenophobia or racism directed towards other cultures. Cole, therefore, rejects the notion that ‘race’ is central to understanding and eliminating racism and instead argues that it will be through the abolition of socioeconomic classes that will eliminate racism. Darder and Torres (2004) make similar arguments and take issue with critical race theorists for seemingly prioritising race at the expense of capitalism.

Some writers (Mills, 2009; Solorzano and Yosso, 2002; Stovall, 2006), however, have refuted the argument that CRT completely ignores the role of capitalism in analysing racism. Mills (2009) counters the claims made by Cole and his arguments for the centrality of class in eliminating racism. Critical race theory is a broad movement within both political and theoretical spheres with multiple approaches and it’s intersectional nature means that different axes of oppression, such as class, are taken into consideration (Mills, 2009; Solorzano and Yosso, 2001). He maintains that while consideration of class as well as other social locations like gender and migrant status as examples, are important in understanding the continuation of oppression against ‘Others”, he argues that ‘race’ and racism are still priorities in this understanding. He, and others, maintain that CRT does indeed consider other social locations in its explanation (Crenshaw, 1991; Solorzano and Yosso, 2002). He also acknowledges that indeed, there are white people living below the poverty line. However, the issue is the proportion of Blacks below the poverty line is still disproportionately higher than Whites and that this disparity is the crux of CRT and, thus, why ‘race’ needs to occupy a central position in seeking to understand and eliminate racism and other existing oppressive structures in society. The argument is that while understanding capitalism and economic modes of production are important, it is still necessary to acknowledge that Whites benefit most from the sociopolitical system currently in
place, hence the why the focus should be on ‘race’ and racism (Mills, 2009; Stovall, 2006).

This chapter began by presenting an overview of critical race theory and describing its use in various fields. With the ultimate goal of social justice and transformation, critical race theory confers special attention to the voices of minority groups in understanding how social and structural processes working in society, both overt and covert, can affect the lives of said minority groups. I assert that with a CRT lens, the narratives of older West Indian women and men will be better understood and will also provide ways for those working within those communities to better support them. In the section that follows, I will present an examination of how the social and structural processes affecting the lives of ethnic minority groups can have an impact on their health.

3.3 Ethnic Minorities, Racism and Health

Biology and culture have often been used to understand and explain the health of the population. Research into health, particularly health disparities, is said to have derived from an 18th century focus on the supposed biological differences between the different ethnic groups (Wilson, 1999). Critical race theorists argue that racial groupings are social constructs and, thus, any explanations based on this are problematic as they ignore other factors, such as structural racism that may be at play (Delgado and Stefancic, 2012). The social construction of race also classifies White physical features as the norm from which others deviate which historically has been used to justify differential treatment based on phenotype (Omi and Winant, 2015). Culture and traditional lifestyles have also been used to explain the health of the population, especially among immigrant groups. When culture is used as a rationale for variations in health, such explanations are used uncritically and without regard for the wider social, economic or historic context at play in the lives of people (Smaje, 1996; Viruell-Fuentes et al., 2012). Such wider context can include lingering socio-economic disadvantage and processes of racialization, which include incidents of racism and discrimination that can have negative consequences on a person, particularly their health (Karlsen and Nazroo, 2002b;
Continuing, when racial, ethnic and cultural groupings are used as explanatory variables, it can lead to the essentialising, leading to stereotyping, of health conditions and illnesses to specific groups (Atkin and Chattoo, 2006). Further, utilising such explanations also leads to the portrayal of cultural practices as deviating from the preferred norm of what may be considered the dominant culture (Smaje, 1996). The explanatory power of critical race theory, therefore, helps us shift the focus from biological and cultural variables to instead consider the social, economic and political context within which people live their lives, which works to prevent victim-blaming (Ahmad and Bradby, 2007). Shifting the focus to one that examines context further advances the main goal of CRT by identifying processes or structures in place that can facilitate desired social transformation, such as the elimination of discrimination and an increasingly equal society. One of the arguments of this thesis is that the process of migration and resulting experiences not only influenced the health of the study participants but also influenced their views on healthy ageing and these, in turn, were influenced by their past experiences within a social and political context.

Adapting the framework put forward by Jones (2000) helps to see how racism operates on three different levels: structural\(^9\), personally mediated and internalised. Structural racism operates on a macro level and gives rise to differential access, through policy and practice, to resources, opportunities, services and power. In contemporary times, structural racism may be difficult to identify or to remedy due to its subtle nature and examples include the systematic denial of mortgages to some ethnic minority groups or discriminatory hiring practices (refer to the sections on ‘ordinariness’ and ‘interest convergence’ in the critical race theory discussion). Personally mediated racism includes prejudiced and discriminatory actions and is the more noticeable form of racism. Racist acts falling under this category may be both unintentional (e.g. daily microaggressions) and intentional (e.g. police brutality). Internalised racism is

---

\(^9\) Although Jones (2000) uses the term ‘institutional racism’, I prefer to use the term ‘structural racism’ as I think that ‘structural’ is better suited to describe an entire system causing disadvantage.
marked by accepting and believing the negative stereotypes and messages about one’s own race and/or ethnicity. The consequences of this can include believing the limitations set by others and embracing white features (e.g. straight hair and fair skin) as the preferred look. Rejecting biological and cultural explanations, researchers have gone on to focus on the role that racism plays in the production and maintenance of socioeconomic inequalities, which then go on to affect health (Smaje, 1996; Williams and Mohammed, 2013), especially affecting ethnic minority groups (Karlsen and Nazroo, 2002b; Viruell-Fuentes et al., 2012; Wallace et al., 2016; Williams and Mohammed, 2013).

The consequences of having a lower socioeconomic status plays a major role in causing ethnic disparities in health (Williams and Mohammed, 2013). As such, one of the markers of socioeconomic status is the neighbourhood in which individuals live. There is research which determined that when communities are segregated, especially by ethnicity, there are obvious disparities, when compared to the white population, regarding access to important social resources, like education, finance and healthcare (Acevedo-Garcia et al., 2003; Williams and Collins, 2001). According to Williams et al. (2010), residential segregation, part of the enduring legacy of racism, restricts access to learning and employment opportunities and this unequal access limits individual and community socioeconomic growth, therefore maintaining the cycle of poverty. In addition to restricting access to opportunities for economic growth, residential segregation also negatively affects health by limiting access to quality health care and information, safe recreational spaces and quality of food, as examples (Williams et al., 2010). Considering this, it is important to explain that the problem is not one of ethnic minorities living within close proximity to each other and within the same communities. Instead, it is the structural racism that is perpetuated by the social and political structures of society that persists today that works to restrict access and, therefore, relegate communities of colour to a lower socioeconomic standing. These experiences come together to influence a person’s health and also how they think about their health as they get older.

Although the research above showcases the negative effects of living within resource-poor neighbourhoods of which a greater number of ethnic minority
people live, there is also research demonstrating a more positive effect on health of large communities of colour. Known as the ethnic density effect, this body of research asserts, albeit with mixed results, that living in communities where there is a high concentration of the same ethnic minority group can have buffering effects of racism and discrimination which can, therefore, prevent the negative effects on health, see Bécares et al. (2012) and Das-Munshi et al. (2010) as examples. Is has been hypothesised that this protective effect on health is due to neighbourhoods with high proportions of ethnic minorities having a stronger sense of community and social support for each other, as was seen in Black, including West Indian, communities in the UK during the 1950s and 1960s (Sivanandan, 1981), discussed earlier in this chapter. Bécares et al. (2009) also found that ethnic minority people living in neighbourhoods with a higher concentration of ethnic minorities tend to experience less racism, which is also true for Black West Indians living among other Black people in the UK (Bécares, Nazroo, et al., 2012).

Above, I briefly showed how the health of the population was historically understood and explained. Initially, the focus was on individualistic factors like biology and culture. Using biology and culture in order to understand the health of the population places the responsibility of health solely on that individual. This, however, is problematic as these explanations are based on the social construction of supposed differences between ethnic groups, which then created a social hierarchy between ethnic groups and cultures. The creation of this social hierarchy has resulted in unequal opportunities particularly for ethnic minority groups which led to their relegation to a lower socioeconomic status and, ultimately, led to social inequalities, and in health. Utilising biology and culture as the reasons for health disparities do not take into account the roles that the aforementioned social and political processes play in creating these disparities nor do they take into account the way these experiences may influence the perception of health.

3.4 The Life Course Approach to Migration and Health

As discussed in Chapter 1, this study seeks to understand how past experiences of migration have impacted the lives of older West Indians in the UK. Specifically,
how some of these experiences may have shaped their views of and, thus,
contributed to their meaning of healthy ageing. To do this, I used critical race
theory in conjunction with the life course approach. The life course approach was
used as an organising tool for data collection (discussed briefly in the
Methodology chapter) because it assists its users in exploring events and
experiences across time (Elder Jr and Giele, 2009). Using critical race theory in
combination with the life course approach, I was able to follow the participants’
stories starting at the point of migration until present day. Doing so, therefore,
provided important socio-historical context about their experiences throughout
their lives and how this may go on to shape their perceptions of healthy ageing in
the present day.

The life course framework is used across several academic disciplines and is
largely concerned with human development, ageing and changes in lives over
time placed within social and historical context (Elder Jr et al., 2003; Elder Jr and
Giele, 2009; Kok, 2007). Within this social and historical context, life course
research takes into account the institutions and organisations of society, the
influence that individuals have over each other and individual decision-making
and experiences, thus making life course research a multilevel principle. For
example, Ben-Shlomo and Kuh (2002) review the life course approach with
reference to studies of chronic disease, specifically looking at how different risk
factors that occur throughout an individual’s life, from gestation through the older
years, can affect the development of chronic diseases. The life course framework
is also frequently used in the field of gerontology. Here, the life course approach
examines the ways in which past decisions and events can impact health and well-
course research found that although the field is “entering its stage of maturity” (p.
414), it has potential for further development especially regarding theory and
methodological innovation. In his discussion, Mayer is critical of the tendency of
life course research to not consider the effects that institutions and social policies
can have on shaping people’s lives. Given this, the current PhD study
acknowledges and addresses this short-coming by utilising the critical race theory
as a way to underscore the ways in which social and structural processes operating
in society work across the life course to impact perceptions of health.
3.5 Chapter Summary

The purpose of this chapter was to review the literature on the historical social and political processes operating in society that have shaped the experiences of West Indians in the United Kingdom. This context, therefore, provides some understanding into how West Indian women and men construct their definition of healthy ageing. Using ideas associated with critical race theory and the life course framework, I was able to demonstrate how racist ideology that has existed for centuries continued to be enacted in contemporary times which then has consequences on the lives of people of colour, especially regarding their health. This too has further impact on their views of what it means to age healthily, hence why we need to understand their perspectives of healthy ageing.

Historically, the reasons for existing social and health disparities placed responsibility on the individual while ignoring the role that wider structures in society like socioeconomics or discrimination can play. The discussion presented in this chapter demonstrated how these same wider societal structures continue to perpetuate an enduring legacy of structural racism, thus affecting the life of people of colour, including Black West Indians. As the Black population increased in the UK, the literature indicated that the public response to their presence was met with overwhelming opposition and that this, therefore, became part of the policy debates and response at the time. The responses to their visible otherness initiated a policy shift in the definition of their belonging in the UK, gradually moving from British citizen to settler or migrant worker. Their visible otherness, therefore, prompted the redefinition of what it meant to be British.

Even with this opposition, the West Indians persevered through the resistance to their presence. Chapters 5 and 6 take this further by presenting analysis and discussion of the data from interviews done with West Indian women and men. The analysis in these chapters examines their perception of healthy ageing within the context of their post-migration experiences in the United Kingdom. The discussion in these chapters, therefore, adds to the discussion on healthy and resilient ageing of older ethnic minority people living in the UK.
Chapter 4  Methodology

The purpose of this chapter is to discuss the research strategy and methodologies that were used in this study. The chapter begins with an outline of the research aim and research questions and addresses reflexivity and a brief review of how the quality of the study might be assessed. The methodological flexibility of qualitative research is dependent upon numerous factors such as, but not limited to, the researcher’s ontological and epistemological positions, prior research on the topic, the overarching aim of the study, the researcher’s values and the characteristics of the research subjects, all of which will be discussed in this section. The next section will discuss the practical aspects of the study, from sampling to data collection and data analysis. The final section will address any ethical considerations.

A qualitative approach was best suited for the goals of this study, as this chapter will go on to discuss, because it allowed for the investigation of the meanings ascribed to varying experiences over their life course (Berg, 2012; Denzin and Lincoln, 2011a), especially regarding the linkages between their experiences of migration and their perceptions of healthy ageing. The strength of qualitative practice lies in its ability to consider the intricacies of each subject, which then gives rise to the depth of information required to explore, understand and explain phenomena.

4.1 Research Aim and Methodological Considerations

The main aim of this thesis was to understand how the processes of migration and associated experiences, placed within social and historical context, have contributed to the definition of healthy ageing among West Indian women and men ageing in the United Kingdom. As such, this study sought to answer the following research questions:

1. What are the post-migration factors influencing the definition of healthy ageing for older West Indian women and men living in South West United Kingdom?
2. How can the identified factors be used to understand perceptions of healthy ageing of older West Indian women and men living in South West United Kingdom?

The overarching goals of the study were to contribute to the broader literature on the understandings of healthy ageing within ethnic minority communities and to inform the wider network of individuals working within these communities.

4.1.1 Theoretical Underpinnings of the Study

The broad aim of this study was to explore and understand the contributors of healthy ageing for a group of people and, as such, utilized qualitative methodologies. While fluidity and flexibility are two of the defining features of qualitative research, it is still important to situate the study, broadly, within a particular research paradigm or perspective. Because the overall aim of this research is based on subjective interpretation of events, this study is situated within the interpretivist paradigm, which contends that reality is person dependent and that the researcher and the subject of the research co-produce knowledge (Guba and Lincoln, 1994; Ponterotto, 2005). Each paradigm and perspective operates with its own assumptions and methods (Denzin and Lincoln, 2011b), situating oneself assists the researcher in structuring and organising the study, which has further implications on the interpretation of the data and the subsequent results, which will be discussed further in the chapter. Through qualitative interviews, I hoped to gain an understanding of the participants’ views of their experience of migration and its impact on their perception of healthy ageing over the life course. This study also draws on critical race theory. Critical theory posits that reality is also shaped by social factors like culture, gender, ethnicity and political climate (Guba and Lincoln, 1994; Ponterotto, 2005). The critical-ideological stance serves as a form of cultural or social critique with the goal achieving a more equal society, advocating for change (Dant, 2003; Henn et al., 2009; Ponterotto, 2005). See Chapter 3 for the discussion on the importance of critical race theory to this study.
4.1.2 Assessing the Quality of the Study

Qualitative research has been criticised for lacking generalisability, reliability and validity; criteria usually applied to quantitative research. There are several practitioners (Lewis et al., 2013; Robson, 2011; Silverman, 2011) who advocate using such criteria, albeit slightly modified, when evaluating qualitative work. The question that then follows is: if qualitative and quantitative research have inherently different and opposing ontological and epistemological foundations, how then can the same criteria be used to judge both types of studies? Yardley (2000) points out that if qualitative studies were to attempt to adhere to the same quality criteria of quantitative studies, the amount of data generated would be so vast that it would be almost impossible to analyse the data with the depth needed, thereby losing the point of conducting qualitative research.

Regarding the applicability of standard by which qualitative research should be judged, Yardley (2000, p. 219) comments, “…claims that a piece of research is of high quality need to be legitimated by criteria which are meaningful to those people for whose benefit the research was intended”. Alternative criteria have been proposed by Lincoln and Guba (1985) and, more recently, Yardley (2000) to assess the quality of qualitative research; this study uses these criteria. I followed Yardley’s criteria for assessing the quality of this study:

1. Sensitivity to context – attention to the relevant literature and theoretical position(s), the sociocultural context, ethical issues.
2. Commitment and rigour – comprehensive engagement with the subject matter, thorough data collection and analysis.
3. Transparency and coherence – theoretical and methodological congruence; reflexivity; research methods and data analysis articulated.
4. Impact and importance – enriches current body of knowledge, especially theoretical; significance for the participant community as well as for policy makers.

4.1.3 Reflexivity

The reasons for initiating this project were intrinsic to who I am and my background. It was my goal to be as transparent as possible not only about who I
am but also about my research processes, experiences and decisions made. In this section, I will write about the biases I bring to the research. This will include my background as a West Indian woman and what this could mean for the way in which I approach potential participants, the way in which they receive me and also the way in which I interpret the data. This reflexivity, according to Yardley (2000), is one of the elements needed to enhance quality in qualitative studies.

Pelias (2011, p. 662) sums up reflexivity: as “…to examine how their presence or stance functions in relationship to their subject. Reflexive writers, ethically and politically self-aware, make themselves part of their own inquiry”. The reflexive process was on-going during the entire study, from the outset through to data collection, analysis and interpretation of the results and, as such, enhanced the trustworthiness of the research (Henn et al., 2009; Pelias, 2011; Yardley, 2000). Throughout this study, I endeavoured to be a reflexive researcher and wrote about those elements of myself that possibly affected the research process (Finlay, 2002).

My position is this study was binary, first as a West Indian expatriate who is several decades younger than the study participants and second as a doctoral researcher. My West Indian background, i.e. having a similar culture to my participants, placed me in position such that I was considered an insider (Pelias, 2011); this position was initially confirmed during a recruitment talk at one of the organisations I visited, when the gatekeeper introduced me to the group and said “…and she’s one of our own, so let’s listen to what she has to say” (Anonymous, research journal, February 2015). My “insiderness” was further reinforced during some of the interviews when I was able to engage with participants in conversation about “home”. This position put me at an advantage to researchers who may be considered as outsiders; without the insider status, participants may not be as willing to open up and it may be hard to understand some of the cultural intricacies without this insight (Bhopal, 2001; Holloway and Biley, 2011).

However, just as my insider status meant that I was able to engage with the study participants in discussions about “home”, this also meant that I was at risk of taking the information shared with me for granted (LaSala, 2003). As an insider, I
often felt like I did not need to ask for clarification when I heard words and phrases like, “us”, “you know what I’m talking about”, “you know Caribbean people” and “back home”. In these instances and as a privileged insider, I was confident that I knew what the participants were speaking about. An outsider on the other hand, may have asked probing questions thereby placing them in a position to possibly elicit more nuanced information (LaSala, 2003). It is important to note that although my insider status helped me gain footing within these groups, I was not viewed in this way by everyone. I was also an outsider in that I am decades younger than the study participants, I did not migrate to the UK during the same time period as they did and I am not a member of their community group.

I engaged in reflexive writing after each interview. Reflexive writing is generally recommended in qualitative inquiry and this, according to Patton (2002, p. 65) “reminds the qualitative inquirer to be attentive to and conscious of the cultural, political, social, linguistic, and ideological origins of one’s own perspective and voice…” The reflexive writing process should document any biases which will help to lessen the likelihood that they do not affect how interview data were interpreted (Kvale and Brinkmann, 2009). Part of reflexive writing, especially in studies conducted within the critical tradition, involves acknowledging the power relations that exist between the researcher and the subject. It can be said that my educational background and my approach as a researcher may have put me in a position of perceived importance compared to the participants but I found this to be almost the opposite. My insider position became a small hurdle for me to overcome, as I would find out while conducting interviews. In acknowledging my researcher and my shared Caribbean background with the participants, I was always aware of the emphasis on “respect for elders” and this affected the way in which I approached potential participants and the way in which I conducted interviews; when participants went off on a tangent, I found it very difficult, almost impossible to interrupt what they were saying to get the discussion back on track. Interrupting an elder would be considered rude in Caribbean culture and I did not wish to offend anyone. Thus, I was constantly aware of my position and that I needed to navigate my identity as a younger West Indian while trying to
conduct interviews as a researcher. The sections that follow describe how the research was conducted.

4.2 Methods

Many of the studies concerning Caribbean people in the United Kingdom have involved participants living in London and other larger cities, which is understandable as many of the jobs available to West Indian migrants were in these cities (Fryer, 1984; Glass, 1960). Other than census data and reports produced by the respective councils of Bath and Bristol, there have been few research studies in conducted in South West England that include people of Caribbean descent and, in particular, older members of this group. Although somewhat limited, there is literature on ageing minorities in Bristol and examples include research done by Fenton (1985), Commission for Racial Equality (1987), Pilgrim with Fenton et al. (1993), Butt and O’Neil, Cheston et al. (2017) and Richardson (2015). Earlier studies indicated that the black and minority ethnic (BME) population in Bristol had poorer health and sociodemographic factors indicative of this (Fenton, 1985; Pilgrim et al., 1993). One study aimed at assessing the health and sociodemographics of the Bristol BME population found that these communities had unfavourable working and housing conditions and that it was common to experience discrimination and racism (Pilgrim et al., 1993). In looking focusing on the middle-aged and older BME population, Fenton’s (1985) study looked at the health and social service usage among these groups. This study provided context to the lives of the minority groups investigated by looking at their family and friendship networks. Regarding the Caribbean community, the research showed that connection to family, the maintenance of Caribbean traditions and respect for older members of their community was important. Unlike the South Asian community who generally lived with extended family members, West Indians typically lived in smaller households with usually a spouse or alone. Although West Indians tended to live in smaller households, Fenton (1985) showed that they still maintained connections and wider networks with other family members and friends, which are important for maintaining bonds with their Caribbean diaspora (Richardson, 2015). Because of the tendency to live in smaller households, this study found that West Indians in Bristol,
particularly the elderly, are more likely to experience some form of social isolation and that they may be dependent on others for assistance with daily living needs. Extra support in terms of care needs and an increase in the numbers of conveniently located day/community centres were areas that Fenton recommended as areas for policy improvement. In terms of health service usage, this study found that, at the time, information was needed on the full range of services available, about how to access the range of benefits and also general help regarding overcoming anxieties about using the benefits system in general; this applied to all ethnic minority groups in the study. The study also found that there needed to be more discussions regarding views on and perceptions of illness and medication and recommend further consultation with ethnic minority groups regarding their concerns for care (Fenton, 1985).

Butt and O’Neil (2004) draw our attention to the ways in which older ethnic minority groups, including West Indians, felt about research that has been conducted on themselves and among their peers. To do this, they sought participant feedback on the quality and suitability of the health and social services in their respective cities (Bristol, Leeds, London). During a series of consultations, the participants expressed frustration about constantly being researched yet not seeing any change in their circumstances. The participants also voiced concerns regarding some of the inadequacies of the health and social services available to them. Specifically, and similar to the findings from Fenton’s (1985) research above, the authors found that the social services were not attuned to the changing support needs of ethnic minority communities. There was a failure to recognise that family networks are changing and that many older people are no longer able to rely on family for care and support and, given this, social services have failed to notice and respond accordingly. The participants in all three cities also discussed other issues surrounding the access and quality of the available social services in that some services can be difficult to access and that information about available services should be specially made available to older ethnic minority members of the community. As a whole, those who took part in these consultations expressed a preference for using and/or attending ethnic minority-led service providers and, in general, expressed a general displeasure at using mainstream services citing racism and ageism. This preference for utilising BME-
led services was also expressed by participants of study seeking to understand the experiences of dementia in older BME adults in Bristol (Cheston et al., 2017). In addition to uncovering the stigma some communities attach to having dementia, the authors found that many of affected with dementia were reluctant to use mainstream/general support services and, instead, were more comfortable using services that were led by members of their own ethnic community. Other important findings of this study included uncovering differences between how different BME communities approached dementia (Cheston et al., 2017). A diagnosis of dementia carries stigma in some communities but in others, like West Indians and South Asians, those with dementia remain continue participation with their activities and remain involved in their social groups. Overall, these studies highlight the need for public services to be more attuned to the concerns of BME communities, especially regarding information and access, perceptions of ill-health and the changing care/support needs of older/ageing ethnic minorities in Bristol. I have not yet found any studies including participants from Bath. While there is, indeed, research on West Indians in South West England, it is still somewhat limited. My research, therefore, adds to the body of literature about older West Indians living in this region focusing in particular on their perceptions of healthy ageing.

Although Bristol and Bath are geographically very close to each other (they are approximately 12 miles apart), Bristol has a noticeably larger Black and Minority Ethnic (BME) community than Bath. Table 1 below gives a quick comparison of ethnic groups in Bristol and Bath. Here, we can see that there is a clear difference between the proportion of BME groups represented in both cities: 16% for Bristol and 5.4% for Bath (Office for National Statistics, 2012b). When we look at the Caribbean population, the percentage goes down even further to 1.6% and 0.4% respectively; compare this to Caribbean populations in Birmingham (4.4%) or London (4.2%).
Table 1 – Ethnic Groups in Bristol and Bath

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Bristol</th>
<th>Percent</th>
<th>Bath and North East Somerset</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ethnicities</td>
<td>428,234</td>
<td>100</td>
<td>176,016</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>White British</td>
<td>333,432</td>
<td>77.9</td>
<td>158,640</td>
<td>90.1</td>
<td></td>
</tr>
<tr>
<td>White Irish</td>
<td>3,851</td>
<td>0.9</td>
<td>1,146</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>White Gypsy or Irish Traveller</td>
<td>359</td>
<td>0.1</td>
<td>58</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Other White</td>
<td>21,950</td>
<td>5.1</td>
<td>6,629</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td><strong>Total White</strong></td>
<td>359,592</td>
<td>84</td>
<td>166,473</td>
<td>94.6</td>
<td></td>
</tr>
<tr>
<td>Mixed ethnic group</td>
<td>15,438</td>
<td>3.6</td>
<td>2,898</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>6,547</td>
<td>1.5</td>
<td>1,116</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>6,863</td>
<td>1.6</td>
<td>170</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>2,104</td>
<td>0.5</td>
<td>219</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>3,886</td>
<td>0.9</td>
<td>1,912</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Other Asian</td>
<td>4,255</td>
<td>1.0</td>
<td>1,160</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>12,085</td>
<td>2.8</td>
<td>499</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>6,727</td>
<td>1.6</td>
<td>672</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Black Other</td>
<td>6,922</td>
<td>1.6</td>
<td>155</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Arab</td>
<td>1,272</td>
<td>0.3</td>
<td>375</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>2,543</td>
<td>0.6</td>
<td>367</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td><strong>Total BME</strong></td>
<td>68,642</td>
<td>16</td>
<td>9,543</td>
<td>5.4</td>
<td></td>
</tr>
</tbody>
</table>

Data (Office for National Statistics, 2012b)

4.2.1 Sampling

This study initially sought to recruit older West Indian women and men, who migrated to the UK between the late 1940s and the 1960s, with “older” being described as over 65 years (see the Chapter 1 for a more detailed discussion on who “older people” are). As discussed in the literature review, this time frame was chosen as it represented the period during which many West Indians migrated to the United Kingdom in the post-World War II years. I also wanted to purposively sample participants from varying backgrounds, specifically women and men who were actively involved in society and those who were not. The purpose of intentionally including a variety of people from different backgrounds and level of inclusion in society was to determine if common themes were present in their varied lives that reflected their experiences of migration. However, the process of finding participants who were not as active in society proved to be difficult even after I attempted to use snowball sampling methods to recruit them to the study. I also had to redefine the age of participation. During the early stages of fieldwork and as I met people at the data collection sites, I realised that there were potential participants who, although were not over the age of 65, they migrated within the desired time period. This meant that these individuals migrated as children and
this, therefore, had the benefit of adding that perspective to the study, further enriching the data.

4.2.2 Gaining Access

Gaining access to the potential study participants was the next step in the study. Nineteen organisations working within ethnic minority or elder communities were identified through word-of-mouth and via internet searches and were initially contacted via email and then phone calls. These included churches, senior centres, among others; for a list of identified organisations in the Bristol and Bath areas, see Appendix 1. My emails to the organisations included an introduction to myself and the study with a study advertisement attached (Appendix 2).

The response rate to these emails and phone calls was very low; I received only four responses. Two were from organisations that became sites for data collection. One response was from an organisation working to promote gender equality in Bristol; they placed my study advertisement on their website but no interviews resulted from this. And another response was from someone who worked in the ethnic minority community in Bristol. Here, in addition to giving me the phone number of a person who would later become the gatekeeper at the second data collection site, this person told me that this is a highly sought-after community with many people pursuing them for information and interviews. She added, “…it would be good for you to appreciate that you are privileged to be able to access these important histories and to treat them with respect and empathy” and “…that this is not like a day care centre, these are feisty independent people who come out to be amongst their own community” (Anonymous, personal communication, 2014). During this exchange, I began to understand that this was an over-researched community as was later alluded to by potential study participants; this is discussed further in the section. I found that having this exchange before I contacted the pool of participants was beneficial in that it helped me prepare for how I should approach gatekeepers and potential participants. From this, I learned that I needed to show respect, empathy and humility and I that needed to be aware that I was asking them for goodwill by donating their time and stories.
Aside from these four, I received no responses even after multiple efforts of calling and emailing. I was a little taken aback but I also began to understand the lack of response to my requests and it furthered my understanding regarding how I should approach this community. I thought that perhaps the lack of response might have partly been due to the perception of emails being somewhat informal and so to try to counter this, formal letters (Appendix 3) were then sent out to various organisations. But I also realised that the lack of response could also have been due to the fact that this group and their gatekeepers received constant requests for information by researchers and journalists and, thus, have experienced research fatigue possibly making them reluctant to respond to me. I briefly considered ‘cold-calling’ but I thought that showing up unannounced could possibly reflect a lack of respect for their time or their meeting spaces so I decided against this. I received one response from the letters I sent out, which resulted in an interview.

Gaining access to people who could potentially take part in the study was not always a straightforward process. This process taught me that rapport development is important with gatekeepers as well as participants as they may need to be convinced why they should take part in the study (Feldman et al., 2003). Gatekeepers, usually the head of organisations and community groups, are individuals who facilitate access to the pool of potential research participants (Ritchie, 2013). In addition to filling the role as facilitator, they act as protectors of their members as well, wanting to know about the researcher, about the project and what is being asked of their members (time, cost, and effort) and if there will be a benefit to their organisation. Gatekeepers can play an important role in the research process as they can not only grant you access to participants and, in my experience, they can also provide you with inside knowledge about how best to approach the group. As I quickly learnt, it becomes important to try to build relationships early on in the study so that gatekeepers and participants are assured about the intentions of the researcher (Feldman et al., 2003). Building these relationships was a process that began as soon as recruitment commenced. As discussed, it started with meeting the gatekeepers of both organisations and introducing myself. I approached the gatekeepers with respect and with understanding that I am asking for their time. I found it important to ask about the
work of the organisations and their roles within them. The gatekeepers were very proud of the work they do to serve their members and appreciated that I wanted to know about this.

### 4.2.3 Recruiting

Recruiting mainly took place within two organisations, herein referred to Organisations A and B, both of which provide services to the black and minority ethnic communities in Bristol and Bath. One interview was conducted outside of these organisations. In addition to the interviews I conducted for data collection, I also interviewed the gatekeepers of both of these groups. I asked them about their members, how they managed oversight of the groups, funding, the different kinds of activities and services they provided and I also about them about concerns for the future of their clubs.

**Organisation A and Organisation B**

These two groups are different in membership size, the scope of their activity and service provisioning, which is due to the different sources and amount of funding, they receive. This is information that could possibly make them identifiable and, for these reasons, I have chosen to discuss them together. Although there are differences between them, the significance of their services is equal in that they are much wanted, needed and appreciated within their communities.

Both of these groups started in the 1990s when many West Indians who migrated to the UK in the late 1940s onwards grew older and wanted a space to socialise in their post-retirement years. It is important to note that although West Indians make of the majority membership in both of these groups, they do not only serve West Indians. In fact, their membership includes older people of different ethnicities including Chinese, White and South Asian. Over the last two decades, these clubs grew in membership and influence in their respective communities. Organisations A and B have between 75 and 170 members and their decision-making bodies are either made up of a formal Board or a management committee.
Importantly, these groups also include some members in the decision-making processes thereby ensuring that their voices are heard and they feel empowered.

These organisations provide a range of important functions and services to members and their families. Activities range from lunch clubs, exercise, singing, sewing, dominoes and day trips to neighbouring cities and towns. These groups provide information sessions for their members by inviting those working in the wider community to give talks, like solicitors, the police and health care workers. As explained by both gatekeepers, these groups provide a safe and comfortable space for elders to socialise, participate in activities that they enjoy, learn new skills and help each other in different ways. In addition to these kinds of activities, these groups perform important community outreach functions. They work with a range of social services, hospitals and other agencies to ensure that their members receive the care they need. But also, these other community services contact and refer service users to these elder groups.

To perform these function, Organisations A and B need funding. They are, however, funded differently in that one secures public and additional sources of funding and, therefore, is able to provide a wider range of activities, a larger meeting space and outreach services. The other organisation receives a very small amount of funding, which is reflected in their meeting space and service provision. Regardless of their funding differences, both groups echo the same concerns; their funding is continually reduced and, as a result, their service provision is at risk. Part of their funding goes to community outreach to support older people who are unable to leave their homes, unable to perform certain activities of daily living or who need companionship and support, whether at their homes or attending various appointments. These efforts require time and financial resources that they continue to undertake even when their budgets do not allow. Thus, in these instances, funding and support for organisations such as these is crucial for their sustainability. Adding to their apprehension about their future, Organisations A and B are concerned about attracting a new generation of older BME people, adding that retirees now are more active, more technologically adept and are wanting to take on more challenges than their predecessors.
Organisations A and B do incredible work within their communities. Through direct and indirect means, they are supportive spaces that encourage sharing memories, friendship, empowerment, advocacy, learning and information sharing. These are groups that are much needed in communities that serve older people.

Recruitment

The gatekeepers of both organisations were very friendly and welcoming from the beginning. I visited Organisation A soon after initial email contact was made and introduced myself to the gatekeeper, who oversees the administration of the centre. The gatekeeper introduced me to the work the centre and provided an overview of how it was run and about its activities. I began to see the benefits of my insider status when the meeting instantly became more relaxed once I told the gatekeeper that I was from the Caribbean; we immediately jumped into conversation about “home”. After the introduction, the gatekeeper gave me a tour around the centre where she introduced me to a room of women sewing and knitting; I was met with a combination of polite smiles and raised eyebrows. After the introductions, I went around to each little group of women and spoke more about the project. There were a few who were very willing to be interviewed but most did not express any interest in participating. In one instance, as I was approaching a particular lady, she held up her hand and declared that I should not come and speak to her as she had no interest in speaking to me. There was, however, one woman who said “she’s one of us so she understands and we should help her” (Anonymous, research journal, December 2014); another example of the benefit of my insider status. Although few other women voiced similar sentiments of disinterest, I was able to distribute a few participant information sheets (Appendix 4) and consent forms (Appendix 5). I was speaking with a woman who explained the reluctance of the other women to participate. She suggested that it was because the members have been interviewed time and time again and they are either tired of it or they feel underappreciated of their time. I began to understand the hesitation among the group; this can most effectively termed research fatigue.

Clark (2008, p. 955) explains research fatigue to occur as
... when individuals and groups become tired of engaging with research and it can be identified by a demonstration of reluctance toward continuing engagement with an existing project, or a refusal to engage with any further research. This reluctance is then attributed to their previous or continuing involvement with research.

Very little work has been done on research fatigue (or how to work with over-researched populations), but researchers (Afshar et al., 2002; Clark, 2008; Sukarieh and Tannock, 2013) agree that research fatigue can result when there is a lack of empathy from the researcher, from being asked the same questions (or particular method) repeatedly, when participants are never made aware of study outcomes, when participants think it is of no benefit to them or simply not trusting the researcher. In my case, older West Indians in Bristol and Bath are a heavily researched group, but not for academic purposes but for journalistic inquiry, school projects or historical record keeping; as was explained to me by the gatekeepers of the main organisations and also in an email response I received by someone working with BME communities. A few members of the other community group I visited also explained that they were so tired of people coming to them and asking for information. I also got the sense that there may have been an element of mistrust towards researchers as there was one particular woman in at Organisation B who said to me “I am happy to talk to you but I don’t have anything bad to say, plenty people ask me to talk about bad things but I didn’t have bad things happen so I don’t know if you still want to talk to me” (Dionne, research journal, February 2015). She expressed similar sentiments on at least three separate occasions; I found this interesting in terms of why she was initially reluctant to speak with me, though she later agreed to be interviewed.

As discussed by Peterson (1999) and Sharp and Murdoch (2006), there are strategies that can be taken to reduce the likelihood of research fatigue, including making the purpose of the research clear, trying to avoid over-researched topics and helping participants see the benefits of research to themselves and in general. Adding to this, I think what helped to set me apart from others requesting information, was that I visited both organisations on several occasions such that they eventually began to warm to me as I was a familiar face. Spending time with the members of the community groups helped to set me aside from others seeking
to gain access to their groups as it indicated my genuine interest in wanting to get to know them. I visited the organisations almost weekly for several months, whether or not I had an interview. I ate lunch with both groups, I supported fundraising efforts and I sat down and had several chats with different members. This was extremely beneficial as after a few weeks, I was a familiar face, was greeted with smiles by the groups and it eventually became easier to recruit interview participants. Additionally, sharing the same background as many of the community members facilitated recruitment, in that I am also a West Indian who moved to England and, thereby, was viewed as one of their own.

During my first visit to Organisation A, I saw further evidence of research fatigue when another centre worker sat down and asked about my project and its goals. She then asked me what will be the product of my research and if the organisation and its members will have something to show for it; the example that was given was about another project that was conducted elsewhere and they received a video summary about their interviews. I understood why the question was asked; many of those who participate in research do not often get to see the fruits of their labour or never hear from the researcher again. I explained that I was carrying out the project on my own, without external funding and so was unable to produce any extensive product, but that I was happy to send, once complete, a brief summary of my findings. In this instance, recruitment may have been easier if I was able to promise potential participants a tangible outcome or product. I learned that the members of these groups are proud of their West Indian background, have a lot to say about their lives in England and the love for their community centres. As such, having the opportunity to showcase these things, whether through a book, video or through another medium would have been appreciated. However, many understood my position as an individual researcher and so were happy to assist me.

After my initial introduction, I was invited to join the group for lunch, after which I went to speak to a small group of men playing dominoes and managed to get three interested. I had another brief conversation with the gatekeeper before I left, I thanked her for her time and she sent me off with a warm hug.
I had a similar introductory experience at Organisation B and was met with similar hesitation by many of the members. Just like at Organisation A, someone explained to me that the members at this centre have been approached several times to do interviews and that they too were tired of it. I visited this community group every week for six weeks. Despite some initial reluctance, I was able to get one or two people signed up for an interview after each visit to the group. Before leaving the initial meetings at both of these community centres, I received permission to advertise the research study on their notice boards, see Appendix 2 (study ad).

Recruiting was very slow process and proved to be difficult at times. It took me almost four months to conduct 16 interviews, slightly over half of my expected number. It was then another three months before I was able to conduct a focus group. This was due to no-shows for scheduled interviews and focus groups. Even though my insider status assisted me with gaining some level of trust, it was still difficult to contact and reschedule with several of the no-shows. Many of the participants were reluctant to give me any contact details so I was unable to call beforehand to remind them of upcoming interviews nor was I able to call them to reschedule missed interviews. When this happened, it depended on me going to the community centre the next week to follow-up with them. Compared with other ethnic minorities, the West Indian population in Bristol is fairly small and the pool of potential participants shrinks when I include the requirement of having moved to the United Kingdom within a certain timeframe. To counter this, I redefined the age of participation. During the initial stages of fieldwork, I realised that there were potential participants who, although were not over the age of 65, they migrated within the desired time period. This meant that these individuals migrated as children and this, therefore, had the benefit of adding that perspective to the study, further enriching the data.

The first few weeks of recruiting were successful in that I was able to engage with the community of interest and schedule a few interviews almost immediately. This was largely due to the fact that I was in contact with established elder groups. But I also wanted to speak with elder West Indians who were not willing or able to get out and be as involved in society; these are a hard to reach population. As I
learned, the process of finding participants who were not as active in society proved to be difficult even after I attempted to use snowball sampling methods to recruit them to the study. Hard-to-reach populations are members of society that are traditionally difficult to involve in the research process, examples include those living in physically remote locations, those involved in criminal activity or certain classes of migrants. Two recent reviews (Bonevski et al., 2014; Shaghaghi et al., 2011) suggested options for overcoming barriers to accessing hard-to-reach populations, including conventional cluster sampling, time-location sampling and facility-based sampling are based on knowing where the potential recruits gather, or in the case of facility-based sampling, gaining access to where they are held (prison, for example). While these are good options for someone conducting research with, for example, drug users or sex workers, these particular methods will not work for me. The population I am trying to reach are hard to reach because, in addition to being small in number, they may be living in isolation and so do not attend community groups or they may have a physical disability, which renders them unable to participate in community activities. In trying to reach these isolated individuals, I asked my gatekeepers and interview participants for their assistance in contacting these individuals. In instances such as these, snow-balling can work effectively in accessing these hard-to-reach individuals (Bryman, 2012). However, this was not the case as I was not able to recruit any hard-to-reach members of the older West Indian population.

4.2.4 Qualitative Interviews

In seeking to understand the meanings the study participants ascribed to their experiences of migration and perceptions of healthy ageing, I conducted semi-structured qualitative interviews. Holstein and Gubrium (2004) view the interview as an active, bi-directional process whereby knowledge is created by the researcher and the participant and is not merely transmitted. The ensuing relationship that develops between the interviewer and the participant during knowledge creation, as happens during interviews, is a feature of the feminist method of interviewing (Oakley, 1981). The feminist approach to interviewing, encamped within the critical paradigm, seeks to breakdown traditional barriers that rise to the typified hierarchical power relationship between the researcher and
the participant as seen in many qualitative studies (Oakley, 1981). To avoid this kind of relationship from developing during the interviews, I often shared information about my Caribbean upbringing and my experiences about migrating to the UK. My overall goal was to have the interview be conducted in more of a conversational manner. Doing so not only helped to create an equal power dynamic between the myself and interviewee but it also added to the conversation, which resulted in the co-creation of knowledge (Oakley, 1981; Yeo et al., 2013).

**Interview Guide**

This study is concerned with the ways in which the experiences of migration have impacted the lives of older West Indians living in the UK and how some of those same experiences may have influenced their perceptions of healthy ageing. In order to do this effectively, I used the life course framework, discussed in Chapter 3, as an organising tool for data collection and data analysis; the interview guide, which provided a topical outline for the structure of the interview (Kvale, 1996; Patton, 2002) can be located in Appendix 6. The life course perspective seeks to develop an appreciation for people’s attitudes, ascribed meanings and the interpretation of events and experiences across different stages of life and the interaction of the aforesaid with social change and human development (Elder, Jr and Rockwell, 1979; Heinz and Krüger, 2001; Kok, 2007). Further, Elder et al. (2003, p. 10) adds, “it provides a framework for studying phenomena at the nexus of social pathways, developmental trajectories, and social change” also within migration studies (Gardner, 2009; Montes de Oca et al., 2011; Wakabayashi, 2010). Given this, the topic guide for the interviews was designed to elicit information at specific key points (pre-migration, early post-migration years, later post-migration years and present day) across the individuals’ lives. Doing so increased comparability across cases and provided social and historical context which helped to answer questions about their lives today regarding their current health and well-being.

**Piloting**

Before data collection formally began, I piloted the interview topic guide on three colleagues within my department and also conducted a pilot focus group with four
colleagues. This helped to ensure that the wording, the sequencing of questions and selected topics extracted the kind of in-depth information desired. Adjustments were made accordingly, including the number and sequencing of questions, the icebreaker used, my tone of voice and the wording of questions.

The Interview Process

I began each interview by reminding the participant about the purpose of the study, that there was no obligation to participate and that they may withdraw from interview and the study at any time. I also gave each person the opportunity to ask questions before we proceeded. We then went through the consent form and secured their signature. I reminded them that the interview will be recorded and informed them of the broad topic areas before the interview began. When reviewing the topic areas, I noticed that a few participants developed an anxious look on their faces. Asking basic questions (age, where they were born, etc.), helped to break the ice and seemed to remove some of the perceived pressure of their task. To encourage the participants to talk, I moved on to open-ended yet still simple questions (tell me about life in your home country, how did you come to decide to move to England, etc). I found that these questions were usually sufficient to get the conversation flowing.

Conducting semi-structured interviews is a balancing act of letting the participant to bring up information they deem as significant while still getting the information I needed. This interview format is flexible enough such that I was able to have productive conversation which gave rise to in-depth information and I was also able to pursue any emerging topics as I was able guide the interview to ensure that the desired topic areas were covered (Patton, 2002; Simons, 2009). Following this approach permitted me to collect the data in a consistent and orderly way, which, thereby enhanced comparability across cases and ensured that I was able to cover all necessary topics. One caveat to this approach was that participants may not have as much of an opportunity to discuss topics that they perceived as being significant, in comparison an unstructured interview (Patton, 2002). To help address this, at the end of the interviews, I asked each participant if there was anything they would like to add to their interview; some took me up on that offer.
All interviews were in-person and in a private room apart from one, which took place in an open room with other people around. The interviews were digitally audio recorded and transcribed verbatim afterwards. I acknowledged the possibility of recall bias given that the study asked participants to remember events from the past. Although audio recordings have the benefit of playback and thereby eliminating some issues of interviewer recall, notes were still taken during the interview in order to document nuances like body language, facial expressions and notes for follow-up. After each interview, I sent my participants thank you cards as an expression of appreciation for their time.

Although I initially hoped to recruit 25 to 30 interviewees, I conducted 16 interviews and one focus group with five participants. The interviews ranged in length between 40 and 90 minutes, with the average being 60 minutes. In addition to the problems experienced in recruitment, as discussed earlier, conducting interviews also proved problematic at times. Non-attendance at interviews was an issue on several occasions, which led to repeated rescheduling at both organisations. This, therefore, significantly lengthened the anticipated data collection period. On the days that I had no-shows to the interviews, instead of immediately leaving, I sat down and enjoyed the company of the group members, which gave me further insight into who they are as individuals and their collective group identity. On one of these occasions, I arrived at Organisation A to find that the interviewee who was scheduled did not turn up. So, I went into the sewing room and sat down with the women in there and told them what happened. They said, “well, you can do the interview now with all of us if you like”, resulting in an impromptu focus group. So, although I was not expecting to conduct a focus group that day, I was presented with the opportunity and gained additional valuable data for the study. Data saturation occurred after approximately 13 interviews, when there was redundancy and no new information was found (Bowen, 2008).
4.2.5  Data Analysis

All interviews were audio recorded and transcribed immediately following each session. Data analysis was on-going throughout the study and did not just occur at one defined point and was both a deductive and inductive process (Ormston et al., 2013). Deduction occurred as the literature review provided the information and concepts used to generate the research questions and, therefore, the broad framework within which to interpret the data. Induction occurred during thematic analysis of the data, giving rise to a tighter framework for interpretation of the findings. Throughout the study, data analysis also occurred in moments of reflection after and between interviews in the ideas that emerged due to self-awareness and knowledge that was used when exploring the ideas of and developing understanding of the research participants (Finlay, 2002; Holloway and Biley, 2011).

The study employed thematic analysis methods to explore interview text. Given that one of the aims of the study was to understand how the study participants’ experiences across the migration life course have influenced their attributes of healthy ageing, thematic analytic methods were used to go beyond the surface of the interview data and, instead, conducted analysis at a deeper level data (Guest, 2012). This deeper level of analysis occurred within and between cases helped to build commitment and rigor into the study (Yardley, 2000). Utilising thematic analysis methods to examine the interview data allowed me to identify and describe the themes that occurred throughout the transcripts and, as a result, I was also able to explore the processes through which meanings and experiences were produced by my study participants (Braun and Clarke, 2006).

Conducting 16 semi-structured interviews and one focus group generated a considerable amount of data. The interview transcripts were uploaded to the QSR NVivo program where initial codes were assigned after a read through of the interview. Although the literature review helped to frame the research questions, the generation of codes and themes was driven by the interview data. Coding and theme generation was a recursive process and involved assigning preliminary codes to text. Given this large amount of text generated from the interviews and
the need to compare and contrast large amounts of data across cases and within individual cases, the Framework Method, which is compatible with NVivo, was used to assist with the management of this data (Gale et al., 2013). When the initial codes were created in NVivo, I exported that file to Microsoft Excel, which then generated a spreadsheet matrix that consisted of initial codes that were generated from the analyses. Once all of the interviews were coded, I began to group the smaller codes into larger groups, or categories. This process continued until the major important categories were identified, which then became the themes.

4.3 Ethical Considerations

This study received ethical approval from the Research Ethics Committee at the University of Bristol, School for Policy Studies; see Appendix 7.

During recruitment, all potential participants were given a Participant Information Sheet (Appendix 4) and were given the opportunity to ask questions for clarification; this happened at the initial expression of interest and at the start of the interview. Before the start of the interview, each person was presented with a Consent Form (Appendix 5) where they were asked to read (or I read for them) each sentence and to initial if they agreed; a final signature was required at the end of the form.

The participants of this study were guaranteed their anonymity with the use of aliases; this was explained to them. I also explained that neither their audio recordings nor any part of their discussion will be shared with others except with the use of aliases and with the exception that I have any concern for their safety or the safety of others.

Hard copies of any study materials (e.g. consent forms, printed interview transcripts) are kept in locked cabinets. Electronic files (e.g. audio recordings, interview transcripts) are stored in separate locked digitally protected files. All information collected will be stored securely for at least 10 years then destroyed, per University of Bristol regulations.
Chapter 5  Post-Migration Life Course Experiences

The literature review highlighted that instead of viewing healthy ageing through frequently used and restrictive terms like successful ageing, healthy ageing should, instead, be viewed more holistically through the resilient ageing framework (Braudy Harris, 2008). In addition to exploring the ways in which healthy ageing is constructed among older people, these early chapters advocated that understanding the post-migration experiences of older West Indians and the present-day impact on their perceptions of health can effectively be done by drawing on critical race theory with further examination using the resilient ageing lens. By using the life course framework as a way to structure data collection and analysis, I explored the post-migration experiences of a group of older West Indians now living in the UK.

As discussed in Chapter 4, the life course framework facilitates the understanding of human lives across time and within a sociohistorical context (Elder Jr, 1994). Instead of regarding migration as a singular event, this study views migration as a lifetime process. The life course framework, therefore, becomes a useful tool for following the stories of the participants of this study beginning before they left their home countries until present day and how these varied experiences impact their perceptions of healthy ageing. Complementing the life course framework, I draw on ideas associated with critical race theory to explore the role that social processes operating in society have played in affecting the lives of the participants of this study. Another significant aspect of critical race theory that bears importance to this study is that of social justice (Delgado and Stefancic, 2012) which is why this thesis is focused on highlighting the participants’ perspectives on what constitutes healthy ageing which could then be used help individuals and groups working within similar communities.

Chapters 5 and 6 the present an analysis and discussion of the findings. The current chapter explores the experiences of the study participants in relation to their process of migration and settling in the United Kingdom while Chapter 6,
through the lens of resilience, examines how these experiences contribute to construction of the definition of healthy ageing for this group. One of the central tenets of critical race theory is to highlight the voices of people of colour, which have often been side-lined (Solorzano and Yosso, 2002). Consequently, a brief narrative of a particular participant will be presented before each theme, which is based on the life course. Narratives, such as the ones presented in this thesis, are one of the main objectives of CRT (Parker and Lynn, 2002) and can also be of great significance to those analysing personal accounts (Olwig, 1998) as stories can give insight on the types of experiences people had when they migrated. These stories are then analysed to understand how people represent and interpret different life experiences, especially regarding the socio-historical contexts in which said experiences took place.

This chapter contributes to the body of literature on the life course and migration experiences of older West Indians in South West England. With the life course framework in mind, the rest of the sections in this chapter are organised into the different stages of the migration life course, which I have identified as (1) pre-migration and migration, (2) early post-migration, (3) later post-migration and (4) present day. Each section below opens with the narrative of a participant whose story I think best fits with that particular stage of the migration life course.

5.1 Pre-Migration & Migration Experiences

Octavia’s Story

Octavia, one of the younger participants in the study, was 56 years old at the time of the interview. She moved to the United Kingdom in 1969 from Jamaica when she was 10 years old. Octavia, like her siblings, was raised by her grandparents. Her parents immigrated to the UK at an age when she was too young to remember them. Thinking back to her early childhood in Jamaica, Octavia recalled days of freedom being able to run around the land, growing food and tending to animals. Her first awareness that she was going to move the UK was when, at the age of eight or nine years, her mother returned to Jamaica and informed Octavia that she will eventually also move to the UK. This was also the first memory that Octavia had of her mother. She felt fear at not
Octavia slowly began to understand the enormity of the situation when she realised that others in her community in Jamaica were jealous of her and of the potential opportunities that life in England could bring. Although Octavia had other siblings living with her in Jamaica, she was going to travel alone, as her parents could only afford to send for one child at a time. Other than feeling scared to leave her home and family in Jamaica, Octavia did not recall having any real expectations for what her life would be but did remember having slight anxiety about meeting her other siblings that were already in England and starting a new school. Feeling bewildered more than excited, she remembered being put on a plane next to two other children and sitting in silence for the duration of the journey. She also recalled in England and being very ill-prepared for how cold it was. In her early days and weeks in England, Octavia remembered crying daily, wanting to return to Jamaica.

Although initially filled with concern and fear for the unknown, Octavia eventually began to settle down as she remembered being somewhat comforted by seeing other children who, like herself, migrated to England from the Caribbean. In discussing her life and experiences, Octavia goes on to work in a factory and then as a chambermaid and eventually worked found work within community centres.

5.1.1 **Motivations and Expectations for Migrating**

As discussed in Chapter 1, the arrival of the *Empire Windrush* to England in 1948 has been heralded as the start of a period of mas West Indian migration to the United Kingdom (Sutherland, 2006) and, as such, most of the participants in this study moved to England between 1954 and 1971. Most were adults when they migrated, except four who moved over during adolescence. As this study found, the reasons for migrating varied only slightly. For those who migrated as children, as in Octavia’s story above, their move to England was about family reunification. Children went to join their parents abroad, which meant that they had been raised by other family members before migration. On the other hand, the main
motivations for the adults moving were a mix of opportunity and the desire for an adventure.

Whether migrating as adults or children, for many individuals and their families, the move often signified a chance to take advantage of economic opportunities that grew increasingly difficult to find in the West Indies during this post-World War II period of high unemployment and increasing cost of living (Fryer, 1984; Phillips and Phillips, 1999). Although economic incentive was seen as the primary reason for migration, this study also found that the participants’ family was heavily involved in the decision for an individual to move abroad, as seen for both Dionne and Frederick,

Well, there were a few people I know from my area who had come to England and then, you know, my eldest sister was in England, was in London. So, some years after, he [father] said would you like to go to England so I said yes. (Dionne, 79, migrated at age 21)

…I my parents they got motor vehicle, a lorry you know small lorries, so I umm in the end, I ended up driving one but in the end my mum says "nooo not for you, too much trouble, you go off to England and find a different sort of life". (Frederick, 73, migrated at age 20)

Correspondingly, the move of a family member abroad also indicated (to their community) that the family had the financial wherewithal to do so. Eartha explained the inter-family competition that often arose,

…and ummm the parents in Jamaica, they had a thing where everybody tried to out-do the other person regarding their children and ummm in my mother age group umm like her friend [name], her daughter is going to England then she would tell my mother. And then another friend would say "oh my other daughter is going to Panama", she would tell my mother. Everybody tell my mother and then I remember [name] said to my mother "what are you going to do with Eartha and [sister]?” Cause we haven't been anywhere yet. (Eartha, 76, migrated at age 22)

Family encouragement was apparent in the extracts above whether through the urging of Dionne’s and Frederick’s parents or whether migration was viewed as a family accomplishment, as seen in Eartha’s narrative. Consistent with other research (Chamberlain, 1999; Olwig, 1998), this study finds that the role of the family in the migration decision is evident as an enabling social force, which also complements the economic incentive to move. The role of the family does not end
here and continues to play important roles later in the migration life course, which I will return to later in the chapter.

With the opening of the UK borders to colonial citizens, many people who left the islands in search of promised opportunities often left spouses and children behind. The children who were left behind were raised by their close relatives (Crawford–Brown, 1994), like grandparents as seen in this study. As such, when the children migrated to England, it was so they could be reunited with their families. Unlike the adults, who chose to migrate, the children were not given a voice in the decision to migrate to England; they were informed. Having the ability to choose to migrate, or at least to be involved in part of the decision-making process, puts the person in a position of having greater control over the entire process and their lives in general. Without this control, individuals are at an increased risk for experiencing psychological distress (Creed and Bartrum, 2008; Smith et al., 2000), expressed as fear and anxiety by some of the participants of this study who migrated as children. Octavia, who was raised by her grandparents, discussed how she felt when she was told that she would be moving,

Well, I remember my mother coming, I remember looking at this woman and thinking "oooh, who are you?" and she [grandmother] said, "this is your mum and she's come over from England and she's going to take you back". And the first thing is that a fear in a way, not that you know what fear was, but this funny feeling like I don't know you and I'm happy here you know and where is England, where is England? I don't know nothing about England and how I am going to get on with you when I get there? I would prefer to stay here 'cause I'm more comfortable.

(Octavia, 56, migrated at age 10)

Later on, she said,

I think it would probably be more scared because you were going on your own as well, is not to say somebody was going and taking you and you were holding somebody's hand. They were just gonna take you, you were gonna go on the plane...

(Octavia, 56, migrated at age 10)

The passages above illustrate how some of the other participants who migrated as children felt. Octavia felt powerless in this situation, she had no choice in what was going to happen to her future. Her emotional responses to being separated from family and the life that she knew were fear, uncertainty and helplessness, which can have consequences on mental health (Dillon and Walsh, 2012). In
addition to the stress of separation discussed by the study participants, there was additional responsibility placed on the younger participants to adjust to their new homes and life with, what is essentially, their new family and this can make reunification difficult. Octavia, whose siblings already lived in England, spoke about feeling isolated from them as she had a different upbringing from them,

...just your accent, you could be talking and people would be looking at you and then didn't understand what you saying, even your brothers and sisters make fun of you. So, you know, you even felt that little isolation although you there and you just felt...it was a sad feeling for a very long time. (Octavia, 56, migrated at age 10)

This differentness Octavia felt led to her feeling somewhat detached from the rest of her family could have negatively affected her self esteem (Smith et al., 2004) as she did not quite feel like part of the family when she first arrived. Similarly, Cicely recalled the unfamiliar landscape that she moved into and how she felt when she was reunited with her parents and siblings in England,

Danielle: And how did you feel when you saw her? 
Cicely: It was strange. Because I always took grandmother to be mother. And likewise, granddad to be daddy. Although, my mom always wrote and always told us about everybody here etc, you know, it was...it took a while to settle and even to be, to feel like a part of the family. (Cicely, 57, migrated at age 14)

Billie, on the other hand, remembered feeling excited about her move to England but once she got here, reality of the new life set in,

Danielle: When you were coming over, what did you think life was going to be like? 
Billie: I have no idea, I was a child. I didn't stop to think. But I tell you what, if I know we were gonna be closed in a house, more or less, twenty-four seven 'cause in Jamaica you have big land and property you run about and play all sorta games with your boy cousin and your girl cousin. It was different here 'cause it's cold out there. (Billie, 65, migrated at age 11)

For children, this early stage of migration is a period of adjustment to a new culture, environment and family life and can be a period of immense stress in the child’s life as seen in the extracts above and as other studies have found (Lashley, 2000; Thrasher and Anderson, 1988). Even as the child migrants have to navigate adolescence, they must do with in unfamiliar surroundings, with restricted freedom and without the comfort of their known caregiver. This kind of separation along with the inability to adequately prepare for their move can
induce, as we have seen, fear and anxiety, which could then increase levels of stress in the child, thus potentially impacting negatively on their health.

On the other hand, the adult migrants were able to decide for themselves whether they wanted to move. And as such, reasons for the adults wanting to move fell into two main categories, to seek economic opportunities and a desire for an adventure. Great Britain opened its borders to members of the empire to assist with rebuilding efforts in the post-World War II era. A few of the participants who migrated as adults recalled hearing about this via newspapers and the radio and believed it to be a good opportunity to move to England,

Sidney: A radio! Yes, that’s right, and they tell you…and someone tell you in the little transistor, "come to England, your mother country need you". In those days…
Danielle: Why did the mother country need you?
Sidney: Plenty of work was here, come to help rebuild England, your mother country. And I went home and I tell my mom. (Sidney, 84, migrated at age 24)

Information received about the “mother country” through the media painted a picture of a country full of opportunities. Additionally, being raised in a British colony meant that people living in the Caribbean islands were raised with similar systems of government and education as the British. As such, many West Indians living in British colonies, like Sidney above, felt a sense of entitlement to be able to migrate to England and take advantage of the promised opportunities afforded to crown subjects (Fryer, 1984; Phillips and Phillips, 1999). The drive to migrate was also spurred by lingering high levels of unemployment, lower wages and limited opportunity for advancement in the Caribbean islands (Fryer, 1984).

While economic opportunities may have been the driving factor for some of West Indians, other participants described themselves as wanting an adventure as their main reason for going abroad. Viola illustrated this when she expressed that, at the time, she was curious about “how the other half lived” and so she seized the opportunity to migrate to England to join some of her other relatives already there. Phylicia, who also migrated as an adult explained her decision to move to the UK,

I came to England with my sister. Because she had marital problems and she said she was leaving and she was coming to England so I said well, I'm coming with you, I'll come for a holiday to see what it's like...and I mean, that holiday…I'm still holidaying laughs how many years later. (Phylicia, 75, migrated at age 22)
Thinking retrospectively, these participants like Phylicia and Viola described themselves as feeling like they were going on an adventure and, as such, did not expect to stay very long nor did they have any expectations for what life would have been like beyond their short time over.

Looking across the interviews, most of the study participants discussed that, at the time, they anticipated moving to England for a only short time, usually five years, something Chamberlain (2009) also found in her work with Barbadian migrants in England. The focus group participants explained the five-year plan,

Aretha: Everybody say five years.
Viola: I thought I was coming for five years and I was here 50 years last September.
Danielle: So how come you stayed? What happened to the five-year plan?
Viola: Five years go into 10...
Darlene: Having a family...and then it just goes on...
Voila: You get work, you get companion, you get friends. You, you, you know, the years just go on...
Darlene: Settle down and you know and... we come to earn money. We come to work.
Josephine: Most of us came here was to work. By five years, you think you'd have enough to go back and settle down and do a business or something. But the five years went so fast, you decide that wouldn't be enough. I bought a house, a son in Jamaica, he came over. So that was it, five years out of the window. I did went back 5 years but it was for holiday. (Focus Group)

Many of the study participants thought that migrating to the UK that they would have been able to make enough money to them enable them to return to their homes to buy land and build their own houses or follow other opportunities, something Olwig (1998) also finds in her research of Caribbean migration. However, this earning potential was not usually achieved. Many of the participants later discussed that they were not able to make as much money as they hoped within their five-year timeframe, possibly due to the structural racism they encountered which restricted their employment and, thus, earning potential (Fryer, 1984; Sivanandan, 1981).

In discussing how they felt at the time of migration, several of the participants, expressed that they did not have any expectations for what their life was going to be like once they arrived in England; see Dionne’s discussion of this,

I didn't have...you know, maybe I'm different from most of that you interview...I didn't come with no great expectations, I didn't know what to expect. I just know
When thinking back to how they felt at the time of migration, many of the participants expressed ambivalence about moving to England. Although several participants discussed learning about England in school, they were unsure about the way of life in the UK but were curious enough to see what life would hold in their ‘mother country’. Simultaneously, they also remembered not having any expectations for what they wanted their lives to become as Martin explained,

I never had any expectations. It’s funny, at school, most of the books and things on the history, it was really about England. London especially and the Queen and Buckingham Palace and things like that. But I never had a picture in my mind about what England was like. I know it would be pretty grim, you know, coming from Barbados where it was nice, dry and brown, things like that. I knew that it would be very grim ‘cause that's what I used to hear about. I never picture what it would be like in my mind. I think it happened so quickly that I never had any time to digest. (Martin, 77, migrated at age 18)

Like Martin, Ruby Dee and Ossie also discussed their lack of expectations regarding their move to England, which happened shortly after they were married,

Ossie: Yeah, I never give it a thought you know, I was just having a good time on the boat you know, with all the girls... Danielle: So then, what were you expecting when you came? If his [Ossie’s] father is saying “yeah, come see how the other half lives”, what were you thinking it would be like over here? Ruby Dee: Don’t know because, at young age you just think, eventually, I'll have to go and join him. If he don't come back, I'll have to go and join him anyway. (Ruby Dee, 72, migrated at age 18; Ossie, 76, migrated at age 22)

For this couple and many other participants, migrating was seemingly a matter of “seeing what happens” mixed with curiosity. Ossie was moving to England to join his father who promised better economic opportunities while Ruby Dee was moving over to join him.

Likewise, Viola remembered migrating and not having expectations for life in England, “I wasn't sort of umm say I'm actually going to do nursing or I'm going to do this...I thought well, I'll come over and whatever comes along, I'll do”. And while she discussed not having any expectations she did, however, recall the expectations placed upon her and others in a similar position. She says of older family members left behind in Barbados,
So, ummm, they was still working and looking after themselves so we came over. And they always say "go and make a life for yourself" and they give us a free hand to come over and so we thought, you come over, get a job and get work and if there's anything you can send back and help them with anything you were doing, like to the house or anything you would help with. (Viola, 73, migrated at age 21)

At the time, migration to England was seen as an opportunity to better yourself financially and while many of the participants declared not having expectations for life in England, there were others for whom sending a loved one away was not only a status symbol, as seen with Eartha in earlier sections, but also as an economic opportunity to support the family remaining in the Caribbean (Olwig, 1998) as illustrated in Viola’s extract above. As such, West Indians living overseas frequently sent money and other goods back, known as remittances, to their loved ones in the Caribbean islands. These remittances provided economic benefit to recipient families and, importantly, also helped to reinforce familial bonds between those who migrated and loved ones ‘back at home’ (Goulbourne et al., 2006).

The participants in this study who migrated as children did not recall having any expectations for their lives in England. Although they did not express having any expectations at that time for their new lives, there were expectations placed on them. Octavia, for example, recalled feelings of sadness once she moved to England and remembered wanting to return to the Caribbean. She was, however, aware of the expectations placed up on and explained,

But then again, it came to a point that you didn't want to go back because if you went back, what would they say, “you came back?” You know? “You went to England, why are you back, did you do something wrong?” So, then you started to think, you know what, maybe I just need to buckle down and get on with it and get on with life. (Octavia, 56, migrated at age 10)

The children were expected immerse themselves into their new homes and families, they were expected to do well in their new schools and they were expected to take advantage of the “opportunities” that living in England provided for the betterment of theirs and their families’ lives, especially regarding educational pursuits (Cervantes-Rodriguez et al., 2008; Olwig, 1998). Octavia highlights this later on during her discussion about expectations as she retold the
story about herself and other chambermaids of West Indian descent overhearing the voices of other Caribbean people recently came to the UK to study,

And in that short, split second, I felt embarrassed. I thought, "what am I doing working here and these people are in the hotel". I thought hold on, I've come here and I've been to school here and the opportunity here, 'cause you're not paying to go to college, you're not paying for your education; what am I doing here? And I said to the girls, there's four of us, I said 'what are we doing?' We need to do something else...and we did, we left. (Octavia, 56, migrated at age 10)

In her 20s, Octavia came to the realisation that she had not taken full advantage of all of the opportunities that migrating to England could have provided. She subsequently spoke about changing the course of her life and enrolling herself in adult education courses and workshops, which therefore led to changes in her career path.

There were, however, two participants who explicitly discussed having expectations for life in England. In Jamaica, Ethel was a married stay-at-home mother whose husband provided financially for the family and she expected that once the family moved to England, that this family arrangement would continue. Ethel’s life, however, took a drastic turn when her husband made the decision to stay in Jamaica and not join his family in England,

He didn't turn up, he said he had changed his mind and that England was a war country and they gonna put him in the war. So, I thought, chicken then. So. oooohh...it broke my heart so bad that I must have had a nervous breakdown ...so badly that I collapsed when I got the news and I cried out loud, I collapsed. (Ethel, 83, migrated at age 27)

This was a pivotal event in Ethel’s life whereby the life that she planned for herself and family quickly changed. Throughout her narrative, Ethel made it very clear that her life has consistently been a struggle to raise her children in England on her own as she often reflected on the different ways her life did not turn out as she expected.

Frederick also reflected on his expectations,

Frederick: Well, I thought pause when I came here, when I left Jamaica actually, I was earning more than when I came to England.
D: So, you thought money would have been better?
F: I thought life would be.
D: What other part of life did you think would have been better?
F: Well, actually, I would be able to earn more money, I'll be home in 5 years and
I'm here for 52 laughs. (Frederick, 73, migrated at age 20)

For the participants that did speak about their expectations, they discussed coming
to the UK to work and then expecting to return to their home countries after a few
years with the wherewithal to help their families and to elevate their financial
positions, thus also fulfilling the expectations placed upon them. But none of these
participants stuck to their five-year plan because they did not expect that living in
the UK would be the struggle that it was and, also, they began to have their own
families and settle down. Looking across most of the interviews, whether
expectations were explicitly discussed or whether they were within the
subconscious, there was a notable disconnect between pre-migration expectations
and post-migration reality, with potentially negative effects on their health and
well-being (Chamberlain, 2009; Murphy and Mahalingam, 2006).

Earlier work with Caribbean migrants (Fryer, 1984; Glass, 1960) also investigated
migration expectations. As was mentioned earlier in the chapter, during the time
of the mass migration, most of the Caribbean islands were colonies of the UK
which meant that, for example, the system of education, religion, government
structure and other aspects of life were closely linked and, therefore, similar to
those systems found in the UK. As such, many of the participants who migrated to
the UK may not have considered this a major undertaking; Ruby Dee, who
migrated in 1962, gives some insight, “ ‘Cause in the days when we came over,
we still under British flag. So, it’s not a big deal to change over.” Like Ruby Dee,
many of those who migrated considered themselves British subjects with England
being ‘the mother country’. This feeling of British-ness and patriotism many West
Indian migrants felt towards the UK therefore meant that many expected that once
they arrived in England, they would be treated as equal British subjects, whether
or not they explicitly stated this. However, this was often not the case as many of
the new arrivals faced discrimination and racial harassment (Fryer, 1984; Phillips
5.1.2 Pre-Migration and Migration Contributors to Healthy Ageing

Considering the narratives above, there are two factors that were evident that have the potential to impact an individual’s definition of healthy ageing later in life and these can be divided into motivations for migration and post-migration expectations for life. In the pre-migration phase of the life course, the role of social networks, via the family, begins to develop in shaping the experiences of those who move abroad. The importance of family in the decision to move abroad was evident throughout most of the narratives in this study, seen mainly as providing encouragement to move. And with some of these motivations comes expectations of self or expectations placed upon the individual by others. We saw that these participants either migrated wanting an adventure or they migrated having hopes of returning to their homes in a more financially secure position. The decision to migrate was, evidently, viewed as a right and something that can be done with relative ease; it was viewed as a move from one home to the next, to the “mother country”. For the study participants, this, however, expectations did not meet reality due to the endemic discrimination and racism at the time that made socioeconomic mobility particularly difficult. Interestingly, even though many of the participants expressed not having expectations for their lives, their stories revealed that they did, in fact, have some expectations, which can be seen when they discussed how they felt once they arrived in England. This is explored in the section that follows.

5.2 Early Post-Migration Experiences

Debbie’s Story

At the time of the interview, Debbie was 70 years old. She moved to England from Jamaica at the age of 14 in 1960. Being raised by her grandparents, Debbie’s mother summoned her to England to join the rest of the family. She remembered being scared and sad to leave her friends and extended family but also excited as the move meant that she was going to be reunited with her sister and parents.

Her aunt accompanied her on the plane and upon landing in England, she remembered being disappointed by what she saw. She was disappointed by how
foggy and dull it was and that she found the style of houses very odd looking. Her expectations, she said, fell flat upon arrival.

Debbie started school shortly after her arrival and found her reception by the white students quite mixed. There were very few students of colour in her school. Though some of the White students were nice to her, she found that many of them they treated her with a mix of curiosity and animosity. Some students were also a bit more hostile as Debbie recounted instances of racist name-calling towards her but quickly added that she was always able to defend herself.

Reflecting on her life just after moving to England, whether the strangeness of her new way of life or her dislike of her surroundings or the racism she has encountered, Debbie spoke of always having to put up things and got on with life.

Debbie's narrative detailed experiences of motherhood and sacrifices she made. Debbie worked in factories and for the local bus station. In trying to bring more money into the household, Debbie decided to train to be a nurse and worked in the field until retirement. Although she and her family struggled financially at times, Debbie is now able to enjoy life as she can afford to do the things she wants to.

In the extract above, Debbie’s sentiments expressed how several other West Indians felt upon arriving in England. Many West Indians left their homes with feelings of excitement and curiosity only to arrive and be disappointed by either by what they saw or by their early experiences (Fryer, 1984). Beulah and Eartha, as examples, both spoke about how they felt when they first arrived,

Danielle: What did you think?
Beulah: To be honest, I want to go back.
Danielle: How come?
Beulah: I don’t know, the place just don’t look right and things like...it look like a factory and tings like that and then I say I want to go back. (Beulah, 74, migrated at age 20)

When I got off the boat, I saw all the houses with smoke coming through the windows, from the chimneys. And I thought, well, I would be able to get a job very quickly with all these factories. Well, I had a shock when I realise that is fire in the house to warm up the place. But my impression of the place, as I said, was dull. Because in Jamaica, we have brightly painted houses with lovely curtains, net curtains and everything muffled attractive. But it was dull with these red bricks. (Eartha, 76, migrated at age 22)
The extracts above indicate the disappointment at the start of their new lives and, perhaps, shock, following the realisation of some of the details of day-to-day living in England.

Martin, on the other hand, knew to expect cold and foggy weather and, thus, he was not surprised when his boat first arrived at Tilbury Docks in Essex. He recalled,

I thought to myself coming over, you got no family. You have to all of a sudden the carefree way that was back in Barbados that would have to be removed. And I have to stand on my own two feet ‘cause I got nobody to rely on. I was lucky in way that umm the chap, my sister husband, got jobs for us so I didn’t have to go looking for a job. (Martin, 77, migrated at age 18)

Martin who was greeted by a family friend, realised that migrating to England meant that the freedom he had back in his home country would be restricted as he now had to provide for himself. He did, however, acknowledge the value of arriving to England and already having a network that he can count on to help him find a place to live, work and settle into his new life. Migrants’ social networks provide functions, such as the ones described by Martin, and are especially important just after migrating and as well as later in life (Bashi, 2007).

Debbie, who migrated as an adolescent, discussed some of the early reception she received from some of her classmates,

And they just look at you as if you’re strange. Some of them were nice, some weren’t very nice. I thought I got on...because they said they could understand how I spoke because. ‘Cause they said, “do you know, them do you speak English”, they wondered where...you know? They think you come from up some tree laughs that’s in my mind thinking, ‘cause I thought, what do you think we live, where do you think we live, you know? We live in some trees? They were very strange. The food was strange. The way they talked, taught us was strange, it was completely different. But you know, we just put up with it. (Debbie, 70, migrated at age 14)

This extract shows the bi-directional uncertainty between Debbie and her classmates, in which both parties regarded the other as peculiar; also noted by Glass (1960). The difference was that Debbie was one of the few ethnic minority children in her school in a different country and, as such, she felt that she had no choice but to accept ‘the strangeness’ surrounding her new life. “Putting up” with
situations that she faced indicates that Debbie felt like she had no choice or control over said situation.

When the women and men of this study discussed their arrival in the UK, the importance of having their families and friends to greet them was crucial in assisting their adjustment to their new and complex lives. This then meant that they were absorbed into existing networks, thereby strengthening their own social networks. These networks, as we will later see, become important contributors to their definition of healthy ageing. And at this point, immediately after migration, some of the important functions of these social networks were to assist the new migrants in finding housing and jobs, which happened with relative ease (Bashi, 2007; Chamberlain, 1999). In the context of finding work, housing and enrolling children in schools most of the other participants in this study, just like Ruby Dee and Ossie, recalled that these processes were straightforward and were without difficulties. Although this couple stated that they did not have “bad experiences”, other aspects of their interview reveals otherwise, which is discussed in the section that follows.

5.3 Later Post-Migration Experiences

Frederick’s Story

Frederick, who is 73 years old, moved to England in 1961 when he was 20. Once he finished secondary school in Barbados, he was employed as a lorry driver. His mother wanting, more for her son, insisted that he move to England to join the rest of his siblings. He thought that if he moved to England, that he would stay and make money for five years and then return to Jamaica.

Frederick noted how easy it was to find work and ended up working in factory; a job he stayed in for over four decades. In discussing his work at the factory, he initially remarked that everyone got along and that all employees were treated equally but later contradicts this.

Frederick lived in a predominantly white village in the South West of England. He said that although he heard the stories about the difficulties of finding a place to
live from other West Indians, he found that it was easy for him and that he never encountered that form of discrimination. Yet, though he says there was no hostility, he also said that he spent most of his time outside of work with his brothers, their families and other West Indians. Family and friends were hugely important at this time and people depended on each other for support. Feeling nostalgic, Frederick remarked that although he and his friends are more independent now and have more money, that the “early days” were better as friendship groups were tighter.

The importance of this West Indian community to Frederick continued to his family-building years and still today.

In exploring the narrative of life in England, the participants discussed being able to find work quickly, usually with the help of friends and family connections. Like many of other West Indian settlers in England (Fryer, 1984; Phillips and Phillips, 1999), most of the participants of this study worked manual labour jobs, such as factory workers or as bus drivers or cleaners. A few women worked in healthcare as nurses or nursing aides. There were also a few participants who eventually left their manual labour jobs and went to work as nurses or within their communities for various organisations or as social workers.

5.3.1 Experiences of Discrimination

The context of reception is important to shaping the experiences of migrants in their new countries, especially regarding the economic and social environment into which they arrive (Nazroo et al., 2007). Once the British Nationality Act of 1948 was passed, migration from British colonies, especially the Caribbean, increased steadily over the next decade. Accounts at the time described an unwelcoming environment for Black West Indians, especially when compared to the treatment of White migrants from Europe (Paul, 1997). Most of the participants of this study, except two, arrived in England either in or before 1962, when the landmark Commonwealth Immigrants Act of 1962 was passed. The concern of the ever-increasing numbers of migrants of colour in the United Kingdom along with the growing anti-Black sentiment among in the public precipitated the passing of the 1962 Act, which drastically reduced migrants from the British colonies (Paul, 1997; Sivanandan, 1981). This act, however, contained
protections for the ‘old dominions’ of majority White nations of Australia, New Zealand and Canada which ensured their continued free entry into the UK. The 1962 act created distinctions between commonwealth citizens based on skin colour which, thus, encouraged further instances of racism and discrimination against people of colour (Fryer, 1984; Sivanandan, 1981) and, therefore, further added to the ‘everydayness’ of racism in society. The participants of this study arrived to and lived in a publicly and politically racially charged climate and racial harassment and discrimination were part of the reality faced by many West Indians who migrated to England in the late 1940s through the 1960s. Martin, for example, discussed some of his experiences with racism during some of his time working at a factory,

Martin: We had to put up with a lot of racial abuse.
Danielle: Really? At work as well or in general?
Martin: At work, at work, mostly at work. Because I was in a little village, you didn’t get it so much as if you were in the cities. It was in a village, it was mostly at work. People used to call you all sorts of names. They call me banana boat, go back to where you come from. And all sorts like that. (Martin, 77, migrated at age 18)

In addition to the verbal racist harassment Martin encountered, he recalled the unfair treatment he received when compared to his white colleagues,

But that was a bit of a problem, problematic because is other people that came in after me was being promoted and I was always side-tracked. Not side-tracked but didn’t take into any consideration. I knew the manager was racist on there so, I used to keep very quiet. All I do, keep quiet and I just carry on with what I’m doing. There will come a time when they will want me, they come and ask me to do it. (Martin, 77, migrated at age 18)

Similarly, for Eartha,

But the white students had the privilege to go into the office, drink the tea and smoke and we couldn’t do anything like that, we would be told off, you know so that was discrimination. And you find that even when you have a few minutes to umm to go off a bit early and you wash your hands and standing and waiting for sister to send you off and somebody want a bed-pan, “nurse! [patient name] wants a bed pan”…it would be the black nurses, they wouldn’t call the white nurses to do it. So that was discrimination. And weekends, we wouldn’t get weekends off that you could spend quality time with your family but the white nurses would have the weekends off. It still happens now I think. But umm we have faced terrible discrimination. (Eartha, 76, migrated at age 22)

In the passage above, Eartha vividly remembered the discrimination she faced, especially during her early days of nursing. Accounts such as Eartha’s are not
uncommon, especially regarding the historic marginalisation of ethnic minority employees in the National Health Service (Simpson et al., 2010). This kind of discrimination in the employment sector was widespread, systematic and operated to keep people of colour, including the West Indian migrants, on the lower rungs of the socioeconomic ladder (Fryer, 1984; Patterson, 1963; Sivanandan, 1981; Sutherland, 2006).

Sidney also faced racism during his years as working as a driver for a milk factory and that while most places he delivered invited him inside, this particular location did not. He said,

\begin{quote}
But this it wasn’t like this you know...it was very bad, you know. Once upon a time, when I bring milk out there, they look at me once and say, “put the milk outside”, I couldn’t come in. But before time, when I tek\(^{10}\) milk in other places in Bath, they tek me in and say, “have a cup of tea”. At [place] and I sit down and have a cup of tea. But here [community centre], they look at me once and say, “put the milk outside and close the door”. (Sidney, 84, migrated at age 24)
\end{quote}

What is interesting and ironic about Sidney’s passage is that the place he referenced in the extract above (community centre) that did not allow him inside, is actually his current community centre, which specially provides services for members of the older ethnic minority community.

As discussed in the literature review and noted by a few participants here, when West Indians first started migrating to England in the 1950s and 1960s, work was easy to find but usually only within certain industries. Many of the new migrants were only offered employment in manual occupations, often without regard for their skills (Fryer, 1984; Patterson, 1963), exemplified in Octavia’s and Debbie’s extracts below,

\begin{quote}
Well, I didn’t go to college, I went straight to work. I remember ringing up for a job and when you rang up, of course by now your accent has gone and you’re able to speak a little bit more refined, and then you turn up and they would just say, “oh, oh, so sorry but the job is gone”. But, you know, you’ve invited me for an interview. So you had a lot of that. And then you ended up as a nurse or a nursing auxiliary as you were called then, or work in the hotel or work in the factory because that’s where the multiple of black people were. I ended up working in a factory. I went to work in a factory. (Octavia, 56, migrated at age 10)
\end{quote}

\(^{10}\) Tek – Caribbean dialect for “take”.

96
As soon as they see you and know you’re black, the vacancy is filled. Very, very difficult so you had to take what you got. I worked Brooks laundry for a while checking the clothes when they come in. I work in a shoe factory. I worked in clothes factory where they make uniforms in [place] for the army and all that sort of thing; I worked there. I’ve worked in the bus station and then…little, little jobs. (Debbie, 70, migrated at age 14)

Octavia and Debbie both remember the obvious racism they encountered when looking for work. As a result of the colour bar that was still operating in several industries in the UK, they found themselves in a position of having to take whatever employment was offered. And, further, the systemic racism which operated at the time ensured that many West Indians were kept in these manual occupations for decades and received some of the lowest pay (Paul, 1997). Although some of the participants of this study recalled the ease with which they were able to find work, as seen above, this was not the case for Debbie and Octavia who were initially looking for work outside of the manufacturing industry.

Looking at other aspects of their lives, the participants of this study also discussed the ease with which they were able find places to start their lives in the UK. For instance, Ruby Dee and Ossie spoke about their early days in England,

Ossie: I got nothing against white people ‘cause I grow up with them.
Ruby Dee: Is only when you come here, you realise...I’ve never seen it but I’ve heard about it. People does talk about ...saying how...the race thing...big notices, you know they say no vacancies, don’t they? No vacancies. But these notices in the window… No dogs, the dogs first, mind. No dogs, no black and no Irish. And everybody...I’ve never seen it because in Bath, it wasn’t that bad. We were lucky, we were so lucky that that man who tell Ossie he have to move did me a favour...because we come to [city] and [city] is very conservative, very placid and pleasant people. They might have their way, they might be two-faced…the older people but we never have that bad experience. (Ruby Dee, 72, migrated at age 18; Ossie, 76, migrated at age 22)

As mentioned earlier, Ossie migrated first and initially stayed in London for a few months and it was here that his landlord suggested that settling his family would be easier down in the South West, which is where Ossie moved to before Ruby Dee arrived. The couple provided some insight into why some of participants of this study did not experience the same levels of racism that many others of their generation did. In the extract above, the Ruby Dee discussed that while they heard about the overt racism that many West Indians faced in the UK, they were
somewhat sheltered from it because they were in a smaller city in the South West and were thankful that they escaped the rampant racism of the bigger cities. Martin, who migrated in 1956, also mentioned the protective benefit of the village that he lived in, “Because I was in a little village, you didn't get it so much as if you were in the cities.” These two participants alluded to the protection from racism that living in geographically smaller places afforded. This is in contrast to other research that examined the difficulties that many migrants of colour in the UK faced due to the rife racism at the time (Fryer, 1984; Glass, 1960), discussed earlier. One possible reason for this is that smaller towns and cities did not have as many openly racist groups that were found in the major cities. So, while the South West did have its share of overt racism, as seen in this study, these instances may not have operated in the same way or they did not occur with the same frequency as seen in larger cities.

Much of the research on the experiences of West Indian migrants during this post-war period took place in and around the major cities, like London, Liverpool, Birmingham and Nottingham, that had strong demands for labour and which corresponds to where a large number of West Indians settled at the time (Fryer, 1984; Glass, 1960; Phillips and Phillips, 1999; Sivanandan, 1982). The high demand for labour seen in manufacturing and other manual labour industries was created by an upwardly mobile White population who no longer wanted these jobs and, as a result, ethnic minority populations were needed to fill these voids, resulting in large ethnic minority populations in these bigger cities. During this same time, the South West of England also had a high demand for labour yet did not have the corresponding proportion of people of colour, including West Indians (Peach, 1966). Peach (1966) theorised that West Indian settlement in the South West and other areas of ‘high demand but low ethnic minority population’ was, therefore, due to less outward migration of the White in that region, thereby not leaving much of a labour void for West Indians and other ethnic minority groups to fill. This resulted in lower ethnic minority populations in the South West.

Although discrimination was mainly discussed as occurring in the workplace, experiences of racism also extended to other aspects of daily life. Beulah, for example discussed her experience going about her day-to-day life,
What I notice in the earliest days right, when we came here, when you used to take the buses. When you used to be on the bus, when you go on the bus, they just used to look at you bad and that's all I can 'member but we didn't pay that no mind. They look at you bad like "oooh, black one again" Well, we just think say that's what they say. They just look at us bad and that's what I can remember. (Beulah, 74, migrated at age 20)

And Martin spoke about his experience applying for a mortgage,

And I had problems because in those days in 1965 the banks didn’t want to lend you any money. I had very good job and a letter from the company, couldn’t get a mortgage. I had a feeling is because of my colour. They didn’t come out with it, you could tell, that’s what it was. So the money I had saved, it was in this other building society. I thought well, I’ll try this building society. Went to see the manager, told him what job I had and everything. He said well unfortunately, we can’t give you 90%, we can only give you 80%. I thought, how the hell am I going to make up the difference? (Martin, 77, migrated at age 18)

Frustrated with his experience, Martin went back to the housing agent and explained what was happening; the housing agent, who was White, said that he would help,

Martin: He said, well you got a good job. Tell you what to do, bring me in a couple of your payslips. So I took them down. He said, where did you... I said [name of building society. He said OK, leave it with me. Next week he phone me up, he said, come and see me, I got your mortgage for you. I thought, well nothing to do with...is just purely because I was Black
D: Was able to get it done?
M: He get it done in a week from the same building society I went to. (Martin, 77, migrated at age 18)

In line with other research (Chamberlain, 1999; Fryer, 1984; Glass, 1960), an examination of the participant narratives revealed the kinds of discrimination many endured which ultimately led to wide-spread race-based exclusion from not just the job market, but also from the housing market, thereby contributing to the production and maintenance of social and health inequalities particularly affecting ethnic minority groups (Viruell-Fuentes et al., 2012; Wallace et al., 2016). Although West Indians in the United Kingdom at this time faced exclusion from several aspects of life, their responses to the encountered discrimination and the resources that they draw upon, contribute to their definition of what it means to age healthily. The mechanisms through which these work are discussed in the next chapter.
During the discussions of racism and discrimination, several of the participants stood resolute and said they never let their negative experiences affect them; that they were able to ignore these incidents and keep going on. Gladys provided an example of this,

Gladys: Well they don’t want to work with you or something like that; they don’t want to work with you.

Danielle: And so when you realised that would happen or somebody felt that way, how did that make you feel?

Gladys: Oh no. I still carry on doing my job laughs. And when they see you don’t take any note of them, they soon become friends with you laughs. Oh dear, I think they used to don’t like the blacks laughs. Yes, they soon come friends with you.

(Gladys, 79, migrated at age 24)

Gladys later went on to speak about the strength that her belief in a higher power gave her so that she can stay strong and move past such incidents. This is discussed further in the next chapter.

Martin also spoke about how he and other West Indians in his position dealt with racism in the workplace,

So we had to stand up for ourselves in those days, there was no race relations or nothing like that. So they think it was a joke, you know, so you got to hit back. One thing you was taught to do, not to hit back. But sometimes you thought, well, I got to stand up for yourself and you really had a go at them. This is how we used to deal with it. (Martin, 77, migrated at age 18)

Realising that they were the only ones to advocate for themselves, Martin and others like him realised they needed to take a stand against the unfair treatment they experienced (Sivanandan, 1981). When he spoke about about his experiences with discrimination above, Martin discussed a collective response of “we”. This “collective specialness” is in response to the mistreatment and exclusion of ethnic minorities in daily life (Chamberlain, 1999, p. 262). This response, thus, enhances cohesion within the West Indian community. Octavia also gave us a glimpse of this togetherness in her discussion of how she felt working in places where there were other West Indians around,

I remember there was so much of us again that you felt that protectiveness ‘cause they were the older ones and they were coming down in age. So you didn’t feel like you were outside of the group, you know you were just welcome in the group. And regardless of what the job was, it was a job so you just got on and did what you had to do. (Octavia, 56, migrated at age 10)
In these instances, social networks continue to expand their functions. Above, Octavia linked the support she got from the older members of the West Indian community with helping the younger ones, like herself, to survive in the harsh climate that racism created. Sidney, who migrated in 1954, is currently an active member of a community centre that provides services to older ethnic minority people. Reflecting back on his earlier days he discussed the lack of places for people of colour to socialise in and, therefore, expressed appreciation for his current group, “Yes, it is important to me. You know...they don’t know how this club is good for us.” Such exclusion described by the study participants was a common occurrence for West Indians at this time (Phillips and Phillips, 1999).

Presented with the opportunity to relocate to the UK, the British government facilitated the migration of West Indians to the UK to help fill the labour void left after World War II (Fryer, 1984; Paul, 1997). Being British citizens, West Indians felt entitled to the same privileges afforded to the British people (Fryer, 1984). Instead, after migrating to England, many were met with a hostile racial climate. As such, historical racism continued to pervade British society and resulted in the marginalisation and socioeconomic disadvantage of ethnic minority groups, like West Indians (Gilroy, 2002; Simpson et al., 2010). As these sections explored the earlier lives of West Indian migrants, the next section moves on to examining their present-day lives.

5.4 Later in Life Experiences

Sidney is 85 years old and moved to England from Antigua in 1954 when he was 24 years old. With a mixture of curiosity and a radio prompt, he sold his possessions and bought a one-way ticket for a ship to England. Thinking he would be gone for only five years, he left his wife and children behind and migrated to the South West of England.

Sidney worked in a factory for most of his life and once that closed, went on to work for a dairy company until retirement age. Sidney’s initial plan was to stay in England for five years but he slowly realised that he would never be able to earn enough money to have the life he would want back in Antigua. His wife, instead,
moved over to England. Even after formal retirement, Sidney continued to work and did so for a cleaning company into his early 80s and he also remained an active member of several community-based organisations.

Present day, he remains active in one or two of these groups. In discussing his health in his later years, he did not bring up any specific illness instead, he is particularly thankful when he wakes up to see a new day and is content to await death “until his time comes”. He equates health with happiness and his belief in a higher power, God.

In thinking about his life thus far, Sidney considers England to be his home but that he is really a West Indian. And although he says he never missed living in Antigua, he remembers writing letters to his family ‘when days were dark and cold’. Even though he has no desire to return to Antigua, he still expresses a curiosity about wanting to know about the lives of those who did choose to return to their islands.

Upon reflection, Sidney views his move to England positively and says that England has been good to him.

Similar to Sidney, the majority of the participants in this study only planned to remain in England for a short time yet they have remained here in their older years. The common thread throughout the narratives is that most of the participants, realising that they were not going to earn as much money as they hoped, began to appreciate the life they built England; they made friends, stayed in their jobs, got married and had children. And as they are older, they continue to stay for two main reasons, their health and also because they feel somewhat detached from the countries where they were born.

Other than having their own families here, it was apparent that for several of the interviewees, health was one of the main reasons that many continue to stay in the UK. Discussions with Cicely and Dionne highlighted this,

So that's why I'm so thankful for England, believe me, I am so thankful for England regardless of the issues we may with the health service, we can still get good care and treatment. I feel now that I would rather remain here.
Danielle: Because...?
Cicely: But with the condition, I'm not saying that I can not get medical support in Jamaica, but financially, you have to pay out...your pockets have to be deep. And,
the operation that I've had, if I did not have the funds to put in this consultant hand, the operation would not go forth. So I am pleased, I am pleased to be here (Cicely, 57, Bristol, migrated at age 14).

Danielle: Do you think moving over here has had any impact on your health?
Dionne: At least, put it this way, over here, you pay your national health and you can get...health is free, healthcare. Well, when I say free...you know what I mean. And some of those people who had retire and gone back home, you see them come back to go back to the hospital to get treatment 'cause it's very expensive. So, although we have to pay the National Health Insurance, still we're better off...I am, sorry, better off, I think than if I was there, unless I had big top job. (Dionne, 79, migrated at age 21)

For some of the participants, a return to the Caribbean meant poorer health or earlier death. Poor health and the necessity for quality and affordable treatments and medicine were important for some. But for others, the security of knowing that good care was available in England, should they need, it is essential for maintaining good health.

Another reason why some of the participants have chosen to stay is that when most of them moved here, many never returned to their homes for decades after. Such that when many did finally go back to visit, they felt like they were on holiday, like strangers or tourists. They often remarked on how so many things changed and that people have moved on. Essentially, the home that they once knew was not the same, illustrated by Viola and Josephine during the focus group,

When I go back now to Barbados, I go back to my hometown where I lived with my parents and sister and friends. When I go back there now, all those friends that I went to school with, most of them over here, some of them have died, some move away to other parts of the island. So, when I go back there now, where is everybody gone, is strange. (Viola, Focus Group)

Similarly, for Josephine,

I'm sure it will be different cuz most of my years as an adult was spent here so going back would be completely different. I'm more into this sort of way of life more than the way of life back home. I would find if very difficult to fit back in with everything that's going on there. Yea so this is, home now. My kids are here so this is home. Quite happy here. (Josephine, Focus Group)

Many of these participants have very few relatives or friends left in their home countries, thus, making the move back to their islands not very feasible and potentially a lonely endeavour. This aside, many described themselves as being
happy with their move to England. For example, in Martin’s later years, he was elected to leadership positions in local government and attributes the successes that he has had to him moving and taking advantage of the different opportunities in England,

Danielle: What do you think has been the impact on your life of moving over here?
Martin: Well I think it shaped my life, inasmuch, I was young enough to help...it helped me to shape my life. It made me grow up pretty fast and that’s because I never had any family over here. So, it shaped my life and it made my life a lot better. You know, I don’t think I would have reached the heights I would have reached here if I was in Barbados. (Martin, 77, migrated at age 18)

Martin’s attitude reflects the overall feeling of the group regarding their sentiments about their lives in the United Kingdom; most of the participants were happy they migrated.

5.5 Chapter Summary

One of the goals of this study was to explore how the process of migration can affect perceptions of healthy ageing. As such, this chapter presented the life course experiences of migration of older West Indians in the South West of England. The first part of this chapter discussed the motivations for and expectations of migration and, by and large, found that the family played a vital role in facilitating the move. Once in the UK, the family role expanded and wider networks develops which became instrumental for helping the new migrants navigate their new environment and settle into their lives. Upon arrival, the narratives revealed tensions in expectations as many, although stating they had none, were disappointed by what they arrived to. Contributing to this disappointment was an atmosphere of hostility towards the migrants as well as the systematic limitation of opportunities for social and economic advancement of people of colour, including West Indians. This disappointment worked to further cement the importance of social networks at this time in helping the participants of this study build a strong and resistant West Indian community and to maintain their connections with their Caribbean roots. The process of moving, the experience of being in a new country, finding solace and company in the company of similar others, and the ability to share the different experiences all work to create somewhat of a shared identity. In coping with difficult circumstances, the
participants of this study also depended on their own will to move past these difficulties in conjunction with their belief in a higher power.

Drawing on the principles of critical race theory and understanding that the experiences of the participants of this study were shaped by their intersecting social locations of migrant status, skin colour and socioeconomic class, we are in a better position to appreciate how these associated experiences contribute to their definition of healthy ageing. Highlighting and tying together their experiences over the life course will bring together a picture of what is important to the health and well-being of this group of West Indians. As we look a little closer into whom the research participants are, it is easy to see similarities between them when looking at the things that motivate them, the things they consider important in life and what makes them happy. When starting a new life in England, they often encountered several difficulties, whether it was trying to make ends meet or the racism and discrimination they faced, they all credited their own resolve and determination for keeping them going despite their hardships. Additionally, they all understood that the support they received from their networks was instrumental in helping them get settled in their new lives.

When considering the hardships they have faced, most of the participants indicated that being able to stand up for yourself and knowing how to make the best of situations as part of the reason they were able to persevere during hard times. Additionally, they acknowledged that having their own families to take care of as the added motivating factor to persist with going on. Also key in helping them get through their hard times was their belief in a higher power. Here, their religion was often a source of strength and comfort to draw on. A few of the participants also added that having an overall purpose, that is, knowing that you want from life, as a good motivating factor when times got tough. For many of these participants, the move to England was a gamble on the unknown, whether it was for family reunification, whether to intentionally build a new life or whether to fulfil curiosity. Whether the plan was to stay for five years or not to have a plan at all, these individuals ended up staying a lifetime, majority of whom not knowing if they will see their homes again.
This chapter of the discussion highlighted that the combination of their experiences across the life course along with their (1) social networks, (2) personal resolve and (3) their belief in a higher power worked together to help these women and men build resilience throughout the years and, therefore, contribute to their definition of healthy ageing. This chapter explored the experiences of a group of West Indians now living in the UK and identified factors used in the construction of healthy ageing for this group. With this, the next chapter will present the discussion on how these factors work in building perceptions of healthy ageing and, therefore, resilience.
Chapter 6  Resilient Ageing

6.1 Introduction

The previous chapter highlighted the ways in which the process of migration has impacted the present-day lives of older Caribbean women and men. The chapter drew on the life course framework and critical race theory to examine the different events in the participants’ lives that eventually shaped who they are today and, subsequently, how they viewed their health in relation to growing older. Therefore, I assert that there are certain events and processes that occurred throughout different stages of the participants’ process of migration that actively contributed to their construction healthy ageing. Based on the discussion from the preceding chapter, I conclude that the following factors are important attributes to their definition health: (1) their social networks, (2) having a positive mind-set and (3) their belief in a higher power. This chapter extends this discussion further by highlighting an additional element in their definition of healthy ageing: (4) engagement with their communities and other activities.

Discourse surrounding the health of older people frequently discusses their health in tandem with concepts such as successful ageing, active ageing and positive ageing (Foster and Walker, 2015; Rowe and Kahn, 1997). As discussed in Chapter 2, these concepts will all be referred to as ‘healthy ageing’. The concepts under the term of healthy ageing suggest that as people get older, they should strive for optimal physical, mental and social health and well-being while the presence of disease and disability disqualifies an individual from having aged healthily or successfully. In line with other research (Bowling, 2005; Cho et al., 2012; Martinson and Berridge, 2014; Minkler and Fadem, 2002; Montross et al., 2006; Romo et al., 2013; Strawbridge et al., 2002) this thesis argues that such terms are too restrictive and also set unrealistic standards for ageing as they do not consider the numerous influences over the life course that can influence the way a person thinks about their health as they get older including, for example, the processes of migration, experiences of discrimination or the socioeconomic situation of the individual. This chapter explores the concept of resilient ageing as
a way of understanding the definition of health for older people. When applied to the older population, resilience, like critical race theory, acknowledges the multiple and intersecting social locations, like ethnicity or socioeconomic status, that individuals may occupy and the potential impact on health and, importantly, it does not exclude those with chronic illness or disabilities (Braudy Harris, 2008). When the concept of resilience of applied to this study population, I will be able to highlight the different factors (risks, assets, vulnerabilities) important to their healthy ageing and also understand how they work together to build their definition of healthy ageing. And in keeping with the main goal of critical race theory, that of social justice, highlighting the factors associated with resilient ageing will allow those working within these communities to understand and better serve the needs of these communities.

In this chapter, I suggest that concepts related to the health and well-being of people as they age need to acknowledge the different experiences that people have had throughout their life course and the resulting impact on perceptions of healthy ageing. Additionally, definitions of healthy ageing should be expanded to consider the ways in which people with differing physical abilities and those with chronic illnesses can live happily and also remain fully engaged with life. Resilient ageing offers a critical view of ageing as it as it forefronts the interests and perspectives of older people and it places value on the historical and social context in which people have lived their lives, while advocating for social transformation.

The previous chapter identified elements that were used in the construction of healthy ageing by West Indians growing older in the South West of England. As such, the goal of this chapter is to examine how these elements work, via the concept of resilience, to build the definition of healthy ageing for these individuals. Doing so will, therefore, add to the body of literature on resilient ageing in both critical race studies and critical gerontology.

6.2 Healthy Ageing Means Being Able to Participate

Illness and physical disability are not the only ways to think about health and, across the migration life course, this group did not define their health only in these
terms. For instance, health was discussed as being able to maintain a sense of independence. Phylisia, for example, acknowledged that she may need to ask for assistance, but does not like the feeling of needing someone,

It means the world to me because then I can get about, I don't like to be depending on people. If I ask you to do something and you don't do it, I get up and do it myself. I ain't asking you three and four times, I just get up and do...I'm a very independent person. (Phylisia, 75 years, migrated at age 22)

Frederick echoed similar sentiments,

Oh, well, I wouldn't call myself sick even though I got…providing I can go long and you know get around and haven't got to ask anybody to help me across the street and things like that, that's what I pray for until the day I go. So long as I can do something for myself and even help others, and haven't got to depend on others to do things for me, that's my goal. (Frederick, 73, migrated at age 20)

Other participants shared sentiments similar to those of Phylisia and Frederick, that an important component of good health was being self-reliant especially as it related to mobility and getting tasks done. Additionally, most of the participants, regardless of their current physical condition, considered themselves to be in either good or moderate health. For many of these individuals, their definition of health was not simply about the absence of presence of disease. Cicely, for example, is diabetic and has had several surgeries for her vascular issues that left her with less mobility. Despite this, she said,

Health is, obviously, the most important thing. I believe I still have reasonable health, regardless of what I have been through and umm I’m going to enjoy it as much as I can and be thankful, thankful for what people can do for me, be thankful for what I can do for others, even with my limitations, you know. (Cicely, 57, migrated at age 14)

Phylisia also shared similar sentiments regarding her health even though she suffered from several health conditions,

Otherwise, I'm in great health because I did have a cancer scare a few years ago. I've had deep vein thrombosis three times last year, which was out of the blue, I didn't fly anywhere, I didn't go any long journey. And I was hospitalised for about a week I think. But that's the only one that weighs heavily sometimes on my mind, the deep vein thrombosis. And now I'm on warfarin for the rest of my life (Phylisia, 75, Bath, migrated at age 22).
Cicely and Phylicia are two of examples of how most of the participants viewed their health. They expressed a positive attitude while they acknowledged their illnesses and associated experiences, which research has suggested helps to build resilience as people get older (Wiles et al., 2012). Debbie, who has several health issues, also demonstrated this positivity, “My health is not that good. But you know what, I'm alive and, you know, that's all that is in life” (Debbie, 70, migrated at age 14).

In the examples above, these participants did not solely define their health in terms of their illnesses and limitations, as with traditional definitions of successful ageing (Rowe and Kahn, 1997). Instead, they redefined what successful ageing meant to them and they accepted their limitations, adapted accordingly and focussed what they were still able to accomplish, which has also been seen in other research seeking to understand healthy ageing from the perspective of older people (Cho et al., 2012; von Faber et al., 2001; Romo et al., 2013).

6.2.1 Doing Things for Themselves and Doing Things for Others

As discussed above, an important aspect of the participants’ definition of health was about remaining engaged with life and their chosen activities, as was explained by Viola, “Well, I say you're retired from your day job as a 9-5 job or something like that but you're not retired from moving about” (Viola, 73 years, migrated at age 21). Part of the definition of being healthy was still being able to take part in the activities they valued; this was expressed by members of the focus group,

Danielle: So, then what does being healthy mean to you?
Josephine: No pain.
Darlene: No pain. No pain.
Odetta: Or that you can walk about.
Darlene: You can eat and drink, enjoy the family, enjoy the grandchildren, you know. Really, yes. Travel as you want to. Cook when you want to. And most of all, worship the Lord, that’s the main thing out of all that we’ve got in this world. (Focus Group)

While the focus group participants did express the importance of the physical aspect of health, via mobility and being pain free, they also emphasised that being
healthy was about involvement in their activities, doing so on their own terms and when they wanted; not being dictated to by their ailments and associated pain.

Martin also directly attributed his involvement in his activities to good health,

Well, I was always active. Umm, but gradually you get older, you start to slow down and bit and I think you notice a change when you start to slow down. I didn’t notice any change ‘cause I used to do a lot of work up in the cricket field…I used to do all the pitch. I didn’t get any help, cut the grass, roll the pitch. So, I was very active. I got piece of land at the back of my house, that I plant different things in it, food; that keep me going. (Martin, 77, migrated at age 18)

Martin’s activities, whether at home or for his cricket club, keep him busy such that he did not notice signs of age-related slowing down.

Similarly, Ruby Dee and Ossie also tie their health to their activities. Rudy Dee explained that while there are days that she does not feel like getting up, she knows she has to as there are people depending on her in her various roles and, as such, she uses this as some of her motivation to get up and get out. She explained this while she discussed her volunteer role as one of the cooks at her community organisation,

I do the two days, Monday and Friday. ‘Cause is a lot in the kitchen. I enjoy doing it! I love getting up and getting myself...if I stay home, I probably would stay in bed all day, watch television, do my housework and start muffled, you know. And at our age, we don't need to go down that road, miserable, don't want to go out. (Ruby Dee, 72, migrated at age 18)

Ruby Dee and Ossie lead active lives within their community. Ruby Dee is a health care volunteer while Ossie volunteers with his local car racing association; interests they have been pursuing for several years. With this couple in particular, the significance of volunteering in their lives was apparent as they mentioned their activities within the first few minutes of their interview, especially regarding what made them happy and contributed to their well-being, also noted in other research (Borgonovi, 2008). Especially for older adults who have experienced major life changes including bereavement or retirement, volunteering is important to well-being as it helps to maintain a sense of identity and purpose in life (Greenfield and Marks, 2004). This is illustrated by the extracts below during discussions about volunteering activities,
Danielle: And then are you both retired, are you working part-time?
Ruby Dee: Retired, we're both retired.
Ossie: Well, we do work without pay.
Ruby Dee: A lot of voluntary work, that’s how you found me at [community organisation]. (Ruby Dee, 72, migrated at age 18; Ossie 76, migrated at age 22)

Ruby Dee and Ossie spoke about their volunteering regarding their employment status and indicated that they considered their activities as still contributing to society. And Cicely, below, also placed value on her volunteering activity as she recently became involved in a charity working with older members of the community. Instead of letting her mobility issues get in her way, she focused on the ways that she can still contribute to society,

…I saw they’re looking for people to probably be befrienders. And I’m saying, there’s nothing wrong with me, I may have a little bit of limitations and I may have appointments at the [hospital], etc. but I can talk, my mouth works fully, my hands work, my smile is fantastic. (Cicely, 57, migrated at age 14)

Volunteering has an important function in the lives of these participants: the participants are contributing their specific skill-set to their communities, which acts as a way for them to maintain their identity and enhance their sense of belonging in their communities (Wiles and Jayasinha, 2013) and as well as expanding social networks (Onyx and Warburton, 2003) which can, therefore, work to prevent social isolation.

The activities of this group ranged from drama groups and civic engagement groups to volunteering in the health and social sectors. When the participants spoke about their extracurricular activities, their faces came alive and it became apparent that their activities and groups are a source of pride in their lives. Going beyond this, it is evident that some individuals in this study perceived their health as participation in activities of their choosing by linking their activities, whether volunteering with the local health services or keeping a backyard garden, to the maintenance of health and happiness. Given that West Indian elders in the UK have high levels of loneliness reported (Victor, Burholt, et al., 2012), it is especially important that these participants are socially active. For this group, participation in their activities meant that although most of these people are retired, they still engaged and active in society. This kind of social participation is
an important determinant of health (Holt-Lunstad et al., 2015) and overall well-being (Forsman et al., 2013).

6.2.2 Activities Build Resilience

It is evident that the participants of this study greatly valued their participation in their chosen activities, especially in their later years. Being able to partake in activities when they wanted to was especially important to them. Also of significance, was the impact of their volunteering activities. In these instances, the effects of volunteering were two-fold: (1) the participants were able to keep contributing to society even though they were retired and (2) volunteering their time and skills added to their happiness. Closely linked with involvement in various activities, the participants also emphasised the importance of the social engagement they received from taking part in their different activities, which will be discussed in the following section.

6.3 Healthy Ageing Means Feeling Connected to Others

This section explores the ways in which the participants spoke about their social connections and the relationship to health. For the purpose of this study, social ties or social connections will be defined as (adapted from Thoits (2011)) connections with other people through membership in groups, whether family and friends, or through membership in organisations (community-based, religious, etc.). Social support refers to functions performed for or assistance given to, either perceived or enacted, an individual by someone they are socially connected to.

In the context of their reception to England, social support was vital to the participants’ experience of settling into their new homes and building their lives (Phillips and Phillips, 1999), whether or not they expected to migrate permanently. These social connections and the resulting support still play a significant role in the lives of this group of West Indians and iterates itself in different ways, mainly through community ties and family networks. As demonstrated in Section 5.2 of Chapter 5, having strong social networks post-
migration helps to ensure a smoother settlement and establishment (Klinthall and Urban, 2016), especially regarding the widespread discrimination many West Indians, like the participants of this study, faced (Phillips and Phillips, 1999; Sivanandan, 1981).

6.3.1 Social Networks in Childhood

As discussed in Chapter 5, for many of people who migrated in the post-war years did so to take advantage of economic opportunities that life in the UK promised. Adults often journeyed to over alone to then be followed by other family members, their spouses and their children. In this study, four of the participants migrated during their adolescent years to join parents who were already in England. As such, their grandparents in the Caribbean raised them. ‘Barrel children’, was a term coined to describe people like Billie, Octavia and Cicely, who stayed in the Caribbean and were raised by close relatives, as their parents migrated to larger countries (Crawford –Brown, 1994). In this early part of the migration life course, the importance of the social network begins to take shape with the grandparents stepping in to play the role of parents. With some children experiencing feelings of loneliness, abandonment and lowered self-esteem, it has been suggested that ‘barrel children’ more likely to exhibit a range of mental health and emotional challenges (Crawford –Brown, 1994; Dillon and Walsh, 2012). For adults emigrating, leaving their children behind was no easy decision and parents still tried to provide support for their children while living apart and often sent letters and clothing (Smith et al., 2004); seen in Cicely’s case,

I pause my mom always did keep in touch, we had letters every month. She told us about the rest of the children that one day we would come along to meet and be with and there was a parcel sent for us every month with goodies and clothes. (Cicely, 57, migrated at age 14)

And like Phylicia, who sent packages back to the daughter she left behind in the Caribbean,

And we sent home clothes parcels for the family and for my daughter that I left there. So everything I bought for the daughter that I had here, I would buy another version and send it down, with a couple of things and send down. So they would have the same clothes. (Phylicia, 75, migrated at age 22)
Even with the letters and material support, the children left behind often viewed their parents as strangers (Lashley, 2000), which in many cases, highlighted by Octavia and Cicely in the previous chapter, made reunification difficult (Thrasher and Anderson, 1988). For the children, learning to cope with their new lives and associated feelings of uncertainty and sadness meant having to subdue these feelings and get on with life. Octavia, for example, went on to say that the feelings of loneliness and isolation eventually waned when she became familiar with her neighbours and started school where she became friends with other West Indian children, thereby building her social network. She says,

I think by the time I got into school and, you know, you started to meet other people and then you started to see other children who had come over, like yourself, and then you had something to talk about. And then we did have that connection because there was another family, and the children, the daughters had come over, so you had that. (Octavia, 56, migrated at age 10).

In thinking retrospectively about her transition to life in England, Octavia acknowledged how important arriving to an already established network was and having similar others that she could relate to. Although the move from familiar to unfamiliar surroundings can have negative consequences on a child, meeting and building a network of other children with a similar background can help to ease feelings of isolation, as explained by Octavia, and this kind of social integration, especially in adolescence exerts a positive effect on physical health (Yang et al., 2016). Strong social networks, such as the ones that were formed early on for these participants, have been shown to build resilience (Browne-Yung et al., 2015), especially by mediating the effects of stressful experiences like migration. These social networks helped the adolescent participants realise that in a country where they were a visible minority, there were others in a similar position. Octavia discussed the importance of being taken under the wings of the older West Indian children and that once these relationships were established, it felt like having kin soon thereafter. Additionally, she spoke about the way social networks acted as protection or a buffer against some of the racism, discussed in Section 5.3 in Chapter 5, that the participants experienced and, further, that these networks served this purpose for both children and adults. The importance of the social networks that Octavia, Billie and Cicely have built as children continued to play vital roles throughout their lives and even today.
6.3.2 Social Networks in Adulthood

In the section above, we saw the consequences of the disruption of a child’s social network and how it important it was for them to feel connected to their families once in their new homes. By its very nature, the process of migration involves uprooting lives and leaving behind important relationships and, based on the participants’ narratives, this has been one of the biggest changes in their lives. Therefore, moving to a community of others who have had similar experiences and staying within that community, at that time, gave the newcomers a sense of familiarity and then later in life, the continuity and stability that the earlier migration process took from them. Several participants discussed that, at the time, knowing that there was a network of people already waiting for them helped to ease the anxiety of moving to a new country helped with daily aspects of life, like finding employment and housing, were made significantly easier (Fryer, 1984; Phillips and Phillips, 1999).

The importance of social networks in the early days

Most of the participants in this study travelled to the United Kingdom either with family, friends or spouses or they arrived to families or friends waiting for them. As demonstrated in the preceding chapter, the social networks of the study participants made settling into their UK lives easier. For example, Frederick, who moved to England when he was 20, was able to find a job quickly due, in part, to his brother’s connections. Likewise, Ruby Dee and Ossie shared similar sentiments regarding the importance of having a network when they arrived. Ossie, who migrated first, spent a short time in London and gave credit to his network of friends for helping him find employment and housing for his family in the southwest where they eventually settled. Once Ruby Dee and their daughter arrived a few months later, Ossie was in their new home awaiting their arrival and was already living in a community made up predominantly of West Indians. Just like Octavia and several other study participants, they live in the same community to this day, highlighting the importance of stable social networks for migrants (Chamberlain, 1999).
What resonates throughout Ruby Dee’s and Ossie’s interview is how pivotal a role their social ties have played throughout their lives since moving to England, especially regarding the practical support they received. Having people around who were in a similar situation built a high level of camaraderie where they all provided support to each other, for example, during child rearing. In most cases, both parents (or the lone parent) always had to work and so having friends and family around who were also in the same situation to keep an eye on the children helped tremendously (Chamberlain, 2011). Ruby Dee expressed gratitude for the support she and the other West Indian families living in the same neighbourhood provided to each other when they were newcomers to their English communities,

‘Cause we were lucky again in that section, when we lived at [location], I was the youngest one there and was a mixture of nations. We had people from Barbados, people from Jamaica, people from St. Lucia and then Ossie and I from Trinidad. And we became a family unit. We didn’t care where you come from, everybody look after each other. My friend, [name], lived at [location] and she would come and help me with the children, then [name], another Bajan lady, look after each other’s children. So, we have the help once we get to know them, so we were lucky, we have that family circle all in [location]. ‘Cause we brought up the children together and so we have some help in that way.” (Ruby Dee, 72, migrated at age 18)

The Caribbean networks formed during this time were invaluable in providing various levels of support to each other, especially those who newly arrived (Chamberlain, 1999). Rudy Dee continued to speak about how grateful she was for her neighbours as they were willing and able to help them adjust to different aspects of life in England,

They would look out for us. And we were young, we only just come, we were latecomers. And they were here longer than we were, and they take us under their wings and take us shopping, show me where to get things and how to count the money and things like that. (Ruby Dee, 72, migrated at age 18)

It is evident just how much Ruby Dee and Ossie, with the dual pressure of having to adjust to new life and being a young family, appreciated the support their West Indian neighbours gave to them. In-turn, they have since provided similar assistance for families that have come after them. Helping other West Indians is still an important part of their lives today as they count several people unrelated to them as their adopted grandchildren,

[Friend] and [friend], which is some Trinidadians I adopt. I adopt 18 of them. Everybody call me granny…’you gotta meet granny, she's fantastic lady’. Then
[friend] say, granny, I bring you another granddaughter or grandson. Full house, which is so nice. A pity I can't adopt you laughs. (Ruby Dee, 72, migrated at age 18)

Although at the time of the interview, which took place at their home, I only recently met the couple and once the interview was over, they invited me to stay for lunch. “Adopting” their “grandchildren” and feeding me, i.e. a West Indian away from her home and family, was their way of ‘paying it forward’ to others within the Caribbean community (Chamberlain, 1999).

The importance of social networks after they have settled in

Even as the interviewees have settled into new lives and have lived in England for a few years, the support from their social connections continued to be just as important as when they first arrived. Frederick discussed some of the things that kept him happy and motivated during these years,

Because we didn't have no money and we all come from the West Indies. We didn't know a lot of people really. We get together more. It hadn't got to be a function. Even when we are starving and tings\(^\text{11}\) like that, we could just phone up a friend say, what you doing, man. I say, well mi no dey pan nutten\(^\text{12}\), you know. Meet you round the pub? You go 'round and have a few drinks, you know. It was a nice experience. (Frederick, 73, migrated at age 20)

Although he spoke about his financial struggles during his early years in England, his friendships with other West Indians were important to him as they helped to build morale and made the hard times more enjoyable. It was these hard times that seemed to keep Frederick and his West Indian community together as they focused more on the positive features of life and less on the negative aspects of their situation. As was previously discussed in Section 5.3 of Chapter 5, some of the study participants recalled systematic discrimination they faced in several aspects of life, which operated to keep them in the lower socioeconomic brackets by limiting their inclusion in the financial, employment, social and housing sectors (Fryer, 1984; Patterson, 2004).

The prevalent discrimination that many people of colour faced throughout the years prompted members of these communities to join together to form

\(^{11}\) tings - Caribbean dialect for ‘things’.

\(^{12}\) mi no dey pan nutten – Caribbean dialect for ‘I don’t have anything planned’.
employment unions, savings clubs (Phillips and Phillips, 1999; Sivanandan, 1981) and to create their own spaces for socialising (Augoustinos and Reynolds, 2001; Field et al., 2015). During these times, spaces where ethnic minority groups, like West Indians, could meet together became (and remain) important in helping to maintain identity, through providing emotional and practical support to members, providing a unified voice for the community and, thus, promoting community cohesion (Lambeth Council, 2013; Wiles and Jayasinha, 2013). With this, having a strong social network, as mentioned earlier, helps to build resilience as does having a positive attitude (Browne-Yung et al., 2015), exhibited by Frederick and several of the other participants of this study.

As seen above, the interactions within the social networks like the ones built by this group of West Indians provided protection from racial harassment. While many of the interviewees maintained that they have had primarily positive experiences living in the UK, they acknowledged that this was due to having close connections with their friends and family once they arrived. Viola best illustrated this,

> I never had any really bad experience ‘cause when I came, I came to friends and family ‘cause I had family that I stayed with and then I had friends in [city] and I started working. It wasn't too bad to get a job. I started working at an old people's home in Leicester and we were with friends so we was quite happy. (Viola, 73, migrated at age 21)

Octavia, however, spoke about her experiences with racial harassment. For her, the support from her network of friends, both perceived and enacted, was invaluable. In a discussion about the racial harassment she faced, she spoke about having a strategy to help cope with those experiences and relying on her social ties was one such approach,

> Because you still had your community, you still had your group of friends that you could meet up with, you know, you could go out, you could laugh it off, you could talk about it or, you know, share something. Or you know that if you were going somewhere, you'd go as a group, especially in the evening, you weren’t gonna be going on your own and if you did, you were just taking a chance and sometimes that chance worked, you got home safely. (Octavia, 56, migrated at the age of 10)

In addition to having an impact on health, an individual’s social ties have a protective effect from the consequences of social stress like discrimination, as
seen above in Octavia’s discussion. The significance of this is that the stress associated with such experiences is less likely to have a negative impact on the individual’s health (Mossakowski and Zhang, 2014). While there other studies that report mixed findings, they still conclude that some form of social support, whether emotional or practical, acts as a buffer from discrimination (Ajrouch et al., 2010; Gee et al., 2006), which Octavia clearly identified in the passage above.

As friends were made and roots set down in the communities, spending considerable amounts of time with other West Indians became part of their lives as new migrants. Frederick does go on to say, however, that in the earlier years, the West Indian community was more tight-knit than it is now, as explained,

> I think in the old days really, West Indians were more together...because we didn't have no money and we all come from the West Indies. We didn't know a lot of people really. (Frederick, 73, migrated at age 20)

He added that as people grew more financially independent, they spent less time together. As a consequence, this resulted in less of a community spirit, especially when compared to the earlier years. Octavia, whom arrived later and is younger than most of the participants, echoed similar sentiments when she spoke about the West Indians who arrived in the years before she did. She said,

> And I think that in their time, they just got by and they did better than us, I would tell them that now. Because when they come and they had to live together, they ate together, they shared together, they socialised together, they had more of a community together but something happened with them. Because once everybody had their own place or had money in the bank, they started to change. (Octavia, 56, migrated at age 10)

Though it may appear that the West Indian community was losing touch with each other, an alternative explanation could be that the way that this community has socialised has changed. When this group of West Indians first arrived, most of them immediately became assimilated into the existing networks of their friends and families, resulting in dependence on these social connections for different types of support (Chamberlain, 1999). There were very few Caribbean-specific clubs for this group to socialise in which, therefore meant that they mainly socialised at each other’s homes. Thus, the absorption into existing co-ethnic networks combined with the interdependence on each other resulted in a very
tight-knit community. But as participants of this study began to work, raise their own families and become more settled into life in England, priorities began to change and so spending a great deal of time socialising, though still important, did not occur as often. Although members of this community did not socialise in the same ways as before, having a network still played a significant part of their lives.

The support function of social networks is important even as they have long settled into their lives in the UK. Although the years passed by and the study participants have long established their presence, the emotional support given by social networks continued to be important. The story of Ruby Dee and Ossie best embodies this. They counted the outpouring of support they received, not just from their West Indian friends, but also from their wider community as a large part of the reason they were able to cope when their daughter died. While this life-changing event happened several years after they moved to England and had settled into their community, they continued to count their social networks as important,

And I think, if it wasn't for the community of [location], the way they treated us, we wouldn't have survived ‘cause we wasn't sure how we was gonna cope. We were never alone (emphasis), we were never alone and it's amazing. And I always would say to anybody, the support that [the community] gave Ossie and I when [daughter] passed, is one in million. If anybody would have given me a million dollars and I didn't have those people around me, it would have been nothing. They were there...it was like a cushion, a bit of cotton wool around us and was there for all of us, and that was something we could never (emphasis) ever forget and can't thank them enough for it. (Ruby Dee, 72, migrated at age 18)

The significance of social support is exemplified in Ruby Dee’s quote above where she very clearly attributes their ability to cope with their loss to the support they received from their community. Knowing that there is a support network has been found to be particularly beneficial to health in older adults (Yang et al., 2016), discussed in the section below.

Social networks in their later years

In their retirement years, the social health of the participants involves, in part, reinforcing family bonds through spending time with the family, especially their grandchildren. Several participants demonstrated this when they spoke about the
importance of their families in their later stage of life, in both giving and receiving care. Frederick and Ossie, for example, both spoke about the fulfilment they received from their duties in helping to take care of their grandchildren. The joy of family-time was illustrated in this exchange between Ruby Dee and Ossie as they spoke about their grand-parent duties,

Ruby Dee: So, she [their daughter] take him to school in the morning and we pick him up and keep him Thursday and Friday and that's Ossie's job. That's granpy's job, that's his buddy. And if he's not there, if I go and pick him up...laughs. If I pick him up and he say, "where's granpy?" He's at home. He's not happy unless he's got his granpy with him.
Ossie: When he come to sleep here at night, he go to sleep with me.
Ruby Dee: I get kicked out of my bed!
Ossie: She got to leave go to spare room! laughs

When asked what made him happy, Ossie explained that a large part of it was being able to assist with childcare duties for his grandson. And similarly, for Frederick, he spoke of his grandchildren being his motivation in life and spoke fondly about taking his granddaughter to her swimming lessons and picking his grandchildren up to attend church.

Many of the participants also discussed the importance of having family to depend on in their time of need or ill-health. For Ethel, who is divorced, and for Gladys and Martin, both of whom have been widowed, they depend even more so on the visits and assistance from their families as they now live alone. Ethel, for example, is extremely proud of the family she has raised. She had a particularly difficult life with many sacrifices made in order to raise her children in the best way possible. In the course of her interview, we discussed her current health issues that led to her retirement and the assistance she receives from her family,

I have my first granddaughter, she's 39 next month. She comes up every Thursday and put me in the bath, scrub my back laughs and she come and help to tidy up the place 'cause I can't reach things as I'd like to and umm well, I suppose is old age bringing all these little...but I'm happy, very happy. (Ethel, 82, migrated at age 27)

Throughout the interview, it is clear that Ethel views herself as being strong-willed and is proud of her independence, yet she still valued the visits and help from her family, as shown in the quote above. These visits give her a sense of belonging. Similarly, for Ruby Dee and Ossie, when asked if they have any
concerns for their health as they get older, they are confident that they can rely on their daughters and their friends,

Well, not really ‘cause if anything did happen to any of us, we got [daughter], she's our backbone, that's the middle daughter, she's there at the beck and call. And [friend], she used to be police in London, she retired and she decide to move nearer to us. That's a bus ride. So, if anything happen to Ossie or me, it would take her less than an hour to get here. And [daughter] just at the back there. And Octavia and them there [friends at her community group], only a phone call away. (Ruby Dee, 72, migrated at age 18)

Just like Rudy Dee, Ethel and many of the other participants, perceiving social support and simply knowing that there are family members or other people they can depend on should it become necessary eases potential worry, limits stress, which can then have a positive impact on their health (Sheffler and Sachs-Ericsson, 2015).

The benefits of the perceived social support seen above extend beyond the family to the wider community, specifically to group membership. Throughout the interviews, it became apparent that participants utilised their group membership status for another purpose in that they formed a security network amongst themselves. During the focus group, for example, Viola explained,

Like, we came here today, and we know who is usually here and is one person that is always here and as soon as we come today he wasn't at that table. Where is he? He just happened to be in London, [name] he's just gone to London. But everybody come in and, where is he, where is he? If you don't see someone you usually see here, you'll hear they've had an appointment, they've gone away or something. Last weekend, I was going away and I let everybody know I wasn't going to be here because then everybody will be, where...you know. You miss people when they're not around. (Viola, 73, migrated at age 21)

In addition, to their much-valued friendships, the group members felt a sense of responsibility to each other in that they let each other know when they expect to be absent from the group. While this type of practical support is important, it is the perception of this support where the benefits are reaped for health (Sheffler and Sachs-Ericsson, 2015). Knowing that this type of support is available lessens the worry on the individual should something go wrong. Therefore, their perception of health is linked with their awareness of a support network, as Viola illustrated above.
Unlike all the other participants, Martin lived most of his years in a small village in South West England. When he discussed the difference between living in the city and living in a village, he focused on his social engagement. Later in the interview, I asked him what happiness meant to him, to which he responded and said that happiness was establishing himself in the village and subsequently getting married to a girl whom he met during their time in the church choir. When asked about the experience of courting his now wife, who was White, he explained,

It was and it wasn't [controversial]. Controversial in that some of the residents used to look at you. It wasn't so controversial once I was introduced to her parents. I thought it might be 'cause these little things in the village always, you know, spread. But because I was well-established through the cricket team, I knew quite a lot of English people and a lot of them was my friends, that's why. So, I used to mix in a good circle of people. So, I used to play cricket most of the times. So, I used to be with mostly a lot of English people most of the time. More than black people actually. (Martin, 77, migrated at age 18)

Here, Martin’s engagement in his community activities helped him establish himself in his village, which then led to the acceptance of his relationship with a White English woman. Martin actively participated in West Indian organisations as well as activities outside of the West Indian community. In addition to being active in his local church and village cricket club, he was elected as shop steward and later went on to become branch chairman of his trade union. He was also the first and “the only Black” person to hold the position of chair of his county’s council and he also held the position of councillor of his political party’s local branch. Though he has given up many of his activities, Martin was still very engaged in local politics and civic organisations and attributed his time spent in all of his activities as the reason for him leading a happy, successful and healthy life. For Martin, and several other study participants, remaining engaged with activities of their choosing builds resilience and, therefore, adds to their definition of healthy ageing.

As discussed in Methodology chapter, all of the participants (except Martin) were recruited through community organisations in Bristol and Bath in the South West of England. Both of these organisations provide a space for daily or weekly gatherings where members not only sit and talk but they also participate in
exercise classes, song and dance sessions, arts and crafts. They also provide outreach services, such as bereavement support and companionship, for members of the wider community should they need it.

The overwhelming majority of the study participants counted their participation in the community group as important to their health and overall well-being, which has been reported elsewhere (Lyons et al., 2016). As an example, when asked about what her participation in her community group meant, Cicely said,

You're with people. You can talk. You can laugh. Ummm there's the music and exercise, there's the singing and it gets you out of the house. You're there sitting on the sofa, you're watching the television and umm maybe you waiting for the phone to ring, maybe it never rings. You too can maybe pick up the phone and say hi to somebody but it's good come out the house. It's exercise for me, you know? And it just keeps me alive, keeps me alive, you know, the fresh air in my lungs, everything. (Cicely, 57, migrated at age 14)

Cicely has undergone several major surgeries that have left her with severe mobility issues at the age of 57. Cicely’s immense appreciation for her community group is likely due to her having to completely readjust her life in order to accommodate her limited mobility. Therefore, the seemingly simple act of being able to come out of the house to meet up with friends is tremendously important to her, which has positive impacts on health, especially as adults get older (Haslam et al., 2014). For Cicely, her definition of health has shifted towards what she is still able to do (discussed in an earlier section) as well as her participation in her group, which she has linked to her health.

Participating in community groups served another function beyond social engagement. Sidney provided insight into this at the end of his interview when he was given the opportunity to add any final thoughts. One of the things he brought up was the significance of his community group present-day,

Once upon a time, we didn’t have, when we go to meeting or we go out, we didn’t have this club...we didn’t have a club, only Percy's. We go to Bristol, we go to dance in Bristol, we go to London, we go to Birmingham. But we didn’t have a club, this is our [emphasis] club now (referring to his community group). (Sidney, 84, migrated at age 24)
Sidney went on to speak about the limited number of social groups and meeting spaces that served the Caribbean community when he migrated to the UK in the 1950s, also noted elsewhere (Phillips and Phillips, 1999). His appreciation for his current community group was due to him, and others like him, being excluded from several aspects of society. This kind of gratitude was observed during fieldwork for this study when several of the interviewees expressed their appreciation at being able to have a space where they can share in memories of “the old days”, organise and participate in cultural activities and celebrations and, in general, have a space that is their own, where they do not need to feel like “an other”, thereby contributing to their sense of belonging in their communities in the UK. Although the experienced discrimination can have adverse effects on health (Wallace, 2016; Williams and Mohammed, 2013), the groups serving the needs of ethnic minority communities helps provides some form of protection from racism by building and maintaining relationships within their communities, thereby enhancing resilience (Aléx, 2016).

Both of the community groups in this study engaged their members by providing access to daily activities, frequent excursions to nearby cities and towns and giving them something to look forward to on a weekly basis. Cecily, Gladys and members of the focus group all expressed that attending their weekly groups invigorated them and gave them a different perspective to life, also demonstrated elsewhere (Wiles and Jayasinha, 2013). According to Gladys, for example, “It makes you feel different and fresh, going out to mix with others” (Gladys, 79, migrated at age 24).

At the beginning of the focus group, I started by asking each member to speak about what kinds of activities they participated in. In addition to this community group, most were involved in church activities or other social groups. Odetta, however, was a little different in that attending this group was her only activity. She said that it was only after joining the group and meeting everyone that she realised how sad she was and that her life was seemingly at a standstill. She went on to say about being involved with the group,
We come in contact with different people, we know different things [group nods in agreement] that you can talk to them, you know more and more about outside. Not about only in your house, like a house is one room, two bedroom. But then once you come here, like you can see different, you can think different, you forget. See, once we are here, we forget that we have got somebody home or anything. And then when we go back, it comes to you. But this [the group] is our life, I could say. And I enjoy that. (Odetta, focus group).

Just as Odetta acknowledged the importance of her community group in helping keep her mind off of her worries, Viola felt the same way about her aches and pains. During her interview, Viola also linked her health and pain relief with socialising at her community group,

So actually, all in all, this place is like a respite, to come up. If you forget to take your tablets in the morning, your pain tablets, you come up here and walk around and chat around and don't remember tablets until you get back home. And I think that's what happened today. I rushed out, came on up and umm and I don't think I took any pain tablets up to now. But going back on the bus, I'll have to take a couple on the way back. (Viola, 73, migrated at age 21)

The quotes above demonstrated the ways that Odetta and Viola connected their participation in their community groups with their mental health and physical health. A significant aspect of group participation, alluded to by Odetta, is the interactions they have with other members and about continually gaining a different perspective from these important interactions. Having such a compassionate support network, especially of people who are in similar positions, positively impacts a person’s mental health (Thoits, 2011), as seen in the ways in which these study participants link the health benefits to their group interactions. The process through which this works is that by simply knowing that there are others in a similar position who can empathise with that person and validate their concerns, impacts emotional health. Odetta, therefore, makes attending her group a priority. And correspondingly for Viola, her involvement in all of the activities at her community group means that she is able to make her mind off of her aches and pains.

6.3.3 Feeling Connected Builds Resilience

As demonstrated by the discussion and participant narratives above, migration presents a major life change and, as such, social networks become even more invaluable. Like other studies on migrant communities (Almeida et al., 2009; Boyd, 1989; Finch and Vega, 2003), this study finds that social connections are
especially important for this group of West Indians throughout the migration life course, especially when building resilience as a person gets older (Braudy Harris, 2008). Further, I reason that migrant networks can be stable and reliable, not just in the immediate period just after migration but as well as lasting throughout the life course, as was established throughout this chapter. The benefits of strong social networks are realised by the study participants as providing emotional support through companionship, material support through advice and assistance with different tasks and activities as well as perceived support from knowing that someone is always available to help when needed. The study participants also demonstrated that having strong social connections provides a continued sense of belonging through shared group membership and peace of mind through knowing help was available if needed. In their later years, social connections continue to build resilience by providing this group of West Indians with space to relax, reminisce and a means to take their minds off of their worries. In this study, the valuable role of social inclusion and the value of society in providing such spaces is even more evident. In Thoits’ (2011) review of the literature on social ties and social support on health, she concluded that one of the mechanisms through which social support and social ties are linked to health is through the daily show of support, especially perceived support, that served as the link through which social ties act positively upon physical health. Thoits also found that belonging and companionship are other mechanisms through which social support influences both physical and mental health. Beyond this, the benefits of strong social networks have been noted elsewhere, especially its benefits on health (Holt-Lunstad et al., 2010; Seeman, 2000; Sheffler and Sachs-Ericsson, 2015; Yang et al., 2016).

6.4 Healthy Ageing Means Being Optimistic

In the preceding section, we saw that feeling connected to others, through various social networks, was an important contributor to having good physical and mental health. With a turn inward, it was apparent during the interviews that mental health and emotional happiness contributed to the participants’ definition of healthy ageing. In the focus group, for the example, Darlene spoke about being healthy as a feeling that emanated from inside the person, “That umm you can,
feel the goodness within yourself. Feel well, feel joyful, you know?” (Darlene, Focus Group). Throughout the interviews and in line with other research of older adults (Todorova et al., 2015), there was also an overwhelming sense of gratitude for being alive and focusing on the positive, which was particularly expressed by those with more severe health problems like Debbie, “My health is not that good. But you know what, I'm alive and, you know, that's all that is in life.” (Debbie, 70, migrated at age 14) and, similarly, for Aretha, “I'm happy, even as I'm going through pain, I'm happy. When I'm feeling this pain a lot, but I'm happy” (Aretha, focus group).

Many of the participants engaged in discussions about the importance of having a positive outlook on life and Cicely’s case is also a good illustration of going beyond thinking about health purely in terms of the physical abilities and limitations and, instead, being optimistic about other aspects of life,

I'm alive, I'm [emphasis] alive. You know, life is for living. Whatever limitations you may encounter in life, the brain still works, the heart is still beating, you can do something with it, you know. (Cicely, 57, migrated at age 14)

The positive attitude expressed by many of the participants, especially when faced with chronic illness and other adversity, like Cicely, are positively linked with maintaining a person’s resilience as they grow older (MacLeod et al., 2016; Wiles et al., 2012).

Another aspect of being optimistic is that of showing strength and putting on a brave face as was particularly expressed by the participants who were in constant pain, evident in this focus group discussion with Aretha,

Aretha: But even now, I suffer a lot with it, especially when the time get cold, sometimes I'm in tears. Sometime, I'm going on the street, I'm still in pain, it never go. The only time it go, is like I sit and I can relax back. But as you hear I get up…but I don't mek up me face13, I don't put nutten that anybody could see that I'm in pain, don't know that I'm in pain. If I don't tell you, you don't know. I stop take them because they doping me’self with painkillers and it don't help me. So I just stop take them and carry on with the pain. That's it. (Aretha, focus group)

Eartha similarly expressed masking her pain to others,

---

13 I don't mek up me face – Caribbean dialect for ‘I won’t show it on my face’.
Yea. So I'm not well at all. But nobody knows, you know they said "oh, how you look so well?" Keep smiling. There's thing that says: smile and the world smile with you, cry and you cry alone. It's the truth. Keep smiling. And if you speak to me on the phone, you wouldn't know is a ill woman talking to you, you know? And umm I keep trying. I'm in my comfort zone at home. (Eartha, 76, migrated at age 22)

Aretha and Eartha both described themselves as having poor health and, equally, spoke about actively hiding their pain from others. Neither of these women explicitly spoke about why they masked their pain from others. Research does, however, suggest that hiding pain or ‘putting on a brave face’ is not only part of presenting a public front that ‘all is well’ but it is also part of the process of positive thinking (Tanner, 2010), as was seen for many of the other participants of this study. What is important here is not only the positive impact that thinking optimistically has on health (Laditka et al., 2009) but also that ‘putting on a brave face’ and continuing to push through the pain indicates that people, like Aretha and Cicely, are choosing not to let their pain and illness defeat them (Tanner, 2010). Likewise, Eartha also expressed masking her pain and throughout her interview, she referred to herself as a loner or keeping to herself. In the quote above, she spoke about being comfortable in the familiar surroundings of her home. Research has found that older people experiencing debilitating pain may also feel a sense of humiliation at their reduced abilities (Kumar and Allcock, 2008). Given this and together with Eartha’s self-described loner status could potentially indicate that she, too, feels humiliated by her pain and chooses to hide it, and herself, away from others, thereby isolating herself further.

Moreover, having a strong mental disposition, especially the ability to be self-motivated becomes important during the times when illness and chronic conditions arise and physical health becomes limiting, also observed by Tanner (2010) and demonstrated by Ruby Dee,

There are some days where we don't always feel perfect and you don't want to get out of bed. But I make myself get out. I make myself, I don't care what muffled...so [daughter] say "mum that's a good attitude". I wasn't very well on the Sunday, I had a cold, I didn't feel good. Come Monday morning, get up, go in the shower, put on makeup, put clothes on and get ready to go. And someone said "if that was me, I wasn't going to get up". I said yea but if I start doing that, I start going downhill. (Ruby Dee, 72, migrated at age 18)

And also Billie,
You have to fight on. You can't give in and I don't give in, I don't give in, I'm a fighter. I've been hit down with many a illnesses but I won't stay down. (Billie, 65, migrated at age 11)

With this, the belief in oneself to still keep going and maintaining a positive attitude, is paramount to building resilience (MacLeod et al., 2016) and is part of these participants’ definition of healthy ageing, as exemplified during Ruby Dee’s and Billie’s interviews. Ruby Dee calls on her inner strength and motivates herself to get up, especially important on days when she is not well; she acknowledges that this motivation will help to prevent her from slowing down or going “downhill”. In a similar way, Billie utilises her inner strength to keep going on and living a full life despite of the illnesses she has experienced.

6.4.1 Having a Positive Outlook Builds Resilience

Possessing the personal strength to overcome the hardships in life as well as having the ability to still push forward in times when you least feel like it, play an essential role in building and sustaining optimism which, therefore, goes on to build and maintain resilience. Although many of the participants of this study have moderate to severe illnesses, most do not consider themselves to be in poor health. Instead, they focused on continuing to live their lives as best as they can and participate in things they enjoy most.

6.5 Healthy Ageing Means Believing in a Higher Power

In the previous section, we saw that most of the study participants, regardless of their physical health, had an optimistic outlook on life and that this optimism was linked with having better mental health. Along the same vein, when some of the participants discussed their experiences with illness and poor health, they often referred to their belief in a higher power as a means for helping them get through their tough times which, thereby, enabled them to view their situation with positivity.

Gender, Religion and Health

Interestingly, there were some differences between the ways in which female and male participants spoke about their religious beliefs. This study found that women
verbally engaged with their faith in a higher power more than the men, a finding which parallels other research (Ellison and Taylor, 1996). These differences could be because the women who spoke about their religious beliefs had more experiences with illnesses than the men in this study and only three men participated in this study so perhaps a larger sample of men would have yielded different results.

On one hand, the men generally spoke about religion with brevity whereas the women, for the most part, engaged in more in-depth discussion about religion. While the women were more likely to discuss their religious beliefs in a variety of ways, the men usually discussed religion specifically relation to health and when speaking about death. Sidney brought up God he was when asked about what being healthy meant to him. He viewed God as being the ultimate decider of who lives in good health and who dies. He said,

Sidney: Takes a while to speak, lowers voice God is, is something special. You know, we can’t see him. Some of the time, you can feel him, when the wind blow through us and give us light and the rain does fall...that's God. Danielle: So what does he mean for your life? Sidney: For me in life, where God is concerned, God gives life, God takes life when time come. (Sidney, 84, migrated at age 24)

Frederick too brought up his religious beliefs during discussions about the ill health of his nephew. Here, his religious beliefs have helped him accept the inevitability of death as he welcomes the prospect of a pleasant afterlife,

Frederick: Same evening that he fell down, he died. I wouldn’t like to go like that. I don't mind dying, I believe in God to have a better life somewhere, but I wouldn't like to be suffering like those people. Danielle: Is your faith in God very important to you? Frederick: Very important to me. Danielle: Would you say...why is it important to you? Frederick: Well, the thing is, when you die, where would you sooner be? Would you sooner rather be with the Lord, while they say paradise, have wonderful life? Or would you like to be in eternal torment? (Frederick, 73, migrated at age 20)

With similar brevity, Martin discussed religion only in the context of telling me that he met his wife at church. Although the church formed part of his social network when he first migrated to England, when asked about present day, he said that he was not a regular churchgoer, which is in contrast to many of the other participants. The women, on the other hand, spoke more freely about church, God
and their religious belief was often interspersed throughout their interviews. The women, without being prompted, provided accounts which reflected the importance of their religious beliefs in their lives, comparable to findings of other studies on religiosity among Christians\(^{14}\) (Ellison and Taylor, 1996; Levin et al., 1994; McFarland, 2010).

A further explanation, suggests that the increased religiosity in women is due to the differences in the processes socialisation of between women and men. Specifically, that particular behaviours and attitudes traditionally assigned to women are congruent with certain aspects of religious beliefs, thereby making women more involved in the social aspects of the religious community (Levin et al., 1994). Women are traditionally expected to be the primary caregivers and to have the responsibility of ensuring that children are socialised in the church while men, on the other hand, are typically socialised to be risk-takers and to have more of a ceremonial function in the church (Levin et al., 1994; McFarland, 2010; Miller and Hoffmann, 1995). Furthermore, the adoption of these roles exposes individuals to different types and levels of stress which might explain the differences in how religious belief is enacted and embodied in daily life between women and men.

Although the women in this study discussed their religious beliefs in greater detail than the men, it was still evident that, regardless of gender, religion was important to most of their lives. Here, God and the church emerged as ways through which the participants socialised, found solace during hard times, used their belief in a higher power to make sense of the seemingly unexplainable and used the teachings of the Bible as guidance for how to live their lives. Moreover, when comparing the data between those who have had experiences impacting on their health to those who have not, the ways in which religious views are expressed are notably different between the groups. In general, those who have experienced traumatic events expressed their religiosity during the interviews more than those who have not. In these instances, many of the participants turned to their religious beliefs as a way to help them cope with the adversities they have experienced.

\(^{14}\) Loewenthal et al. (2002), however find that most studies comparing religiosity between women and men have usually been done among Christians and not many among other religions.
seen in other research (Manning, 2013). The use of different mechanisms, such as religious belief, to help overcome hardships is part of the process of building resilience (Browne-Yung et al., 2015).

The findings from these interviews are comparable to other studies on religion and health. In general, religion and religious involvement exerts a positive influence on health and well-being (Brewer et al., 2014; Ellison and Levin, 1998; George et al., 2002; Hovey et al., 2014; Lee and Newberg, 2005), especially among the elderly (Moberg, 2005). Specifically, the mechanisms through which religious involvement affects health are via social connections, lifestyle and behaviours, religious practices and through affecting cognition and personal resources especially during times of stress and suffering (Behere et al., 2013; George et al., 2002), which I will now look at in detail.

6.5.1 Explaining the Unexplainable

One of the key ways religious belief was expressed in the interviews was when participants spoke about life events or situations that they perceived to be out of their control. For example, Billie vividly recounted the circumstances surrounding her different experiences with illness during her interview whereby she recognised God as the reason that she is here today,

Danielle: After the cancer scare, coming up through the years until your stroke, everything has been fine until then?
Billie: No. My eyes start playing up, this one [points to her eye].
Danielle: Your right eye?
Billie: Umm hmm. And doctor said, 2008 now, by the end of January 2008, I will be blind. Here am I again, God work another miracle.
Danielle: Did he say why? What was going on?
Billie: Some...pause a retina. Something growing in the back of the eye. But here am I, here am I. (Billie, 65, migrated at age 11)

For Sidney, God was a force that gave and took life. When discussing health, it was God, and not the doctors, was the ultimate decider of the outcomes. He explained,

For me in life, where God is concerned, God gives life, God takes life when time come. We can never say waiting ‘til tomorrow or half year or I have too many money...or you know...some people have money and they run to doctors and doctors give them dis and dat and tek de money from dem because...for pills or whatever. Only for a time, only for a time and they slow down and they keep slowing down
and then well, doctors heal them because they have money they can press a button and everyone run to them. But...we not here forever, we not here forever and I don’t know…I know I won’t be here forever. (Sidney, 84, migrated at age 24)

As seen throughout the stories of several participants, having this belief in something unseen either helps the participants with accepting particularly traumatic life events or helped them come to terms with the current state of their health.

Known as mastery, this is the belief that events and circumstances in life are under the individual’s control and, therefore, do not occur because of chance (Pearlin and Schooler, 1978). As indicated by the way they told some of their stories, a few of the study participants did not have within them this sense of self-mastery when they discussed life events and outcomes. For example, Ethel is an 82-year-old woman who was still very active in both of her community groups and church. During the interview, Ethel considered herself to be in good health and, thus, did not express any pressing concerns. Throughout our discussion, it was evident that she faced much emotional anguish as a result of the physical abuse she experienced as well as the racism she encountered in her employment as either a cleaner or a bus driver. While speaking to Ethel, it became evident that she relinquished control over events in her life and associated outcomes to her belief in a higher power. As an illustration, she believed that her survival of a particularly bad hurricane was due to God’s intervention. Although a positive link has been found between having a strong belief in a higher power and having a higher sense of self-mastery (Ellison, 1993; Krause, 1995), this is not the case for Ethel; just as she used her religious belief to explain her good fortune, she similarly used it to explain occurrences that she perceived to be out of her control like, for example, when she discussed getting pregnant before marriage, “still going to my church, until the devil got to me, I got pregnant.” (Ethel, 82, Bristol migrated at age 27). Here, Ethel assumed very little responsibility for her actions as she relinquished control to a divine other, thereby absolving her from guilt.

There is, however, disagreement with the finding of a positive connection between religious belief and self-mastery mentioned above. Instead, Koenig et al. (2001) suggests that the belief that a higher power is in control of an individual’s
life reduces that person’s self-mastery and, thus, decreases the individual’s belief in themselves which, thereby, highlights a potentially negative effect of religious participation. Conversely, the kind of religious belief exhibited by several other study participants, exemplified by Ethel, could possibly enhance an individual’s self-efficacy as the belief in prayer and the subsequent relinquishing control to a higher power is that person’s way of keeping control and, thereby, helping her/him make sense of their situation (Ellison and Taylor, 1996). Ellison (1991, p. 81) highlights this,

Divine relations may reduce worry or self-blame by encouraging individuals to cede psychological control of problematic situations that appear irreconcilable, or to attribute responsibility for particularly difficult life events to a divine other.

Given this, there are important implications for mental health as a positive association has been found between self-esteem and the belief that God has ultimate control of life outcomes (Schieman et al., 2005) as well as overall health and well-being (Brewer et al., 2014). Thus, although Ethel may have less self-mastery, her turning to God may have a buffering effect by protecting her from the stress she has endured in particularly difficult situations (Koenig, 2012), as she is not constantly worrying about how she can change a situation that she perceives to be out of her control.

Similar to self-mastery, religious coping also helps individuals make sense of and deal with particularly traumatic experiences in life, especially among those who are ill (Hebert et al., 2009; Taheri-Kharameh et al., 2016). Cicely, for example, is one of the youngest participants and endured the pain of losing a child and has also had several operations on her legs and feet, which has left her with mobility issues and unable to work. Despite this, she is one of the most positive participants. She is extremely grateful for life and gets out to help others when she is able to. For her, she relinquished control over her difficult experiences to God, which has enabled her to cope with and accept the negative experiences that she had had to deal with during her life; one such experience is illustrated below. Recalling, she was about to go into labour when the nurses gave her the news that her baby was going to be still-born. She remembered not wanting their sympathy and said to the nurses,
In seeking to explain the link between religion and health, Ellison and Levin (1998) suggest that coping is one of the mechanisms through which religion has a positive effect on health, especially mental health. They find that there are circumstances in life where individuals do not clearly understand what and why that particular event has happened and so, religious coping, via praying, counselling and small group fellowship provides the tangible and emotional support that the person needs. Religious coping, as exhibited by Cicely above, also helps the individual assess the stressful situation as being part of a “divine plan” and an opportunity for “spiritual growth” (Foley, 1988).

Religious forgiving, seeking spiritual support, waiting for or seeking partnership with God in problem solving are some of the different forms of religious coping the women and men in this study used to deal with major life events and the illnesses that have experienced (Pargament et al., 1998). Religious coping provided many of the participants of this study with social comfort found in a religious community; offers a sense of meaning to the event and outcomes; it provides emotional support; and gives the individual a sense of control over the situation (Pargament et al., 1998). Religious coping was especially noticeable when Cicely continued her discussion on the loss of her daughter,

So yea I dealt with it. I even…when the pastor came and he said "oh how do you feel?" I said "look, this was the Lord's work, if she was meant to be here, I would probably be calling you in a couple of months to say let's christen her. Unfortunately, I'm calling you to say can you take her funeral for me". He say, you're taking it just like that. I said "how else can I deal with it, how else can I deal with it". It's not in my control, definitely not. And I've moved on and I can talk about her at any time, 'cause it keeps her name alive and all the memories of her. (Cicely, 57, migrated at age 14)

Her belief in a higher power and the control she relinquished gave her the strength to endure the pain of the death of her baby; the situation, she recalled, was not under her control, which made it easier for her to accept and, thereby, move on, even as she discussed making plans to bury her baby. Using religious belief as a way to deal with stressful situations has also been found in other studies examining religion and coping (Hebert et al., 2009; Taheri-Kharameh et al., 2016;
Williams et al., 1991), especially true for Black Americans and West Indians living in the United States (Ellison and Taylor, 1996; Taylor et al., 2007).

Likewise, Gladys expressed her religious beliefs when she discussed negative experiences, specifically when she spoke about her experiences of discrimination at her place of work following her move to England. During the interview, it was evident that she did not let the discrimination she faced at work affect her as illustrated by the following conversation,

Danielle: How come you think you were strong enough to stay?
Gladys: Well, I think is the grace of God. You know I think is the grace of God. I just don't take any notice. Even now. I just carry on, do what I'm doing and if I see them, I say good morning, good afternoon or things like that and you know, they must say she must be stupid but I just carry on. (Gladys, 76, migrated at age 24)

Gladys employed a form of religious coping identified as “religious forgiving”, whereby she turned to her religion “for help in letting go of anger, hurt, and fear associated with an offense” (Pargament et al., 1998, p. 711). Religious belief was also used by Black Americans and Black West Indians living in the United States to help them cope with similar experiences of discrimination (Hayward and Krause, 2015), which was found to have a protective effect on their mental health (Ellison et al., 2008).

It is important to note that most of the participants brought up their religious beliefs unprompted, further highlighting the significance of religion in the participants’ lives. Subsequently, many of the participants linked their religious beliefs to their definition of health. This was seen when during comparisons of religious discussions across the interviews, whereby there was a difference between those who extensively discussed their health and those who mentioned health with less detail. In general those who spoke in great detail about their health issues (or experiences that impact on health) tended to discuss their religious beliefs more. The participants who spoke most about religion are those who have experienced severe health issues, endured physical abuse, experienced mental breakdown, faced racial discrimination and/or have suffered through bereavement. For example, Billie’s religious beliefs were highlighted while she recounted her different episodes of illnesses during her interview. For her, God
was the reason that the cancer healed while she was on the operating table, illustrated during a conversation with her doctor and her pastor,

"Mrs Billie, I don't know what just happened, but we opened you and we watched", he saw the cancer there but then it start moving up and it changed. "What, what do you mean?" Half was cancer and half wasn't. And then he used the words malignant and one was benign. "You are...you are...a miracle worker". The pastor was there, I wasn't a Christian then, I used to go to church now and then. And the pastor was smiling. I say "why are you smiling?" He says "you don't understand Billie?" I says no. He said "God has healed you, he's left it so man could see the difference, half was cancer and half was just a stone." (Billie, 65, migrated at age 11)

The importance of religion in Billie's life is clearly evident as we see that she utilised religious coping to understand what has happened via her belief in God’s powers to influence her stressful situation. As further evidence of the significance of religion in her life, her church pastor attended her medical appointments with her. She looked to him for further religious support in helping her understand what happened (Pargament et al., 1998, p. 711). With similar results, a study that investigated the connections between religious faith and cancer, Koffman et al. (2008) found that, among Black Caribbean and White British patients with cancer, the Black Caribbean patients were more likely to draw on their religious beliefs to help cope with their illness. The Black Caribbean patients were more likely to reference the Bible to help them comprehend the role of cancer in their lives, they were more likely to refer to God as a healing force, as Billie did, and they were also more likely to call upon and accept tangible and emotional support from their religious networks, such as pastors.

Through her various episodes of illness and her survival of physical abuse, Billie believed that God is the reason she is alive today and is able to cope with things outside of her control and, as such, she firmly believes in the power of prayer,

On the birth of my new grandson, I prayed and I prayed and I asked for certain things and they was met. I believe in prayer, some believe in medicine, tablet, whatever. I believe in prayer. Prayer go up and blessing come down. (Billie, 65, migrated at age 11)

Similarly, Eartha and Cicely both credit God as the reason for their survival after several heart attacks and a long and difficult surgery, respectively. Further underscoring the importance of their religious beliefs and the linkage with their
perception of health, many participants expressed their gratitude to God for their lives and health. Cicely, for example, expressed sentiments of being blessed that she is alive after everything she has been thorough while Rudy Dee conveyed her gratitude to God for her and her husband having good health in their later years.

The forms of religious coping expressed by the participants in the preceding discussions have been shown to help individuals understand and come to terms with their health-related stress (Ferraro and Koch, 1994), which therefore benefits their mental health and overall well-being. In addition to the positive mental outcomes derived from religious coping, other studies have demonstrated the positive physical outcomes of using religion to help with overcoming illness such as with stroke (Giaquinto et al., 2007), cardiac illnesses (Ai et al., 2007; Hughes et al., 2004; Oxman et al., 1995) and cancer (Shaw et al., 2007), all of which are illnesses that have affected the participants of this study. These studies conclude that having a strong religious belief, as expressed by the participants of this study, helps those recovering from illness by providing them with hope, emotional comfort and the belief in a happy afterlife. The emotional comfort provided by religious belief reduces illness-related anxiety and acts as a protective buffer against mental stress. Further, Zimmer et al. (2016) argue that given that people tend to become more religious as they reach advanced ages, they conclude that the connection between religiosity, spirituality and health needs to be further studied in order to add to the puzzle of what gives rise to a good quality of life as a person ages.

Although limited, there are a few studies that suggest that religious belief can have negative consequences on health such as when religion is used as a reason for not seeking medical care (Simpson, 1989) or when religious belief increases anxiety levels via threats of punishment for sins (Pargament, 1997); this kind of religious coping was not seen in this study.

6.5.2 Building Social Connections Through the Church

Religious belief is heavily linked to building closer connections with family and friends. More specifically, attendance at religious services and events bring people
of shared values and interests together which then act to develop and maintain
friendships (Lim and Putnam, 2010). Additionally, attendance at religious services
and the resulting interactions with members of the congregation can act to
strengthen friendship and family bonds (Rote et al., 2013). The bond-building
seen with religious belief and practices can often start early in childhood when
families, like Ethel’s, gathered together in the early hours of the day to participate
in morning devotions (quiet family time dedicated bible study and worship).
During the interviews, many participants discussed the church and service
attendance as being one of their important activities. The networks formed
through the church can be long-lasting as in the case of Martin who joined his
community church shortly after moving to England and subsequently meeting his
wife via their church choir. Later in life, the church continued to play an active
role in many of the participants’ lives with some members, like Debbie, Gladys
and Ethel, attending church services every week, which has been found to have
positive outcomes on health (Çoruh et al., 2005; Hummer et al., 1999, 2004;
Strawbridge et al., 2001).

The mechanism though which religious service attendance affects health
continues to be studied (Assari, 2013) and some argue that it is the social support
aspect of religious involvement that exerts positive effects on health (Brewer et
al., 2014; Rote et al., 2013). While the effects of social support and feeling
connected were discussed in Section 6.3 of this chapter, this current section will
focus on the religious aspect of social support. According to Levin et al.,

participation in religious communities provides members with a framework for
deriving meaning from their life experiences and with structured opportunities to
interact with others who are alike with respect to values, beliefs, and attitudes.
(Levin et al., 1994, p. S137)

Therefore, for the West Indians in this study who migrated to England in the
1950s and 1960s, attending weekly church services was not only a chance to
socialise with others who share similar religious beliefs but was also an
opportunity to interact with others from shared backgrounds and similar histories.
Gladys, for example, commented that once she arrived in England, she started
going to a church of the same religious denomination and reflected that going to
church with the family she did have over here, made her adjustment a little easier.
This kind of social support provided by religious participation is multidimensional and includes time spent within that network as well as the tangible and emotional support provided by that network (e.g. food when ill, transport to religious services) (George et al., 2002). The kind of support provided by religious participation is evident in Beulah’s extract, where she clearly reaps the emotional benefits of her attendance at the Kingdom Hall\(^\text{15}\),

Well, happiness...because I go to the Kingdom Hall and that’s what I know. And so happiness, I don’t know if you know any Witnesses where you from. But it make I feel so happy and strong and, you know? (Beulah, 74, migrated at age 20)

The focus group participants of this study not only stressed how important attending church service was but also that outside of the church service, they often meet for fellowship,

Josephine: On Friday, we have a fellowship at the church for old age pensioners, for people that retired. I attended that. But since July, we're off until September.
Darlene: I'm Darlene and umm on Friday, I usually come up here, first thing, and then I have my lunch and then afterwards I go to fellowship at the church. From 2:30 until 4:30 and at the moment we're on holiday break.
Danielle: Similar church?
Darlene: Same church! [church name], on [location]. It's quite enjoyable. They go into the bible, biblical, teaching about Christ and then we sing songs and then afterward, we'll have a cup of tea together, fellowship together and end up going home about 4:30.
Josephine: We have a bit of fun time as well. Sometimes in bible or general subjects, just a little fun time. (Focus Group)

As seen in the discussion above, more than just a meeting space, the church itself provides a means of active socialisation for its elderly members. Several of the interviewees placed great importance on the network that church community provides which helps them in their time of need. Participation in religious activities, as previously discussed, increases the levels of social integration and social support, which has been found to offer protection against loneliness later in life (Rote et al., 2013).

6.5.3 Guiding Actions

In addition to social support, religious belief provided some of the study participants with direction on how to live their lives as was evident in the

\(^\text{15}\) A Kingdom Hall is a place of worship used by Jehovah's Witnesses.
interviews with Debbie and Dionne. When asked about the role of God in her life, Debbie responded,

Debbie: Very important, a central part of my life. Yea, central.
Danielle: How is he central in your life?
Debbie: Well, without him, I wouldn't be here for a start and I, I can tell him anything, I can put my trust in him. You know, he's the head, he's always the head you know, I don't do anything without consulting him. (Debbie, 70, migrated at age 14)

Debbie believed that God was the source of guidance in her life. Equally, Dionne placed faith in the teachings of the Bible and, thus, believed in living her life according to its words and with whole acceptance,

Well, I believe in God and I believe in what the bible says. I believe one should accept what the scripture says and ummm try your best you live by it. (Dionne, 79, migrated at age 21)

Similarly, Beulah emphasised the function of her religion belief on staying on the right path and not socialising with those who will lead you astray,

You are not perfect but at the end of the day, you know the rule, you don’t mix with other people that will turn, that will make you do wrong. You mix with good people and I always mix with…and I encourage my kids for the same. (Beulah, 74, migrated at age 20)

And this is also the case for Frederick who spoke of living his life according to the prescriptions of his religious belief by not indulging in tobacco or drinking alcohol; this kind of religious participation has been linked to the long-term maintenance of health promoting habits (George et al., 2002; Strawbridge et al., 2001; Yong et al., 2009). Religions, including Christianity, which is the religion of the study participants, generally promote what they consider to be healthy lifestyles by encouraging their members to treat their bodies with respect and to be appreciative for good health.

6.5.4 Religious Participation Builds Resilience

The sections above considered the different ways in which the participants of this study viewed religion and the various roles their religious beliefs played in their lives. We saw that their religious beliefs provided social support through network building and church attendance. We also saw that their religious beliefs helped
them cope through difficult times by either helping them relinquish control or helping them to understand traumatic experiences. And, finally, their religious beliefs provided guidance for which to live their lives. In general, the participants that expressed their religiosity more frequently and in greater detail were those who had more intense experiences of ill health.

Given that there are positive links between religious belief and health (Brewer et al., 2014; George et al., 2002; Hovey et al., 2014; Lee and Newberg, 2005), it follows that belief in a higher power helps to build resilience in the participants of this study; noted elsewhere (Manning, 2013). Religious practices and belief provides the study participants with the ability to adapt to changing life circumstances. Religious belief also adds to their definition of healthy ageing as seen through their linkages of their health and happiness to their beliefs especially regarding the social support received and in dealing with hardships, also seen in Caribbean populations in the United Kingdom (Wray and Bartholomew, 2006) and in the United States (Nguyen et al., 2016). Religious belief, therefore, is a significant source of resilience in the lives of these study participants.

6.6 Chapter Summary

In this chapter, the meaning of healthy ageing was presented for a group of older West Indians living in South West England. For the study participants, healthy ageing was re-examined with the resilient ageing lens. All of the participants in this group experienced major changes and challenges throughout their life course. Beginning with the upheaval of their lives by migrating to the United Kingdom, the associated complexities of adjusting to a new life and the difficulties they faced particularly the racism and discrimination they experienced in many aspects of their lives. Throughout the years, many of the study participants have encountered a range of adversities including bereavement and severe challenges to their health. Notwithstanding these complex challenges, the vast majority of these women and men remained positive and chose not to define their health solely based on their current illnesses or limitations.
In reference to the resilient ageing framework that was discussed in Section 2.2.5 of Chapter 2, there are three elements that affect a person’s resilience: risks, assets and vulnerabilities (Luthar and Cicchetti, 2000; Masten, 2001). Recalling, risks are events or processes that can negatively affect an individual’s health and development while vulnerabilities are factors that can make a person more susceptible to risks. Assets are factors or processes that can mitigate or avoid the consequence of risks and vulnerabilities. If the findings from this study are applied to the resilience framework, the table below shows the attributes of resilient ageing for the study participants.

Table 2: Resilient Ageing for Older West Indians Living in South West England

<table>
<thead>
<tr>
<th>Risks</th>
<th>Vulnerabilities</th>
<th>Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migrating as a child</td>
<td>Bereavement</td>
<td>Social connections</td>
</tr>
<tr>
<td>Racism and discrimination</td>
<td>Weak family and friendship networks</td>
<td>Activities and community engagement</td>
</tr>
<tr>
<td>Health issues</td>
<td></td>
<td>Optimism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Belief in a higher power</td>
</tr>
</tbody>
</table>

The findings indicate that the risks for this population include migration, particularly for the participants who migrated when they were children as family separation and reunion proved to be especially stressful early in the migration life course. After arrival and for the next few years, the racism and discrimination they experienced were also identified as risks to their health and well-being while in their later years, their varying health issues became risks. Potential vulnerabilities were bereavement and weakened social connections, albeit these were for a small minority of the study group. The participants’ definition of healthy ageing was based on the following attributes: their participation in activities they valued, their social connections, their positive outlook on life and their belief in a higher power; these are their assets and are what the participants of this study consider important to their healthy ageing.

It is important to make clear that this study, like others (Browne-Yung et al., 2015; Gattuso, 2003), does not view resilience as a quality that either is or is not
possessed by an individual. Instead, I conclude that, for this group, resilience is a process that developed over their life course, based on their varied experiences. As such, these women and men draw upon the components of their definition of healthy ageing in order to help them overcome difficult situations. This study particularly highlights that even through traumatic experiences, like separation from family, severe illness or death of a loved one, the participants overwhelmingly remained positive and focused on what they are still able to do. The findings of this study add to the literature on ageing and health by forefronting the perspectives of older West Indian migrants on what healthy ageing means to them. This study highlights the sociohistorical experiences that have had an impact throughout their life course. With a critical turn, I advocate that these findings can be used in a transformative manner by considering how various structures in society, like an adaptive and supportive environment or public service policies for example, can be modified to support the needs of this group, thereby contributing to their overall resilience.
Chapter 7  Discussion and Conclusion

The goal of this study was to examine the influences on and attributes of healthy ageing among older West Indians living in South West United Kingdom. As demonstrated in Chapter 2, there is a disconnect between academic definitions of healthy ageing and the perspectives of healthy ageing among older people. And within this literature, there is even less information regarding the views on healthy ageing in ethnic minority communities (Phillipson, 2015). As such, it is important for research within these communities to acknowledge the ways in which their intersecting identities and resulting experiences, which can be based on ethnicity, migrant status or gender as examples, can shape definitions of what it means to age healthily. Drawing out these narratives and seeking to understand how their social locations could shape their experiences responds to some of the objectives of critical race theory (CRT). Without essentialising, the participants of this study have a unique set of experiences due to their intersecting identities of being Black migrants in the United Kingdom. Consequently, this research was situated within the social and historical context of experiences of migration, which was made possible by effectively utilising the life course framework and CRT. Taking analysis further, I used the resilient ageing concept to examine these experiences with a view to understand the attributes of healthy ageing for the participants of this study. The findings from this study, therefore, add to the literature in social gerontology on healthy ageing within ethnic minority communities. As such, this final chapter will present the findings in relation to the overarching goal and the research questions discussed in earlier chapters. First, I will provide an overview of each chapter of the thesis. Then I will discuss my findings in relation to the research questions and how this contributes to existing knowledge. The next section will consider the implications of the findings for theory, policy and practice. The section that follows will discuss the study’s strengths and limitations. After this, I will provide suggestions for future research agendas.

7.1 Overview of the Study

Chapter 1 provided the background and context of the study. Highlighting the relationship between the West Indies and the United Kingdom provided the
historical context needed to understand the contemporary experiences of Caribbean people in the UK. This history showed that centuries’ old legacy of racist rhetoric still impacted the lives and opportunities of people of colour currently living in the UK. This chapter also outlined the context of ageing in the UK, where I showed that because people are living longer, some of the policy emphasis has been on reducing the costs to services by older people by keeping people as healthy as possible. These healthy ageing definitions are focused on maintaining optimum physical and mental health and are traditionally referred to as successful ageing or active ageing. While this goal is not in itself a bad thing, it is economically driven and also does not consider how older people, themselves view healthy ageing. Due to this, there is the need of a greater understanding of the social and historical context within which healthy ageing is defined and how this can then be applied to the benefit of those communities. The need for this kind of understanding formed the theoretical base of this study. That is, critical race theory highlights the political and social processes operating in society that can impact a person and, especially, how they perceive the world and themselves. As such, Chapters 2 and 3 presented a review of the discussion on these topics.

Chapter 2 presented the discussion on healthy ageing. It was noted that terms under the umbrella of healthy ageing have become influential over the thirty years in both policy and academia to describe the ideal ways in which people should age. Although successful ageing and active ageing continue to be used, there is on-going debate whether these terms accurately represent the views and ageing experiences of older people. The literature found that there is also a need to understand the healthy ageing experiences of ethnic minority communities as research within the last twenty years shows that not only is there a lack of research in ethnic minority communities but that their experiences over the life course, especially regarding the social and historical context, can also impact perceptions of healthy ageing and that research that has been done has shown that their meanings can be different. In the final section of the chapter, I suggested that resilient ageing could be used to fill the gaps in the literature about the ageing of ethnic minority older people. Further, resilient ageing could be used to explore and create deeper understanding into the constructions of healthy ageing among older ethnic minority groups. Resilient ageing, therefore, offers a more inclusive
and holistic view of ageing as it considers various impacts on life and advances the notion of thriving despite hardships encountered.

Supporting Chapter 2, Chapter 3 drew on elements of CRT and the life course approach to examine the different social and political processes impacted the lives of ethnic minority groups, West Indians in the case of this study. I highlighted how the enduring legacy of racism and discrimination impacts the lives of people of colour. These are the experiences that many West Indians who migrated to the UK in the 1950s and 1960s endured.

Both of these chapters highlighted that although ageing in the UK is widely discussed, there is a gap within gerontology literature whereby ageing in relation to ethnic minority groups and especially migrants has been given less consideration, also noted by others (Nazroo, 2004; Phillipson, 2015; Torres, 2015; Wray, 2003). Additionally, if we were to apply terms like successful ageing to older people and, particularly, ethnic minority groups, they would be too restrictive in that they would not consider the experiences individuals would have had because of their varying intersecting identities, such their ethnicity, class, migrant status, gender, etc. Critical race theory, which believes in the power of stories and acknowledges these intersecting identities, advanced my understanding of the ways in which the participants’ experiences of racism and oppression have impacted their lives. With the life course approach, I was able to follow participant narratives from the point of migration until present day, thereby adding valuable social and historical context to the study. And, going further, the concept of resilient ageing allowed me to consider all of these experiences with the goal of understanding how these participants perceived ageing healthily. By utilising these three constructs, critical race theory, the life course approach and resilient ageing, the findings from this study on ethnic minority ageing add to the literature in social gerontology and also contributes to the healthy ageing debate by exploring the healthy ageing perspectives of West Indians living in South West England.
Chapter 4 discussed the research methodologies that were used in this study. The overall aim of the study was to understand the influences on and attributes of healthy ageing for older West Indians residing in the UK. Therefore, this study is methodologically interpretivist and qualitative interviews and one focus group were the methods of data collection. Utilising these methods and with a critical approach, I was able to find out how their views were shaped not only by their experiences but also by other factors such as the political climate and them being a ‘visible other’. In order to see how these socio-political processes played out over time and to see how the participants’ earlier experiences continue to impact their lives, I adapted the life course framework to structure data collection and data analysis. In doing so, I was able to see how a range of experiences, based on these socio-political processes, contributed to an individual’s perception of healthy ageing, beginning in their pre-migration years up until present day.

Chapters 5 and 6 presented the discussion of the study’s findings. Chapter 5 answered the first research question and identified a number of elements associated with the process of migration that influenced research participants’ definition of healthy ageing. Answering the second research question, Chapter 6 built upon this and examined these elements with a view to understand the construction of healthy ageing through the resilient ageing concept.

7.2 Final Discussion and Study Conclusions

The overall aim of the study was to identify and examine the characteristics of healthy ageing for a group of older West Indian women and men living in South West England. I conclude that their experiences and construction of healthy ageing can be understood by utilising the concept of resilience, via resilient ageing. Briefly, resilience is defined as the ability of a person to recover, both physically and psychologically, after having experienced some form of adversity (van Kessel, 2013). This concept has been applied to older populations in order to understand how they overcome and thrive despite the hardships they have encountered (Braudy Harris, 2008; Browne-Yung et al., 2015; Gattuso, 2003; Wild et al., 2013).
My research showed that there are a set of complex and interconnecting factors that influence the ways in which the study participants thought about their health as they got older. And these same factors operated continually throughout the life course and did so within a system whereby events either contributed positively to health or had consequences on health that, in turn, went on to shape their definition of healthy ageing. Arising from this is how my participants dealt with these aforementioned events, adapted to the situation and, therefore, built resilience and continued to live full lives as they get older. Traditional definitions of healthy ageing, like successful ageing and active ageing, place responsibility of a person’s health solely on that individual without consideration for the complex and varied experiences a person may have (Martinson and Berridge, 2014; Romo et al., 2013). My research, instead, shows that healthy ageing consists of interconnecting attributes that operate on both a personal/internal level as well as an external to the individual. This PhD study adds to the field of social gerontology and resilient ageing research because my findings take into account the important contributions of socio-historical context and wider society when considering the different factors that promote participants’ resilience and, thus, influence their meaning of healthy ageing.

As discussed in earlier chapters, the concept of resilience consists of risks, assets and vulnerabilities. By looking at how the process of resilience was built across the migration life course, I was able to identify the elements of healthy ageing for the participants of this study. In the pre-migration and migration phases of the life course, the process of moving to the UK was a risk for the participants who migrated as children, where is a risk is considered anything that can negatively affect the health and development of a person. For these individuals in particular, migrating at a young age meant that they were torn away from the people that were closest to them and put into an unfamiliar environment with family they did not know, which, as shown in Chapter 5 caused undue stress for the child. Children also had the pressure of having to adjust to their new way of life as well as coping with feelings of anxiety about having to live up to expectations that were placed upon them. For the adults, however, migration was not found to be a risk as any potential stress associated with the process of migration was attenuated by the participants’ social connections. In these instances, social connections,
particularly family, acted as the impetus for migrating and family also became a source of support when they arrived in the UK. Once in England, family and in some cases, other West Indians, were instrumental in helping the new migrants find work, housing and establishing themselves in their new lives. For participants who migrated as adults, social connections were found to be assets.

Once in the UK, both in the earlier and later stages of the migration life course, adults and children faced widespread discrimination and racism throughout the 1950s, 1960s and the early part of the 1970s (Paul, 1997); this was a risk for all of the participants. During these decades, particularly the 1960s, the British government enacted a series of immigration policies that gradually controlled the entry of and removed citizenship from people who migrated from the colonies while preserving the right of entry from citizens of the majority White Commonwealth countries (Fryer, 1984; Paul, 1997). As racism became part of the national policy, racist incidents increased which affected the lives of the participants of this study. With this risk, there were associated vulnerabilities, which intensify the negative effects of the risk, and included their systematic exclusion from equal opportunities and resulting lower socioeconomic status. Even with this adversity, the participants were able to draw on a range of resources to help them through difficult times. These assets included their social connections, their positive outlook and their belief in a higher power.

In the later stage of the migration life course, the participants are older and retired from employment. Here, this study identified illness as their main risk with bereavement and weakened social connections contributing to their vulnerabilities. Although many of the study participants had some form of health issue, most described themselves as being healthy and happy, thus making their optimistic outlook an asset. Other assets still included their social connections and belief in a higher power. Also, at this stage, their participation in activities was vitally important to their lives, also making this an asset.

The assets of resilience that were discussed above constitute the attributes of healthy ageing for this group of West Indian women and men. These assets promote resilience by protecting the individual against the potentially negative
effects of the identified risks and vulnerabilities. In summary, attributes of healthy ageing for the participants of this study are: participation in activities, feeling connected to others, having a positive attitude and believing in a higher power.

In this study, the approach taken was one that rejected resilience as a binary characteristic inhering within individuals. Instead, and in line with other research (Browne-Yung et al., 2015), I approached resilience as a network of influences internal and external to the individual. The narratives in this study showed that while the participants did consider their health in physical, mental and social terms, it was the manner in which they were reflected upon that contrasts the traditional definitions of healthy ageing. In addition to these, the study also found that spiritual beliefs were part of their definition of health. This research supports previous work examining the views of older people on healthy ageing (Cho et al., 2015; von Faber et al., 2001; Romo et al., 2013) and shows that older people did not consider these aspects of their health with a deficit view, instead, they discussed these in more holistic ways.

The physical health of the study participants was highlighted by the importance placed on the continual participation in the activities of their choosing and also contributing to society, this was particularly emphasised later in their life course. This group clearly linked their health with being an active part of society and it was important for them to remain autonomous regarding their chosen activities. A dominant theme expressed within this context was that of capability despite their physical limitations or illnesses. Their perception of health also consisted of feeling connected to others and the importance of their social networks was emphasised throughout their entire migration life course. The participants’ social networks helped them to adjust to their lives in the UK, they acted as important spheres for building and maintaining bonds and they provided opportunities to join together to form a collective ‘we’ as protection against experienced discrimination. In their later years, their social connections still provided opportunities for maintaining their bonds, but they also presented opportunities for personal growth through continued learning and gaining new perspectives, as offered by their community groups. Having a positive outlook was also identified as being important to the health of this group, as was especially noted later in their
life course when many of the women and men grappled with bereavement and illness. This positive outlook was manifested as optimism during hard times, as gratitude for being alive and as a display of inner strength and willpower to keep pushing forward despite challenges faced. The narratives also revealed that the belief in a higher power was present throughout the life course of most of the study participants, especially during discussions of traumatic experiences. This belief in a higher power helped them find solace during difficult times, it helped them find meaning to and acceptance of traumatic events and it also provided an outlet for social participation.

Although this study identified four contributors to the resilience of these West Indian women and men and, thus, their perception of healthy ageing, it should be noted that they are interconnected and work together. Throughout the narratives, it was evident that the participants of this study located themselves as strong and resilient individuals. Despite the upheavals of migration and associated experiences, they called upon their inner strength, spiritual connections as well as their connections to others and their communities to thrive and, therefore, construct their definition of healthy ageing.

7.3 Implications of the Findings

The findings of this study highlight the problem with using traditional definitions of healthy ageing, namely successful ageing and active ageing. This research, therefore, emphasises the importance of considering lay views of ageing, something that traditional definitions do not. By investigating the influences on and attributes of healthy ageing for older West Indians, this study adds much needed context to the consideration of ageing experiences of ethnic minority groups, as called for by others (Nazroo, 2004; Phillipson, 2015; Torres, 2015; Wray, 2003) and the findings of this study, therefore, contribute to the body of knowledge within gerontology and ethnicity studies.

While there exists a body of knowledge on the historical experiences of West Indians who migrated to the United Kingdom during the so-called ‘Windrush years’ (Fryer, 1984; Glass, 1960; Peach, 1986; Phillips and Phillips, 1999;
Sivanandan, 1981), there is limited research examining ageing and health among this cohort of individuals, particularly in South West England; see Wray and Bartholomew (2006) and Fenton (1985) as examples. Utilising the life course concept along with CRT, I was able to explore the attributes of healthy ageing through the concept of resilient ageing. With this knowledge of the participants’ attributes of healthy ageing, we can understand the mechanisms through which they work which could then be the target for policies and interventions supporting these communities. I maintain that instead of focusing solely on a deficit view of ageing, growing older should be viewed more positively and re-examined with a view of adapting the resilience framework. What this PhD study adds to existing literature is the examination of the processes and experiences of migration across the life course while incorporating the resilience ageing construct to facilitate the exploration of their healthy ageing perceptions.

7.3.1 *Implications for Gerontology*

Past research tended to problematise the ageing experiences of ethnic minority populations by suggesting that their health status is ‘part and parcel’ of their ethnicity instead of investigating the varying experiences they have had which could have impacted their lives (Zubair and Norris, 2015). In agreement, Torres (2015) contends that gerontology still has yet to fully engage in research that presents an inclusive view of healthy ageing whereby the impact of social and political processes are considered. Research needs to move beyond ‘the problems’ of ethnic minority ageing and, instead, recognise that there are wider societal aspects impacting on ageing experiences of these groups that ought to be considered. My research responds to these calls and fills this gap in the literature by utilising the life course approach and CRT to draw out participants’ stories and to examine the different social and political influences across the lives of a particular ethnic minority group in order to bring to light perceptions and attributes of healthy ageing, via resilient aging. The main contribution of this thesis, therefore, is the utility of CRT, the life course approach and resilient ageing together, thereby adding to field of social gerontology. What my findings on resilient ageing add to social gerontology is the incorporation of the views of older ethnic minority people while emphasising the importance of their
experiences and backgrounds, which serve to provide valuable socio-historical context.

Utilising critical race theory, this thesis explored the ways in which varying experiences over the migration life course have influenced perceptions of what it means to age healthily in a group of West Indians living the UK. My findings, therefore, respond to calls (Nazroo, 2004; Phillipson, 2015) for increasing knowledge about diverse ageing experiences within gerontology. In keeping with the overarching social justice agenda of CRT, I suggest that these findings should be used to consider how society as a whole and smaller, individual communities can better support the needs of ageing ethnic minority groups, such as the West Indians who took part in this study, thus maintaining their resilience. This thesis highlighted that ageing should be promoted as meaningful as opposed to a time fraught with problems and concerns. This thesis adds to ethnic minority ageing literature by demonstrating that a set of four interconnecting factors (participation in activities they valued, social connections, having a positive outlook on life and their belief in a higher power) contributed to the definition of healthy ageing and, therefore, their resilience for older West Indians in South West England. The emphasis here is on uncovering and understanding the strengths of this group in order to strive for positive outcomes. This research also shows the benefit of critically exploring influences across the life course with the goal of understanding how healthy ageing perspectives are formed, how they operate and how we can help those working with older ethnic minority groups better support and harness their strengths.

7.3.2 Implications for Theory, Policy and Practice

As discussed earlier in the thesis (see Chapter 3), the overarching goal of CRT is to provide social and historical context to the lives of ethnic minority groups, so that we as researchers, policy makers and practitioners can better understand how racialisation processes can impact their lives. Going further with this understanding, we can then advocate for social and political change towards inclusivity therefore contributing to the social justice agenda of CRT.
The findings from my study highlight and contribute to the discussion about the value of CRT in trying to uncover and examine how these racialisation and discriminatory processes can impact individual lives. Discussions with the participants of this study revealed that their intersecting social locations of their ethnicity, their migrant status and the resulting socioeconomic class affected their lives and were the basis of their subordination. By foregrounding their narratives, we learned about feelings of disappointment when they arrived in the United Kingdom. In particular, we heard stories of exclusion from the financial, housing, employment and social sectors. With CRT, we are better able to understand how a hostile society contributed to and resulted in the systematic socioeconomic oppression for migrants of colour, such as the West Indians who migrated to the UK during this time period. In response to the arrival of Caribbean people from the UK’s own colonies, policies and laws were shaped overtime to make it increasingly difficult for migrants move to the UK and find meaningful work.

Critical race theory is also important to this study because it helps us to remember that although a person may not discuss or actively identify certain interactions as being racist, this is no indication that racism is not happening; I found this tenet of CRT particularly pertinent during data collection and analysis. Known as ‘ordinariness’, it helps us remember that racist incidents may be difficult to identify or to discuss and, because of this, we should consider that people might speak about racism in different and sometimes subtle ways. During data collection for this study, I noticed that there were a few interviewees who did not explicitly state that they experienced racism or discrimination. Instead, they indirectly discussed the effects of being discriminated against (as one brief example, one participant who worked at a factory in the same position for 40 years). Occurrences such as these add to the debate within CRT regarding the usefulness of storytelling in social research; CRT challenges us to look deeper into the narratives people share. If we, as researchers, do not acknowledge the subtle ways that individuals may discuss racist and discriminatory incidents, we place these important stories at risk by not having deeper understanding and therefore not allowing these stories to reveal their truth. In doing so, we also run the risk of assuming that racism and discrimination did not occur which would be to the detriment of ignoring the possible impact of said racist incidents, which have
resulted in the continued marginalisation of the West Indians in the study, as well as other ethnic minorities groups.

People of colour and other minority groups are encouraged to engage with and discuss their experiences with oppression (Delgado and Stefancic, 2012; Solorzano and Yosso, 2002), such that their experiences can be used in a transformative manner. The main agenda of CRT is that of social justice and social transformation and for this thesis in particular, the goal was to uncover and understand the structures and processes, which occurred over the life course, that helped this group to build and maintain resilience and they got older. Once we have gained this understanding, we can begin to transform the social, political and educational institutions not just operating with those communities, but in wider society in general.

Stories, such as the ones I have presented in this thesis, challenge the current prevailing narrative, that is, an ethnic minority group consistently linked with poor socioeconomic and health outcomes. Instead, with CRT, we are better able to examine and use the experiences of people of colour to challenge the status quo and, ultimately, empower groups that have been discriminated against. Although this thesis has made valuable contributions to discussions on ethnic minority ageing, it should be noted that these findings are not applicable to all Caribbean communities in the United Kingdom. In acknowledging the anti-essentialist aspect of CRT, these findings are unique to this particular group of West Indians in South West England. Therefore, experiences of other West Indians elsewhere in the United Kingdom should be investigated to learn about their unique set of experiences.

Using CRT and the life course approach, this thesis examined the experiences of a group of West Indians in the UK, who have been marginalised, in order to understand their perceptions of what is important to their health and well-being today. These findings on healthy ageing for older West Indians are presented through the lens of resilient ageing. With this in mind, researchers, policy makers and practitioners are able to get a more complete picture of the socio-historical context within which individuals have spent their lives, which can be of
significance in understanding their perspectives on their health. Critical race theory can broaden and deepen the quality of practical approaches taken to ensure the health and well-being of ethnic minority communities. Direct implications of CRT in practice are that institutions serving or policies directed at the needs of minority communities can critically look at their current approaches to determine whether or not they are employing ineffective universal methods across the board or if they are considering past and current social context.

In line with social justice agenda of CRT, this thesis uncovered the attributes of healthy ageing, via the concept of resilient ageing, for this particular community of Caribbean people in Bristol and Bath. This study found that healthy ageing is made up of interconnecting factors, which operate across the entire life course and exists on both on personal and external levels. The findings suggest that these life course experiences can either weaken resilience or build resilience. These are known as risks and assets. The implications of this is that if we go further, these findings suggest that knowledge of these risks and assets can be used transformatively such that we can consider how different aspects of society, such as supportive environments or public service policies and interventions, can be re-examined through the resilience lens and go on to adapt a resilience framework, with the goal of building resilience in these communities. When the needs of this group are considered and supported, we continue to contribute to their overall resilience and, therefore, healthy ageing.

The findings of this study revealed that healthy ageing is more than maintaining optimal physical, mental and social health. This thesis considered the ways in which social and political structures in society have contributed to the study group’s definition of healthy ageing and found that the attributes of healthy ageing are expansive and are dependent on the individual as well as the impact that wider society had upon that person. This study, thereby, challenges the notion of individual responsibility of healthy ageing by highlighting that, in addition to personal resources, there are external structures that contribute to this.

Ageing policy in the United Kingdom often discusses ageing in relation to the maintenance of optimal health. This study has raised important questions for
ageing policy in that ageing should be considered beyond the ‘optimal health’ viewpoint, as this restricted interpretation does not align with the definitions of health for older people. This study also suggests that ageing policy should consider the contribution of the ageing foreign-born population to the proportion of older people in the UK. This is pertinent given that the foreign-born population almost doubled to 13.1% between 1993 and 2014 (Vargas-Silva and Rienzo, 2016). With this recognition, comes the need to understand and accommodate a diverse set of definitions and attributes of healthy ageing.

The study findings indicate that research and practice needs to examine different definitions of healthy ageing by considering the different pathways through which the attributes of healthy ageing work. By using an interpretivist perspective, I was able to see how these women and men drew on personal and external resources to create their definition of healthy ageing. Going further, the evidence from this study suggests that the attributes of resilience and, therefore, healthy ageing are drawn from internal and external influences and, as such, any community efforts aimed at healthy ageing should take this under consideration. The utilisation of resilient ageing challenges the traditional definitions of healthy ageing that are focused on deficits. Resilient ageing, instead, forefronts the authentic and realistic aspects of healthy ageing whereby there is recognition for the ways in which people accommodate and adapt to their limitations to remain healthy.

7.4 Strengths and Limitations of the Study

Reflecting on the PhD process, there were some valuable lessons learned; these are considered below.

One of the strengths of this research is that, to my knowledge, this is the first study to combine the life course approach and critical race theory. Utilising these together, I was able to analyse the findings such that I was able to draw out influences on healthy ageing over the span of the migration life course. This was done with a view of highlighting the ways in which social and political processes operating in society have affected the lives of my study participants, from their perspective. In addition to understanding these processes, I selected specific...
participants and presented their narratives of migration according to each phase of the migration life course, thereby highlighting voices from a marginalised community.

Throughout the study, I learned that my background as a West Indian was advantageous during certain parts of the process. I initially hoped that me being from the Caribbean would be beneficial, but I did not realise just how useful it would be until I started recruiting and data collection. Once the gatekeepers realised I was from Antigua, they were more willing to listen to what my project was about and encouraged me to tell the members of their community groups that I was West Indian. I was able to recruit quite a few study participants because they were sympathetic to the needs of a fellow West Indian. Having a shared background was useful during the interviews and data analysis. Many of the participants included me when talking about ‘we’ and ‘us’ and during reminiscing about living in the Caribbean. Being able to share some of their experiences and them knowing that I have a genuine and personal interest in what they have to say, put the study participants further at ease.

The study sample consisted of a small number of people. I initially hoped for at least 30 participants to participate in interviews and focus groups but recruiting proved to be difficult and took longer than expected. Interviews and focus groups have different exchanges and interactions regarding the ways in which discussions are inspired. The study consisted of 16 interviews and one focus group and while the study could have benefitted from having more than one focus group, this was not possible due to the aforementioned issues with recruitment. I was still, however, able to attain data saturation during fieldwork.

I also tried to recruit participants from a wide range of backgrounds, especially those who were infirmed and, as a result, were not able to participate in social activities on a regular basis. I attempted to do this during the beginning of the recruitment period by contacting carers’ networks, churches and senior citizen community groups. I also thought that snowball recruiting would have led me to such hard to reach populations, but I was unsuccessful. However, learning from this and with ethics approval, I perhaps could have sought the assistance of a
single gatekeeper specifically to assist with recruiting housebound study participants. Even though I was not able to recruit isolated individuals, I do believe I was still able to recruit participants with a broad set of life experiences.

Finally, the study could have been enhanced by including participants from a variety of localities in South West England. This would have added a wider range of data and enabled comparison between different backgrounds, which potentially could have yielded more in-depth data. However, the limited resources of the researcher prevented this. While this would have been a good goal to achieve, this study still adds valuable diversity to studies done outside of London.

### 7.5 Recommendations for Future Research

Based on my study findings, I present suggestions for future research agendas.

Future research should continue to add to the literature on how other ethnic minority communities view their health, as they get older. This is because the ethnic diversity in the United Kingdom is increasing and many of these people are ageing here. With this, the findings indicate that these communities may also have different or diverse views on what it means to age healthily. As such, developing further understanding about what constitutes healthy ageing in these communities is needed. Following this, research should also continue to use qualitative methodologies to provide this much needed insight because, as explained in Chapter 4, they allow the research to uncover meanings behind and connections between different experiences.

This study found that healthy ageing was impacted by both personal and external factors. Further research, therefore, could be done to explore additional external factors and which would enhance our understanding of the ways in which such factors help to build resilience.

Future research should also be extended to include other stakeholders, such as policy makers, programme planners and community workers. Their contributions could add valuable data about the experiences of working within ethnic minority
communities. This will provide information from a different perspective, potentially, about the barriers faced when working in diverse communities.
References


Chaston, R., Baghirathan, S., Shears, P., Chacun, A., Currie, K. and Bristol BME Dementia Research group, Alzheimer’s Society, Bristol City Council. (2017), *The Dementia Experiences of People from Caribbean, Chinese*
and South Asian Communities in Bristol, Alzheimer Society, Bristol, available at: http://eprints.uwe.ac.uk/31198/.


Feldman, M.S., Bell, J. and Berger, M.T. (Eds.). (2003), Gaining Access: A Practical and Theoretical Guide for Qualitative Researchers, AltaMira Press, Walnut Creek, Calif.


Haslam, C., Cruwys, T. and Haslam, S.A. (2014), “‘The we’s have it’: Evidence for the distinctive benefits of group engagement in enhancing cognitive health in aging”, Social Science & Medicine, Vol. 120, pp. 57–66.


McKay, L., Macinytre, S., Ellaway, A., Medical Research Council (Great Britain) and Social and Public Health Sciences Unit. (2003), *Migration and Health: A Review of the International Literature,* MRC Social & Public Health Sciences Unit, Glasgow, available at: http://www.sphsu.mrc.ac.uk/library/occasional/OP012.pdf.


Appendices

Appendix 1 – Organisations identified as working within the ethnic minority or elder communities in Bristol and Bath:

1. African Voices Forum
2. Barbados and Caribbean Friends Association
3. Bath Ethnic Minority Senior Citizens Association
4. Black South West Network
5. Bristol Black Archives Partnership (BBAP)
6. Bristol Black Carers
7. Bristol Older People's Forum
8. Bristol Women's Voice
9. Church of God of Prophecy
10. Easton Community Centre
11. Golden Ager Club
12. Hannah More Senior Citizens Club
13. Linkage Bristol
14. Malcolm X Community Centre/Elders Forum
15. New Testament Church of God
16. Southdown Methodist Church Centre
17. St Agnes Church
18. St Pauls Afrikan Caribbean Carnival
Appendix 2 – Emailed Study Ad

You Are Invited!

Hello! My name is Danielle and I am from Antigua. I am a student at the University of Bristol and would like to learn about the ways in which moving from the Caribbean to England have impacted on your health and well-being. This study is for adults only and is voluntary.

Would the study be a good fit for me?
This study might be a good fit for you if:
- You were born any English speaking Caribbean island
- Moved to England in the 1940s, 1950s or 1960s.

What would happen if I took part in the study?
If you decide to take part in the study, you would:
- Call Danielle or be invited to hear more about it
- Be given an information sheet and consent form
- Take part in a one hour interview

To take part in this project or for more information, please contact Danielle Ward at:
Tel: 0117 331 1095
E-mail: Danielle.Ward@bristol.ac.uk

The person organising the study is Danielle Ward at Centre for Research in Health and Social Care, School for Policy Studies University of Bristol, 8 Priory Road, Bristol BS8 1TZ
Appendix 3 – Recruiting Letters

St. Agnes Church
Thomas Street
St. Paul’s, Bristol
BS3 9LL

March 4, 2015

Dear Reverend Green,

My name is Danielle and I am a student at the University of Bristol currently studying for my PhD. The main goal of my PhD project is to learn about people’s experiences of moving to the UK from the Caribbean in the 1940s through the 1960s.

I would welcome the chance to come and speak with you and, possibly, your members to see if they would be interested in taking part in my project. I plan on conducting private, individual interviews that will be arranged at a day, time and place suitable to those interested. The interview would last between 30 and 60 minutes, all interviews will be kept confidential and those participating will remain anonymous as no names will be used. For your perusal, I have included a Participant Information Sheet and a flyer for the project in this letter.

I would love the opportunity to discuss this further with you; would it be possible for you to please contact me on either the telephone number listed below or the email address?

Phone: 0117 331 1095
Email: danielle.ward@bristol.ac.uk

Thank you for your time and I look forward to hearing from you.

Kindest Regards,

Danielle Ward
Appendix 4 – Participant Information Sheet

Participants Information Sheet
November 14th, 2014

Caribbean Elders Project

What is the purpose of the study?
The purpose of the study is to understand how your experiences of moving to the UK in your earlier years may have influenced your health and well-being today.

Why have I been invited to take part?
You have been invited because: (1) you consider yourself to be a West Indian/Caribbean person (2) who moved to the UK between 1945 and 1965 and (3) is over the age of 60.

Do I have to take part and what will happen if I do?
No, you do not have to take part if this study, it is 100% voluntary. If you want to take part, you will be contacted to arrange the interview, which will occur at a time and location most convenient for you. The interview will be conducted by Danielle Ward and will be expected to last about an hour.

If you decide that you no longer want to take part, you are free to withdraw from the study at any point. After the interview, the information you have given me will be combined with interviews with other people. This means that if you decide to withdraw from the study after this has happened (1 March 2015), your contribution will have to remain a part of the study.

Will taking part in the study remain confidential?
Anything said during the interview will only be between you and Danielle and is confidential. However, if Danielle has serious concerns for your safety or if what you do affects the safety of another person, she will need to inform an appropriate person. The information from your interview will be used anonymously so you will never be able to be identified.

Things like the consent forms and your contact details will be kept in locked cabinets. The interview recording will be stored in separate locked digitally protected files. All information collected will be stored securely for at least 10 years then destroyed, per the Data Protection Act.

The study has received ethical approval from the University of Bristol School. If there are any issues with how the interview was conducted, you may contact the researcher’s supervisor:
Sarah Payne – 0117 954 6775 or Sarah.Payne@bristol.ac.uk

What do I do now?
If you wish to participate, you can sign up now or you can to complete and return the enclosed reply slip either in person, by e-mail or via post.

Danielle Ward, Centre for Research in Health and Social Care, School for Policy Studies, University of Bristol, 8 Priory Road, Bristol BS8 1ZD • 0117 321 1095 • danielle.ward@bristol.ac.uk
Participant Information Sheet  November 14th, 2014

Return Slip
Resistance and Resilience: Older West Indians in the UK

Would you be interested in finding out more about this study? (Please circle as appropriate)

Yes  No

If yes, please complete the details below:

Name

Daytime
Tel:

Evening
Tel:

E-mail:

Best time to call  Morning  Afternoon  Evening
(Please circle)

Please return slip to:
Danielle Ward, PhD student
School for Policy Studies, University of Bristol
8 Priory Road, Bristol BS8 1TZ

Tel: 0117 331 1095
E-mail: Danielle.ward@bristol.ac.uk
Appendix 5 – Consent Form

Interview Consent Form
November 14th, 2014

Participant ID Number: 

Caribbean Elders Project
Participant Interview Consent Form

Please INITIAL if you agree with each sentence below:

<table>
<thead>
<tr>
<th>Please read the following</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have read and understood the participant information sheet for the above study. I have had the opportunity to ask questions and I am satisfied with the answers and explanations provided.</td>
<td></td>
</tr>
<tr>
<td>2. I understand the purpose of the project and my involvement in it.</td>
<td></td>
</tr>
<tr>
<td>3. I understand that my participation in this study is entirely voluntary and that I am free to withdraw from the study up to the point of data analysis (March 1 2015). I also understand that it may not be possible to withdraw any data I have provided.</td>
<td></td>
</tr>
<tr>
<td>4. I understand that while information gained during the study may be published, I will not be identified. My personal answers and results will remain confidential.</td>
<td></td>
</tr>
<tr>
<td>5. I understand that I will be digitally audiotaped during the interview.</td>
<td></td>
</tr>
<tr>
<td>6. I consent to the use of anonymised direct quotes in the write up of the project.</td>
<td></td>
</tr>
<tr>
<td>7. I understand that data will be stored securely, per the Data Protection Act.</td>
<td></td>
</tr>
<tr>
<td>8. I agree to take part in the above study.</td>
<td></td>
</tr>
</tbody>
</table>

Please print and sign below in the space provided and add today's date.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Researcher Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Danielle Ward, Centre for Research in Health and Social Care, School for Policy Studies University of Bristol, 8 Priory Road, Bristol 821 177 || 0117 311 1009 || danielle.ward@bristol.ac.uk
Appendix 6 – Interview Guide

**Background**
- Household composition and personal relationships (family, friends, community)
- Working, retirement status
- Self-identification, i.e. consider to be White, British
- Why
- Ethnicity, Why
- Which island born in and when
- Describe different things considered important to your health and well-being
- What do you think is the impact of migration on health

**Migration**
- Experiences and feelings during the move
  - How moved? What did on the boat; who spoke with; how felt; how treated; made friends on the boat; stayed friends post-move
  - Contact with family/friends on the boat? What about after... how long after was able to contact family/friends once in England?

**PF**
- Describes family life
  - Left any children, family behind? How often saw/spoke with them?
  - Own children here?
  - Living situation at that time (e.g., in a bungalow, etc.,
- Occupation, housing, neighborhood
- Communication with home country
- Leisure activities
- Motivations in life, Opportunities
- Difficulties faced
  - Difficulties raising a family in the UK vs. 'home'
  - Any particular difficulties?
  - How experiences influenced decisions, choices
  - Describe different times considered important to your health and well-being
  - Identifying range of factors with perceived impact on health and well-being
  - How/why these factors have impacted health

**Retirement & Present Day**
1. If retired, when? If not, reasons why not?
2. Transition to retirement?
3. Housing, neighborhood, social networks
4. Family life and social networks now
5. Communication with home country
6. Leisure activities, interests – how did you come to join?
7. Community activities and groups: What’s important, what’s missing
8. Motivations in life
9. Difficulties faced, Opportunities
10. Describe different things considered important to your health and well-being
    - Issues/experiences that have made a difference to health and well-being: how and why
11. Any long-standing illnesses that maybe it doesn’t impact you day-to-day but maybe you still need to see a doc?
12. Has the way you thought about health changed over the years?
13. Who can you talk to about certain things, when something is troubling you?

**Place for Present Day**
1. Well-being vs. healthiness now vs. then

---

**BE SURE TO ASK**
- Has the way you thought about health changed over the years?
- Do you ever go to the doctor? How do you find that experience?
- When you arrived, did you know how to access a doc? Did you know about services and how to access?
- Access health services before you came?
- Are there times when your health hasn’t been so good? Struggled with health in the past?
- Any long-standing illnesses that maybe it doesn’t impact you day-to-day but maybe you still need to see a doc?
- How did they come to join the group?
Appendix 7 – Ethics Application

Project Title: Resistance and Resilience: Older West Indians in the UK

Expected Duration of Research Activity
In the original application, the data collection period began in October 2014 and lasted through April 2015.

The proposed change includes adding time to the research activity; July 2015 through September 2015. This request is being made to include an additional method of data collection, focus groups, which will be detailed below.

Study Objectives and Aim
The aims and objectives of the study remain the same as detailed in the original application.

Research Methods and Sampling Strategy
Interviews were the method of data collection stated in the original application. The proposed change includes the addition of two focus groups.

To-date, there are two main organisations through which the study population has been identified, recruited and interviewed. This study proposes to recruit individuals for the focus groups from these organisations. This continues to be a qualitative study and, as such, will utilise a purposive sampling approach. The researcher will seek to include in the focus groups those who have previously participated in the study. However, new participants will not be excluded if they wish to join. On the basis that I have visited both of these centres several times and have explained my work to several individuals, most of the group members are already familiar with the project. Existing relationships will be of benefit here.

Information from previously conducted interviews can be used as the basis upon which existing data can be gathered during the focus groups. This methods enables an awareness of the participants’ shared understanding and construction of their daily lives and associated experiences. The social element of focus groups will add to the depth and of information gathered from previously conducted interviews.
The focus groups are not expected to last longer than 45 minutes. Two focus groups will be conducted, one from each centre and will include 5-8 people. The focus groups will be facilitated by Danielle Ward.

Potential Benefits and to Whom
As stated in the original application, there are no direct benefits to the participants. However, this study will offer participants to have their voices heard, which can be rewarding as some minority groups often have that experience.

Potential Risks/Harm to Participants
The researcher will continue to make every possible effort to ensure that the research does not cause any harm towards the participants. The study does not intend on recruiting vulnerable adults but there is the potential that during the focus groups, someone may reveal that they are at risk for being abused and/or exploited or the subject matter being discussed may cause emotional distress.

The following table addresses how the potential risks will be handled.

<table>
<thead>
<tr>
<th>RISK</th>
<th>PRECAUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distress during focus groups</td>
<td>Participants will be reminded that they are not obligated to take part in the study.</td>
</tr>
<tr>
<td></td>
<td>Participants will be reminded of their right to end their participation in the focus groups up to the point of data analysis (September 2015).</td>
</tr>
<tr>
<td></td>
<td>Should the researcher recognise signs of distress during focus groups, the session will be stopped and the individual(s) will be given time to compose themselves. The participant(s) will be given the option to end their involvement in the focus group or to continue.</td>
</tr>
<tr>
<td></td>
<td>Should participants request information relating to topics discussed in the focus groups, relevant information and documentation will be made available and supplied.</td>
</tr>
<tr>
<td></td>
<td>The participant(s) will also be encouraged to contact their GP, local church, elder care group or AGE UK.</td>
</tr>
<tr>
<td>The potential for abuse or exploitation is revealed</td>
<td>Every effort will be made to protect the confidentiality and anonymity of each participant. There are, however, certain circumstances where confidentiality may be threatened.</td>
</tr>
<tr>
<td></td>
<td>Before any research begins, participants will be informed about the steps taken to ensure confidentiality and will also be informed of the limits of confidentiality.</td>
</tr>
<tr>
<td></td>
<td>Should a situation arise whereby confidentiality needs to be broken, e.g. the researcher has serious concerns for the safety of the participant or the participant’s behaviour may affect the safety of</td>
</tr>
</tbody>
</table>
Recruitment Procedures
As previously mentioned, focus group participants will be identified through the two organisations where the original interview participants were recruited. The researcher will contact the gatekeepers for access to the sites and remind them of the purpose of the study. Once access has been granted, the researcher will then re-visit the sites, remind participants about the study and inquire about interest. Once more, potential participants will be made to understand that there is no obligation to participate in the study. Participant Information Sheets, Consent Forms and Study Ads will be on-hard for distribution.

Informed Consent
Informed consent for the focus groups will be similar to the procedure explained in the previous application for this study.

Data Protection
Data protection for the focus groups will be similar to the procedure explained in the previous application for this study.

Confidentiality and Anonymity
Given the social nature of focus groups, there is the potential that sensitive data may emerge during the sessions. The Participant Information Sheet, the Consent Forms as well as the researcher will explain that personal and sensitive matter may arise during the sessions and that each person should keep what they hear confidential. The researcher will also explain that the data will be anonymised and that no personal information will be made available. Participants will be made aware of the limits of confidentiality and anonymity via the Participant Information Sheet and the Consent Form. If there is a reason to suspect that the participant is at risk for harm (or is harming others), the researcher will inform her supervisors who will assist with deciding the appropriate course of action and if confidentiality needs to be broken. Should confidentiality need to be broken, the participant will be informed accordingly.