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"Care from the heart": Older minoritised women's perceptions of dignity in care

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Introduction

Recently, quality of care for older people in Europe has come to be associated with patient-centredness, equity of access to services, and maintaining dignity and autonomy (Ariño-Blasco et al., 2005; Heijkenskjöld *et al.*, 2010; Jakobsen and Sørli, 2010; Yu and Saltus, 2012). Dignity can be understood as the inherent value of human beings, and our fundamental right to be respected and acknowledged as worthy (Gallagher *et al.*, 2008). In the context of care provision, dignity aims to enhance sense of worth (Fenton and Mitchell, 2002; Clark, 2010), and the concern with dignity has led to care frameworks and policies that emphasise providers' obligations to promote and protect older people's rights and dignity (Bayer *et al.*, 2005; Calnan *et al.*, 2006; Bridges and Nugus, 2010; Black and Dobbs, 2013). A key driver underpinning the policy directives has been research showing how vulnerable individuals, including older people, are treated by service providers with a lack of respect and sensitivity for their dignity (Lothian and Philp, 2001).

Such policies and care frameworks, however, have been less straightforward in protecting the individuality, rights and dignity of older recipients of care, leading to debates on what dignity means and involves (Fenton and Mitchell, 2002; Jacelon *et al.*, 2004; Nordenfelt and Edgar, 2005), and whether it is a useful concept in guiding practice (Fenton and Mitchell, 2002; Macklin, 2003). There is now a general consensus that dignity in care means different things to different people (Fenton and Mitchell, 2002; Clark, 2010), but – despite the difficulties involved in operationalising

this dynamic and multi-layered concept – older people tend to agree on its importance (Lothian and Philp, 2001; Giuntoli and Cattan, 2011).

Progress in identifying the components of dignity comes from qualitative research exploring the perceptions of service providers (Ariño-Blasco *et al.*, 2005; Heijkenskjöld *et al.*, 2010; Jakobsen and Sørli, 2010; Yu and Saltus, 2012) and care recipients (Bayer *et al.*, 2005; Calnan *et al.*, 2006; Bridges and Nugus, 2010; Black and Dobbs, 2013), and by comparing these (Walsh and Kowanko, 2002). Possible differences in perceptions and expectations of care and support between (and among) groups of older migrants – as well as migrants and non-migrants (Giuntoli and Cattan, 2011; Saltus and Folkes, 2013) – have also been explored.

The evidence shows that older people from all ethnic backgrounds value care and social support from various sources – including family, friends and neighbours – and older people from minority ethnic backgrounds also have similar expectations of this as the national majority population (Grewal *et al.*, 2004; Moriarty and Butt, 2004; Cattan and Giuntoli, 2010; Giuntoli and Cattan, 2011). Differences between experiences and expectations of care and support do exist, however, influenced by ethnicity and culture (Giuntoli and Cattan, 2011). Exploring whether and how expectations differ between older migrants from different ethnic groups and between older migrants and non-migrants, Giuntoli and Cattan (2011) report both common expectations of what care should involve – with dignity, trust and communication being important, and views on how care should be provided differing between groups (due to cultural backgrounds in some cases).

This is perhaps not surprising, for cultural values and norms are known to impact on people's lifestyles as well as on how people view illness, what they expect of care, and how they seek help and access services (Bowes and Wilkinson, 2003; Milne, 2004; Lawrence *et al.*, 2006; Moriarty, 2008; Botsford *et al.*, 2011). Care and support preferences and expectations are shaped not only by cultural traditions, but also by a complex set of social, interpersonal and pragmatic factors. As such choice, expectations, and decision-making can be understood as being dynamic and evolving. Factors influencing decision-making include personal preferences and values; individual agency; knowledge about and acceptability of services; family roles and relationships, e.g. proximity of family members (Moriarty and Butt, 2004;

Gunaratnam, 2006; Seymour *et al.*, 2007); and wider social factors, including the intersecting impacts of ageism, racism and social status (Saltus and Folkes, 2012, 2013).

Giuntoli and Cattan (2011) stress the need for more research into older migrants' knowledge systems, as well as for a theoretical framework that can explain, first, the interactions between culturally-based and individual expectations, and, second, how differences in beliefs and attitudes to care between different groups of older migrants and between migrants and national majorities arise. This paper aims to contribute to both propositions, in two ways. First, it combines the analytical framework of intersectionality with the theoretical life-course perspective, so developing a relevant and appropriate approach to guide our understanding of how conceptualisations of dignity and care are formed. Second, it presents findings from a large, mixed-methods study that used this approach to capture dignity perceptions and care expectations of older migrant women from Black and minority-ethnic (BME) backgrounds, and service providers' understandings of good-quality, person-centred delivery. This paper focuses on data exploring the perceptions of dignity, and care expectations, of older, community-dwelling women aged 50 and over, (threshold defining old age as described by Welsh Assembly Government (WAG, 2007). Findings relating to the concept of dignity as understood by the participants, and how this might be shaped by personal and social life histories and multiple identities, are reported elsewhere (Saltus and Pithara, 2014) – as are the results of the survey on service providers' perceptions of care given to minority-ethnic older women (Yu and Saltus, 2012).

Intersectionality and a life-course perspective

This paper argues for the relevance of intersectionality rooted in a life-course perspective to guide research on the multiple forms of dignity and care perceptions within diverse migrant female populations – understandings rooted and taking shape within shifting landscapes of belonging, ongoing transnational connections, and complex realities unfolding across the life course. Both frameworks acknowledge the multiple, conflicting and dynamic influences on individual human existence through roles and identities adopted throughout life, and the interplay between micro- and macro-level realms of social life. In trying to understand and explain older people's

attitudes and beliefs regarding dignity in care and old age, it is argued that significant events and changes (such as migration and settlement) cannot be separated from the multiple identities and social roles that people adopt throughout their older lives – or from the impact of wider societal inequalities (such as classism, racism and sexism), which also shape how people are positioned, recognised and acknowledged in different social encounters and contexts throughout life. As a theoretical model, the life-course perspective has been developed and used in numerous disciplines (including sociology, anthropology and psychology) independently and multidisciplinarily (see for example: Stein and Moritz, 1999; Hareven, 2000; Elder *et al.*, 2003; George, 2003; Hutchison, 2011). This approach attempts to understand a person's life and behaviour at specific stages in life by focusing attention on three dimensions of existence: the individual level, looking at the sequence of significant events, experiences and transitions from birth to death; the family level, looking at how a person's life is 'synchronised' with those of other family members across time; and the macro level, looking at how culture and social institutions shape individual lives (Elder *et al.*, 2003; Hutchison, 2011). Thus, the life-course approach conceptualises individuals reciprocally connected on several levels across generations, focusing on the interaction between the individual and their environment, and how historical time, social location and culture affect the individual experience of each life stage (Maddox and Campbell, 1985)

Critical race, feminist and class theorists have for decades engaged with the interconnections between societal inequalities. However, the concept of intersectionality was first introduced in the 1970s by Kimberlé Crenshaw in her research exploring the intersecting impact of 'race' and gender on Black women's experiences of employment and violence (Björnsdóttir, 2010). Since then, intersectionality has developed into an interdisciplinary, theoretical framework for analysing multiplicity, social diversity and structural inequality (see for example, Brah and Phoenix, 2004; McCall, 2005; Hancock, 2007; Walby *et al.*, 2012). Intersectionality, as the name suggests, emphasises that different dimensions of social and personal identity cannot be separated into discrete and pure strands; rather, they are fluid, dynamic and interacting (Brah and Phoenix, 2004). Who we are has individual dimensions but is also essentially relational, emerging from our differences from and similarities to others (Phinney, 1996; Rosenfield *et al.*, 2006;

Hankivsky and Christoffersen, 2008; Chaney, 2011). These social relations are situated within interrelated systems of power relationships linked to ascribed notions such as 'race', class and gender, which in turn (re)produce an inequitable distribution of resources to groups in society, creating dominant and subordinate groups (Björnsdóttir, 2010). Intersectionality, focusing on multiple axes of identity and on power relations, allows a more detailed level of exploration and understanding of the intersections between different identity characteristics and the experience of inequalities, guiding methodological design and providing a theoretical framework for understanding data or events (Cole, 2009).

Within the context of migration, intersectional frames – such as Anthias' (2008) work on translocational positionality – are important, providing a conceptual frame that recognises people's multiple locations, positions and belongings in a situated and contextual way. Such work pushes beyond the potential pitfall of essentialising axes of difference, and making concrete notions of belonging. We take account of multiple interrelated dimensions of personal and social identity, significant events and changes in the course of life (such as migration and motherhood), drawing out their significance in shaping beliefs and attitudes towards the meaning and expression of dignity in old age, within the context of care expectations.

Methods

Data collection and participants

Recruitment targeted older women (aged 50 or over) living in Wales who self-identified as Black Caribbean, South East Asian (Chinese), South Asian (Bangladeshi Muslim) or Indian by upbringing, birth or acculturation. Two women who were not yet 50 but saw themselves as older women were included. The methods used in the overall study are detailed extensively elsewhere (Saltus and Pithara, 2014).

Qualitative methods were chosen as most appropriate to explore the multi-layered concept of care, and its meaning for older women. Semi-structured interviews were conducted to ensure that the key topics of interest identified at the start of the study were raised and discussed with all participants. Given the importance of nonverbal communication, and desire to elicit responses in a conducive social context and to

foster trust and engagement, face-to-face (rather than telephone) interviews were conducted. Although a focus-group methodology was considered, one-to-one interviews were deemed more appropriate, given the need to explore the individual care expectations of women, and the facts that care is not a tightly defined concept (Gillham, 2005) and the geographical area includes rural parts of North Wales.

An interview schedule was developed, piloted and peer-reviewed; this drew on research and policy literature, the knowledge and experience of the research team, and reflections on the preliminary engagement work and discussion groups with older women from the target groups. The schedule included perceptions of age, dignity, care and care expectations.

The study was promoted to cultural, religious, arts and equality organisations frequented by and important to the target groups. Five part-time community researchers, employed from the target groups, were responsible for recruiting and supporting the participants, conducting and (where necessary) translating the interviews, and validating transcripts. The sample was generated using purposive sampling; thereafter, snowball sampling allowed each person to nominate one other potential participant.

Information about the study and consent forms was given to potential participants, who had two weeks to talk to family, friends and carers before deciding whether to take part. Potential participants were informed that participation was voluntary, they could withdraw at any time and their interview would be anonymised. All researchers were trained in how to work ethically with vulnerable, consenting adults, and their carers and supporters. Ethical approval to conduct this study was granted by the Ethics Committee of the Faculty of Health, Sport and Science, University of Glamorgan, in July 2011.

Data collection took place between February and August 2012, through interviews in participants' homes, community centres, churches, and public areas such as cafes. The interviews were audio-recorded with the participants' permission.

Analysis

The interviews were anonymised, translated, transcribed and, using the qualitative analysis software QSR NVivo (version 8), analysed according to the methods of

thematic analysis (Braun and Clarke, 2006) by two members of the research team. All participants were exclusively assigned and identified via unique identification codes only. Initial categories were created based on the interview themes, and the final conceptual themes identified following reading, re-reading, coding and re-coding of the data (for a detailed description see Saltus and Pithara, 2014). The key themes explored here revolve around participants' perceptions of growing old, meaning and attributes of care, and care with dignity. The findings are presented in narrative form, illustrated by verbatim extracts.

Findings

Participants

Table 1 about here

Table 2 about here

Interviews were conducted with six women of Indian heritage, seven Caribbean, eight Bangladeshi and 11 Chinese (Table 1). While two women were 48 years old, the others ranged from 52 to 78 (Table 2). Most participants lived in South East Wales (n=24), and the rest in North Wales. Of the 32 participants, 11 were employed or self-employed), 12 were retired and nine had never worked. Eight lived with their children and nine with their husbands. Most had family members living nearby and met them regularly. A significant number of women were supporting or caring for relatives or friends, with five providing one to 19 hours of care per week, three 20 to 49 hours, and four 50 hours or more. The experience of migration linked all participants, with two women born to parents who migrated to Wales in the early twentieth century, and the rest arriving at different life stages – from within the last ten years to over 40 years ago (Table 3).

Table 3 about here

Understanding of care

Many participants understood care as encompassing both tangible (physical) and intangible (psychological) dimensions. In the former, the emphasis was on personal care and practical support – for example, in daily living, translation and medication. In terms of the intangible dimension, most participants expressed care as sustaining

emotional connections with the care providers. One participant directly distinguished between physical and psychological care (although for most participants, the two were inextricably linked):

Participant 028, Indian heritage, 52: *I think there are two aspects: one is physical and the other one is mental. If I won't be able to wash myself, I would like someone to wash me; that's a physical care, isn't it? But when I'm sad, I want someone to sit by my side and say a few things that makes you feel better; that's mental care. So you are taking care of both then, isn't it?*

Care was most commonly understood as 'looking after' someone:

Participant 014, Caribbean, 70: *I think if you are going to care for somebody, you have got to treat them with respect and a bit of love. You don't have to be slobbering all over them. A bit of love, a bit of respect and dignity again comes with it, make them feel dignified and you haven't sort of looked at them and said, 'You can't do this and you can't do that!' You can say, 'Try!'*

Most of the older women had cared for children, parents, husbands and grandchildren, and notions of care were deeply rooted in a familial context. Moreover, it was an important social marker; caring for family members was considered by many women, especially Bangladeshi, as part of their role as daughters, wives and mothers, and a duty to their family:

Participant 022, Bangladeshi, 62: *For me, [care] was about my duty towards my husband, I wanted to make sure he was OK [...] We should look after our husband and, whatever you do, Allah will give you that much in return.*

Perceptions of how to maintain a sense of dignity in later life underpinned participants' notions of care; dignity-enhancing care was understood as an expression of the respect, worth, honour and value of the older person. Older age was often linked to specific milestones that signified passage or transition into new life stages, mainly from being a mother and wife to being a grandmother, carer to one's husband or elder within the community. These milestones involved changes in status within the family unit and community, and were understood to be dignity-enhancing. Most women described older people as worthy of greater respect because of their age and life experiences. In this context, older age was also linked to social and cultural notions of expected behaviours and roles that appeared to be shared and transmitted within their specific domestic, social and cultural, or ethno-linguistic network settings. Many women's own sense of self, dignity and self-respect appeared to be shaped and influenced by their own and their social-network

members' perceptions of abiding by these rules. Differences existed, however, between and within groups of women, in the extent to which they abided by these social mores.

Migration and associated changes resulted in discontinuities for women and their families, in terms of traditional cultural notions of behaviour, including social and cultural perceptions of age and family. Life in the UK meant that women had to reassess previous notions of appropriate behaviour, especially their expectations of family attitudes and behaviours. Discontinuities also existed in adopting new roles linked to transitional points in women's lives, for example from mother to hands-on grandmother, or from full-time employment and work outside the house to other dignity-enhancing and age-related roles, such as being an elder within the community. Discontinuities in the ability to follow traditional cultural norms of behaviour as well as expected social and family roles, resulting from migrating away from one's cultural and familial context, led to discord between how life transitions were experienced and what was expected based on cultural perceptions and norms. This meant that some women did not experience dignity-enhancing roles such as that of elder within the community or the family, caring for grandchildren or being cared for by children, leading to lack of participation, autonomy and loss of dignity. What emerged from the data, however, was that notions of care and support were rooted in cultural or ethno-linguistic connectedness between members of the same family or culture.

Within this context, children and close relatives were viewed as most knowledgeable about their care and support needs, whether religious, dietary or everyday habits, as well as best able to meet the psychological aspects of caring. In some cases, women described how they perceived care given by a family member as different from that given by a professional, describing this as 'love care' – that is, 'care from the heart':

Participant 015, Caribbean, 54: *I think it's more about, um, the fact that, your family and friends, it's not paid care, it's, it's love care, it's care from the heart. So that does make a great deal of difference because professionals come in and it's a job, you know, there is, you know, they come in, they do a job, they've got, there are time constraints and all those other things, whereas with family and things, it's, they tend to take more time, I think, whereas I think it's just not about getting the job done, it's about ensuring that that person is OK [...] It's not just about cleaning and getting things cleaned or getting this person washed and dressed and sat in the chair, it's*

more about, you know, 'Are you alright?'. There's conversation, there's other little things.

Sources of care provision and care expectations

Meanings of care as linked to duty, the cultural value of honouring and caring for older people, and community connectedness sat alongside the perception by some that the delivery of such care and support was shifting, as were their own care expectations. Some differences emerged between participants. Those of Bangladeshi heritage whose families remained nearby continued to rely only on them for support and care, and the wider community for social support, whereas some Chinese participants revealed their hesitation to ask for additional care or support because of concerns of burdening their children, the fact that their families did not often live nearby, or the fear of distracting them from their own work and family life. A few Chinese older women described being unable to care for their own parents because of migration, and in turn not expecting their children to care for them in old age:

Participant 004, Chinese 52: *I wished that my children can care/look after me. But that's what I wished, it still depends on whether they are free to take care of me or not? [...] Look at me, I'm the same, although I care and miss my parents but I didn't live with them, all I could do was to ring them more frequently and speak to them on the phone.*

In this case the cycle of caring for one's parents had broken and this had in some cases changed women's expectations for care.

For many of the women of Indian-Welsh and Caribbean heritage who conducted their interviews in English, care was understood to be the responsibility of social-care or voluntary organisations rather than the family. Reasons for this included unwillingness to burden relatives, notions of professional care-givers being more suited to and knowledgeable in providing support, and the understanding that – within the new living and working conditions – care and support may have to be provided by 'outsiders'.

Participants were asked to share their concerns and fears regarding the time when they would require active support and care with everyday activities, an exploration of which revealed their care expectations. Foremost for many were concerns linked to maintaining their bodies, and their day-to-day lives. Bathing and dressing rituals,

food and daily activities were considered vital to both the structure and quality of life, and one issue that caused concern was the loss of dignity associated with a decline in ability to care for themselves and dependence on others (especially non-family members) for personal and intimate care.

Another key theme to emerge was concern that being cared for in old age would mean they would lose their identity, humanness, autonomy and worth. For some women, attention to their individuality was crucial in delivering responsive and appropriate care:

Participant 029, Indian heritage, 63: *Respecting my identity, for example, I am a professional so they should defer to me and respect my professionalism, [...] my knowledge and lifestyle. On the contrary, when an elderly person goes to live there [in a care home], they become a number, they lose their identity ... and the care-givers ... do not want to recognise that that person could be, could have been a professional or a teacher or a qualified nurse or some sort of established person, and they come to the nursing home or care home because they do not have people to look after them at home or the environment at home is not quite appropriate, that's why they come but when they come to care homes they become a number rather than a personality.*

The acknowledgement of different cultural backgrounds, appropriate communication and language skills, as well as respect for the individual and their life experiences, were raised by many women as necessary components of good care.

Many participants raised concerns about dignity-diminishing practices linked not to age but to ethnic-minority background and status, describing cases of their dignity being threatened through insulting or threatening behaviours. Some women were concerned that such potential loss was over-determined by their social identity as belonging to a minoritised, migrant group. Inequitable treatment was also frequently linked to women's language abilities, with Chinese and Bangladeshi women in particular aware of the impact of their limited English-language proficiency. Chinese women, some of whom received less family support from their families than their Bangladeshi counterparts, described the impact of this on their self-respect, not only in everyday life but also in care contexts:

Interviewer: Can you tell me of a time when you were made to feel like your views, your needs were not really understood [...]?

Participant 04, Chinese, 52: *Obviously, my English is not good, sometimes in the clinic, sometimes they can understand, sometimes they can't understand you.*

Interviewer: *So, what did you do?*

Participant 04: *(thinking) If I think that's important, I normally ask them to write it down so that I can come home and check with people.*

Interviewer: *How did you feel at that time?*

Participant 04: *I felt I'm useless and helpless.*

Maintaining a sense of dignity and autonomy shaped other, specific care expectations. Being cared for in homes or by people who shared their own cultural beliefs and background was raised by many women, even those well integrated within Welsh society, as was the desire by a minority of women from the Caribbean and Chinese communities to return to their country of origin when older, or be cared for in homes catering for people from their own ethnic background. Underpinning the latter sub-theme was the need to find ways to avoid the risk of being discriminated against, based on being an older minoritised migrant:

Participant 011, Caribbean, 60+: *[...] the other alternative is, it would be good to go, move to St Kitts! [...] I would love to have six months here and six months there, but the level of care if you were ill, you would get that good care over there. [...] it is the way they are thinking they will be only too pleased to help you and they will treat you with care and dignity. You would get it there. You wouldn't get that here, you are just a number as well. The way you are treated, you are treated differently because of your skin colour.*

Just as women preferred to be cared for by family members, some also expressed their desire to receive care at home, by a female care-giver, though not necessarily of the same cultural or ethnic background. Many women thought that staying at home was ultimately better for their wellbeing. Some women associated care homes with physical and mental deterioration, loss of dignity and an earlier death.

Participant 012, Caribbean, 69: *I wouldn't mind going into a home as long as you were treated with your respect and dignity and they didn't just like to put you in one room and leave you there and you didn't see anyone for days.*

Lastly, care also involved women having control over their own lives through information and collaborative decision-making, where possible. Being heard or listened to irrespective of language differences was perceived as an important component of this, especially for some women of Bangladeshi heritage. There was an awareness of services provided by 'outsiders', but limited access to direct information. Women of both Bangladeshi and Chinese heritage in particular relied heavily on local cultural groups and associations not only for social exchanges, but also for vital care information and knowledge. Many other women who took part in

the study had more direct and sustained knowledge of available social support, regardless of intention to use them.

Discussion

This paper has presented findings from a larger study looking into older migrants' perceptions of old age, dignity, and dignity in care. Data presented here focus on older women migrants' perceptions of care and their care expectations, a currently under-researched area. Studies so far have explored conceptualisations of dignity in the context of caring for older people in the UK (Woolhead *et al.*, 2004; Baillie, 2009; Webster and Bryan, 2009). Other studies (e.g. Walsh and Kowanko, (2002) have found that patients felt dignity was maintained when they were given choices and had an element of control over aspects of their care; Woolhead *et al.* (2004) describe how older people felt treated like objects when not consulted; and Lothian and Philp's (2001) study highlights that giving older people and their care-givers adequate information to allow them to make choices about care increased their autonomy. However, within this body of evidence, very few studies have examined the views and experiences of women from minority-ethnic backgrounds. There is a growing body of research on the experiences and views of older people from BME backgrounds that explores barriers and challenges to care provision, views on the quality of local health- and social-care provision, and care needs and expectations (see for example: Bowes and Dar, 2000; Koffman and Higginson, 2001; Bowes and Wilkinson, 2003; Mold *et al.*, 2005; Sin, 2006; Manthorpe *et al.*; 2009; Cattan and Giuntoli, 2010). Yet few studies explore what dignity means to people from minority-ethnic backgrounds, in order to increase awareness of their perceptions and needs, and of whether these may differ from those of the national majority population.

Many philosophers have sought to conceptualise dignity in terms of both autonomy and capability (for an overview see Gallagher *et al.*, 2008). Shotton and Seedhouse (1998) specify that individuals tend to lack dignity when they find themselves in inappropriate circumstances, or in situations when they feel foolish, incompetent, inadequate or unusually vulnerable. Old age, with the resulting decrease in functionality and cognitive abilities, arguably results in such feelings. Other authors have asked whether the concept of dignity is useful in care provision as it offers no guidance on how to provide care, apparently proposing nothing

conceptually different from respect ([Macklin, 2003](#); [Wainwright and Gallagher, 2008](#)). However, from the study dignity emerged as more than just respect, being a fluid and dynamic understanding of self and others through the relationships developing with one's social environment throughout life ([Saltus and Pithara, 2014](#)).

Moreover, the importance of the family in care provision, and perceived differences in the attributes of paid and non-paid care raise the notion of 'care from the heart' as key to dignity. The data reveal that overall, all women were well aware of the concept of care through their own experiences as family care-givers; 'care from the heart' reduced feelings of vulnerability and potential loss of dignity. Moreover, with dignity itself being a concept first learned and practised within the family unit, feeling safe, appreciated and respected was understandably an experience felt primarily among family and close friends. Acknowledgement of the worth of the older individual – and for their life experiences, multiple roles over the years, and achievements – was thus perceived as important in providing quality care.

Matiti and Trorey (2008) highlight the importance of assessing individual expectations of care in order to develop practical ways of providing this. The participants expected care that was individualised, appropriate and responsive and that encapsulated both physical and psychological aspects of empathy and concern. Participation in decision-making, and acknowledgement of previous life and roles (so viewing old age as an accomplishment rather than time of incapacity) were all attributes of good-quality care. All participants were aware of the changing nature of family ties and obligations. This study reveals that, despite their desire to be cared for by their own family members, most women understood that this would not be possible and they would need to depend on professional care. Common to all women was the perception that any care provider must display a dignity-enhancing orientation or attitude, and a high level of professional competence, compassion, engagement and intentionality. This means that care-givers must show genuine caring on a psychological level rather than simply providing practical and personal assistance.

Existing literature on culturally sensitive practices has been criticised for assuming older migrants and national majorities have different care and support expectations

due to 'culture' and 'ethnic background', despite scant literature to support these assumptions (Giuntoli and Cattan, 2011). Yu (2009) has pointed out that health and social-care expectations of older migrants are not necessarily based on monolithic cultural principles, and older migrants from the same ethnic group do not necessarily organise their health and social care based on these principles. Cultural principles are argued to be dynamic rather than constant, being continually reconstructed and renegotiated based on migrants' changing life circumstances (Dean and Khan, 1997, Yan and Wong, 2005, Giuntoli and Cattan, 2011). To address the changing nature of culture and identity, this study – rooted within the wider context of life-course experiences and social identities – locates the understanding and conceptualization of care within a life-course and intersectionality framework.

The need for care in later life differs from that in other life stages, evident in participants' linking of old age with dignity loss through reduced autonomy, functionality and independence, in a sense losing part of one's identity. Differences existed, however, in women's perceptions within and between ethnic groups, with factors including language skills, social integration, and perceptions of family connections and obligations. Moreover, the study highlights the social nature of dignity and of wider societal structures that can impact and shape care expectations and encounters. Participants were aware of how they may be perceived as older migrant women. Pellegrino's (2005) concept of 'imputed dignity' – dignity as a perception rather than essential feature of moral life – is useful here in exploring the positioning of older people underpinned by societal ageism, as well as how population groups are recognised (or not) as being of worth or value. With this comes the need to attend to the wider societal context in which care and support are offered, delivered and experienced; a narrow focus on the person could limit the development of professional competences needed to engage and work in an inter-cultural context. Gallagher also raises the need for dignity in health-care providers in the context of self and work in order for them to care with dignity, including a review of their working conditions (Gallagher, 2004). This might be useful progress in clarifying understanding of how dignity is operationalised and the barriers to providing care with dignity. Starting to think of dignity more concretely (such as basic capabilities to be encouraged in older people to promote dignity) might be another way of moving forward.

Limitations

First, the interviews were conducted in different languages, and the words used to convey key concepts such as 'dignity' or 'care' differed slightly. Participants were invited to share their views and offer alternative terms, so arriving at notions of care with which they were comfortable. Second, as noted in previous publications (e.g. Saltus and Pithara, 2014), we remain mindful of the specificity of experiences of older women living in rural and semi-rural Wales, and of much more work being needed to develop our knowledge of experiences of those in a range of locales. The sample was diverse in age, mobility, club and group membership, and length of time living in Wales. Third, in targeting women with a history of migration and specific ethnic, linguistic and religious groupings, we do not wish to stereotype individuals' experiences or their linked ethnic-minority groups. Although we have argued for the need to explore concepts of dignity and care from the perspective of people from diverse backgrounds, we were mindful of the conceptual and methodological imprecision underpinning the use of concepts such as 'minority' and 'ethnicity', and the calls for specificity and closer exploration of the role and use of ethnicity markers (Ahmad and Bradby, 2007; Aspinall, 2007; Burton *et al.*, 2010; Salway *et al.*, 2011).

Conclusion

Research on minority ethnicity and ageing has highlighted that older people, regardless of ethnic, cultural and religious background, have common expectations about the quality of services and importance of dignified care; however, they also have individual expectations, aspirations and desires based on their life experiences and backgrounds. There is a need to explore cross-, trans- and inter-cultural values and orientations that shape how older people from a range of backgrounds make sense of concepts such as dignity and care.

All the women, to varying degrees, expressed anxiety about future care and support and were mindful of the changing nature of family connections and social networks that, for those dependent on their families, could lead to vulnerability. This held especially true for some women of Chinese and Bangladeshi heritage, with common misconceptions that these ethnic-minority groups 'take care of their own' exacerbating their vulnerability. Information and pathways to access care and support services are needed.

The study has shown the importance of understanding care as both personally and socially mediated, shaped by the wider social context and life-course experiences. In building an evidence base on how dignity and care are conceptualised and experienced cross-culturally, it is equally important to explore social dignity.

Although we focused on women, the specially gendered notions of care and support need further exploration, examining the interdependent and mutually constitutive nature of individual identities and social categories such as 'race', gender, and socio-economic status within the framework of migration, transformation and adaptation.

This study is relevant to the current UK and EU debate on the lived experiences and care expectations of ageing migrant groups, adding to the small-but-growing research base on the disadvantages that such people may face in later life and the cumulative nature of social inequalities. However, more work is needed to develop further theories and empirical evidence that draw out the benefits of ethnic-group membership (linked, for example, to resilience, transnational ties, transmission of cultural knowledge across generations, and ethnic density) and that explains the diverse outcomes in ageing. Of importance is the need to develop further models and theories that allow for variations in the meaning of ageing, the shifting nature of social identities and roles, and the real, practical and accumulated significance of the disruptions, discontinuities and transformation of practices and behaviours brought about by factors such as migration and transnationalism.

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