**The experiences and expectations of care and support among older migrants in the**

**UK**

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This paper reports and critically discusses, against the literature on culturally sensitive and cultural competency practices, the findings of a qualitative study which explored the needs and expectations of older people and their carers from eight different migrant communities and the White British majority. The study investigated the accessibility and acceptability of care and support services in Bradford, UK, a city with a large migrant population. A total of 167 study participants were recruited from February 2008 to October 2008; of these 134 were older people and 33 carers. The age ranged from 25 to 90 years. The study found that older migrants and their carers described expectations of services as complex constructions of 'abstract expectations', the study participants' general beliefs regarding what services should be about, and 'pragmatic expectations', their specific views about how they would like to receive care and access services. All groups, irrespective of their ethnic background, expressed three 'abstract expectations': high standards of good practice; cultural understanding; responsiveness to individual expectations. This similarity did not imply a similarity in their preferences for how services should provide for their 'abstract expectations'. Dignity was a central expectation for all older people in the care of their bodies. However, a number of culturally specific 'pragmatic expectations' emerged in the

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practices that older people and carers associated with maintaining dignity in older age. Nevertheless, differences could not always be explained as an outcome of different cultural backgrounds, but were rather linked to individual characteristics and life experiences. This study indicates that whether and how older migrants' knowledge systems inform their expectations of care and support should be object of investigation rather than taken for granted, as implied in some literature on culturally sensitive practices. Exploration of older migrants' knowledge systems may help us to understand if older migrants' expectations differ with regard to *what* they expect to receive from a certain service, their 'abstract expectations', and/or *how* they expect to receive it, their 'pragmatic expectations'. This information should help to identify if different communities require different culturally competent interventions and of what type: interventions at the organisational level, at the structural level, or at the clinical level.

**Keywords**: cultural competency; cultural sensitivity; older migrants; elderly care; emotional needs

**Introduction**

In recent years, research has shown a rapid growth in the number of migrants ageing in Europe, with higher rates of increase in the middle-old and oldest-old age groups (Fenton, 1987, Blakemore 1999, 2000, White 2006). Despite some variations in countries and migrant communities (White 2006), this phenomenon is common to the five types of older international migrants identified in the literature: older forced migrants, European labour

migrants, older non-European migrants, older family joiners and returning post-retirement migrants (Warnes *et al.* 2004, Dwyer and Papandimitrou 2006). This rapid increase in older people is mirrored across European populations (de Groot *et al.* 2004), due to longer life expectancy combined with a decline in birth rates. These demographic changes have important implications for health and social care sectors and create new requirements for the facilitation of social inclusion and access to public services across Europe (Warnes *et al.* 2004, Messkoub 2005, Dwyer and Papadimitriou 2006).

Since the nineteen eighties, social work theory has increasingly emphasised the significance of culturally sensitive practices for services to meet the needs of users from different cultural backgrounds (among others, Devore and Schlesinger 1981, Graham 1999, Schiele 2000, Sue 2003, Yu 2006, 2009). This approach criticises the dominance of the Eurocentric worldview in social work and attempts to develop practice on the basis of other cultural groups' knowledge systems, for example African worldviews regarding the interconnectedness of all things (Graham 1999, Schiele 2000), Confucian principles such as ren (Yu 2000), and the five pillars of Islam (Dean and Khan 1997).

Different authors have referred to culturally sensitive practices using different expressions, for example cultural sensitivity, cultural competence, cross-cultural expertise, cultural awareness, and cultural responsiveness, with cultural sensitivity and cultural competence the most popular terms (Whaley 2008). In an examination of the semantic relationship between the terms cultural sensitivity and cultural competence Whaley (2008) demonstrated that the two expressions are at opposite ends of a common dimension. Cultural sensitivity refers to clinicians' awareness and knowledge of different cultural beliefs, traditions and behaviours, whereas cultural competence refers to the specific skills

and knowledge of the techniques that can be useful to act competently with a culturally diverse clientele (Whaley 2008). The results of Whaley's (2008) analyses are consistent with other authors' argument that awareness and knowledge of different cultural traditions are necessary but not sufficient to provide culturally competent services (Brach and Fraser 2000). Cultural competency in service provision implies moving beyond the promotion of cultural awareness or sensitivity towards an 'ongoing commitment or institutionalisation of appropriate practice and policies for diverse populations' (Brach and Fraser 2000, p. 183). Awareness, knowledge and skills are critical elements of cultural competency in social work as well (Yan and Wong 2005). However, in addition, Yan and Wong (2005) emphasise the relevance of social workers' self-awareness of their own cultural background for the effectiveness of cultural competency practises.

Despite the growing popularity of the concepts of cultural sensitivity and cultural competence and the development of cultural competency guidelines and policies, especially in the United States (U.S. Department of Health and Human Services Office of Minority Health 2000, National Association of Social Workers 2001), these concepts have been criticised on several grounds. Some authors have criticised the lack of rigorous research evaluating the impact of cultural competency techniques on any outcomes, including the reduction of racial and ethnic disparities (Brach and Fraser 2000). Others have criticised the unevaluated assumptions that often characterise these approaches, particularly the assumption that older migrants' expectations are both strongly and consistently culturally characterised (Gross 1995, Simon and Mosavel 2008, Yu 2009). Yu (2009) points out that the literature on culturally sensitive practices is often underpinned by two beliefs; that 'all members of the same ethnic minority group organise their health and social care according

to their cultural principles' (p. 57), and that older migrants' 'cultural principles are monolithic' (p. 57). These assumptions imply that older migrants tend to have different expectations of care and support services compared to the indigenous, national majorities. However, there is scant research on these assumptions (Simon and Mosavel 2008). Most of the literature on cultural competency models has discussed the models from two perspectives. Firstly, there are the criticisms of the view that 'culture' and 'ethnic background' are the most important factors to address in order to tackle health inequalities in multi cultural societies. Blacksher (2008) and Simon and Mosavel (2008) demonstrate the complimentary and at times stronger saliency of class and socio-economic status to understand health inequalities. Wimmer (2009) discusses the importance of not taking the concepts of ethnicity and culture as 'unproblematic *explanans*' in migrant studies, in other words, as self-evident units of observation and analysis. He refers to the boundary-making paradigm and shows how this approach considers ethnicity as an '*explanandum*, i.e. as a variable outcome of specific processes to be analytically uncovered and empirically specified' (p. 244). Secondly, there is critique that focuses on the limits of the classic anthropological view of culture, which underpins most cultural competency models. In this view culture is conceptualised as an organic and separate whole of values, customs, beliefs, etc. for which it is possible to clearly define what is 'inside' and what is 'outside' (Simon and Mosavel 2008). Dean (2001) and Yan and Wong (2005), who draw on constructivist and post-modern perspectives, suggest that cultural expectations are constantly re-constructed and re-negotiated by immigrants according to their changing life circumstances. Consequently, they cannot be conceptualised as stable and unchangeable sets of values and norms. Other authors have investigated elderly care practices in different

migrant communities and shown that in many cases cultural principles are not monolithic but change over time to adapt to the migrants' life circumstances (Ajrouch 2005, Chiu and Yu 2001, Lan 2002). However, these studies have focused on the investigation of traditional values and practices of single migrant groups and on the relevance of such values for the development of culturally sensitive practices for these groups. Little is known regarding why and how differences and similarities arise across groups of older migrants and between older migrants and national majorities, and to what extent older migrants' expectations and use of services differ in their everyday life from those of national majorities.

The purpose of this article is to explore these latter issues and their relevance for culturally sensitive practices. It does so by describing and discussing the findings from a study which set out to explore commonalities and differences in care and support needs and expectations and in the perceptions of accessibility and acceptability of care and support within and between older migrant groups and national majorities. The study was conducted in Bradford, a Northern city in England, UK, with a high proportion of migrant groups.

**Background**

In the UK, the population aged 65 and over currently accounts for 16 per cent of the total population and, in line with the rest of Europe, is predicted to continue rising. The fastest increases in numbers is in the 'oldest old' group, those aged 85 years and over, who represent over two per cent of the population (Dunnell 2008). By 2020 it is estimated that ethnic minority people will comprise 5 per cent of the 60-plus population, compared with about 1.7 per cent in 1991 (Grewal *et al.* 2004). As a result, increasing government policy

attention has been given to the implications of an ageing population for future services for older people (see for example Department of Health 2001, 2006, 2007, Social Exclusion Unit 2006).

Several local initiatives, including in Bradford (Bradford Metropolitan Council 2007), have also been launched. However, in a review, Darlow *et al.* (2005) noted a general lack of research on issues of social care in Bradford. The report criticised existing research for being too focused on specific migrant groups (Pakistani, Bangladeshi, Indian) to the exclusion or under-representation of others, particularly migrant groups of white European background (Chahal and Temple 2005, Darlow *et al.*, 2005). It suggested that there was a need for further in-depth research in this field, taking into account the individual needs of elders and carers in different migrant groups at local level. Indeed, one of the difficulties for service providers in Bradford has been the uncertainty of not fully understanding the experiences, needs and preferences of older people and their carers with regards to health, social welfare and other services (Outside Research and Development 2006).

**Methods**

The study involved older people and carers (the term 'carer' is used throughout this article and has the same meaning as 'caregiver' in the US literature) from eight migrant communities and the white British majority. The eight migrant communities were: Polish, Ukrainian, Italian, Hungarian, Pakistani, Indian, Bangladeshi, and Afro Caribbean. The research had two distinct stages: a literature review and the data collection, analysis and synthesis. A total of 134 older people and 33 carers were recruited and interviewed from February 2008 to October 2008; 126 were females (75.45%) and 41 were males (24.55%).

Older age was defined as being above 60 years of age for women and above 65 years of age for men. However, some study participants, predominantly men of South Asian background (Pakistani, Bangladeshi and Indians), self-identified themselves as 'old' although they were not above 65 years of age. Table 1 and Table 2 provide a break down of the study participants by ethic group and age.

(Table 1) and (Table 2) about here

Older people and carers were approached through gatekeepers of a range of community groups and organisations, for example mosques, working men's clubs, and carers' organisations. Each organisation was provided with written information about the project, including posters or newsletters in appropriate languages. The recruitment aimed to include older people and carers who were service users at the time of the interview, who were not service users at the time of the interview, but had been in the past, and who had never accessed care or support services at the time of the interview. Only a minority of the participants had previously participated in evaluations of specific services.

The data collection consisted of two phases. In the first phase a total of 21 focus groups were carried out, of which 12 focus groups were with older migrants and 5 focus groups were with their carers. The focus groups varied in size from 3 to 21 study participants. In the second phase, 53 in-depth interviews with 38 older people and 15 carers were undertaken. Participants were partly identified through the focus groups and partly newly recruited on the basis of their self-reported care needs and current or past experiences of social care services.

The focus group interview schedules explored the extent to which older people and their carers considered that their care and support needs were, or might be met, and by whom. After piloting the interview schedule, case studies, in the form of vignettes, were developed to stimulate discussion and to ensure understanding and articulation of the issues being explored in the focus group interview. These were well received by the study participants as they enabled them to contribute to the discussion without necessarily disclosing personal experiences. We also found that older people were more likely to express their personal needs and desires if hypothetical cases based on familiar situations were presented to them than if they were asked to consider something that seemed more abstract. The focus group interviews provided an opportunity for participating older people and carers to get to know and trust the research team, which helped in the exploration of personal and often sensitive experiences in the in-depth interviews.

The purpose of the in-depth interviews was to give interviewees an opportunity to talk through their lives (narrative approach), while reflecting on their contacts with and experiences of a range of services, such as health, community support, social care or housing. This enabled exploration of the 'caring period' as well as the transitional time preceding caring for/being cared for. In some cases, older people's experiences related to experiences outside the UK and helped to ground perceptions of current services, needs and aspirations within their cultural framework.

Sixteen interpreters were involved in the study to assist those study participants who were not fluent in or did not speak English. The interpreters were recruited through the Bradford Interpreting Unit for the following languages: Urdu, Gujarati, Punjabi, Bangla, Hungarian, Polish, Ukrainian and Italian. To ensure that the research team and the

interpreters shared a common understanding of research practice, roles and responsibilities, needs and expectations a two-day training event was organised before the interviews commenced. The training event provided an opportunity to explore the interpreters' beliefs and expectations about their role, the research, and the research team. Most interpreters embraced a positivist view regarding their role. They saw themselves as neutral in the interview process and thought that the meanings of the study participants' answers could be reported unambiguously. In order to stimulate self-awareness among the interpreters, the research team presented a number of exercises based on ad hoc case studies. The aim was to encourage discussion among the interpreters about what the 'right' translation of a number of controversial extracts from imaginary conversations was. These exercises highlighted how important it was for the interpreters to discuss with the research team any difficulties they experienced in the translation process.

In each interview session, the interpreters were required to translate the interview questions from English to the relevant language and the interviewees' answers from the relevant language into English. This gave little time to consider problems in their translations. To ease this task the interpreters were asked to comment on the interview schedule of both the focus groups and the individual interviews. These discussions highlighted some potential issues concerning the translation of certain words, for example 'carers', in particular languages. Consequently, the training and the ensuing discussions helped to improve the clarity of the interview schedules and to strengthen the inclusion of the interpreters in the interview process.

All the interviews were conducted by the first author and transcribed verbatim by a professional service. The analysis of the focus group interviews was based on 'Framework

Analysis' (Ritchie and Lewis 2003), which is framed around five recursive phases: construction of an *indexing or coding table* based on issues and questions derived from the literature review, aims and objectives of the study, and recurring views and experiences of the study participants; *indexing or coding* the data, where the thematic framework is applied systematically to the raw data; *charting*, where a number of charts representing key themes identified through the indexing process are created, and the data sorted by means of distilled summaries of the participants' views and experiences; *mapping and interpretation*, where the summaries in each chart are used to find associations between themes to provide explanations for the findings.

The analysis of the in-depth interviews was informed by a narrative approach. Here the interviewee tells a story, thereby constructing a social reality which is 'meaningful' (Elliott 2005). The analysis needs to be theoretical, in that themes are drawn from the interviewees' realities of the social and cultural world. The analysis is not simply about 'what' people say but also about 'how' they express their experiences, desires and expectations. This process of analysis is particularly suited for qualitative research where it is likely that those involved have different life experiences and social realities. A systematic approach to analysing the study participants' narratives in order to discover the patterns, regularities and meaning-making processes within their interviews was devised based on Franzosi (1994, 2004). In this approach the subject, the action and the social actors mentioned by the study participants are first defined. This is followed by examining in detail the social actors (in this case those involved in help and support) and the action (here the action of receiving help and support).

The electronic qualitative software package Nvivo 7.0 (QSR International 2007) was used to organise, code the data and assist with its analysis. The data was coded and analysed by the first author. In addition, for validity purposes, a sample of the interviews was coded by the second author and the codings compared to identify and discuss any possible disagreement.

The combined synthesis of the focus group interviews and the narrative interviews led to the identification of common themes in the study participants' experiences of care and support and to the identification of their expectations regarding the accessibility and acceptability of services.

Ethical approval for the study was obtained from the Faculty Research Ethics Committee at Leeds Metropolitan University. All participants in the interviews were given an information sheet detailing the project and their rights to withdraw from it at any time. In order to make sure that the study participants felt comfortable with the interpreters who were assigned to them, the name and photo of the interpreters were printed in the information leaflets. This gave the study participants opportunity to contact the research team if they knew the interpreter and felt that this could jeopardise the confidentiality of their interview. Each participant provided written consent to participate in the study prior to the interview. All interviews were conducted in a familiar location, such as a community centre and were tape recorded with the interviewees' consent.

**Findings**

The analysis of the focus groups and individual interviews showed that the study participants' views about caring relationships and access to services were linked and complex and could be heuristically divided into two components:

1. 'Abstract expectations', which referred to the study participants' general views regarding what an accessible and acceptable service should consist of (e.g. respect for dignity, high professional standard, communication). Irrespective of their ethnic background, the study participants shared the following abstract expectations: that emotional needs such as communication, trust, dignity and relief from loneliness were met to achieve a satisfactory and long lasting caring relationship and that services delivered 'high standards of good practice'.

2. 'Pragmatic expectations' which consisted of the specific meaning that each 'abstract expectation' held for older migrants and their carers. 'Pragmatic expectations' consisted of older migrants' and their carers' views of what precisely was important to maintain dignity in older age, which issues were important in the caring communication, and what professional practices were particularly sensitive.

These two types of expectations are presented under the following two main themes: emotional needs and access to services needs, which are based on Helgeson's (2003) classification of support. These needs refer to people's experiences of the availability of people who can listen, care, sympathise, and make one feel valued and loved, and the provision of information or guidance.

### *Emotional needs*

Participants' experiences of help and support were often strongly linked to emotional needs, based on psychological factors, feelings and wishes, with communication, trust, dignity, and relief from loneliness identified as particularly important for participants. The importance of these emotional needs was consistent across all the ethnic groups involved in the study, suggesting that the participants shared common 'abstract expectations' regarding how their emotional needs were met. However, with regards to their 'pragmatic expectations' about how services should address older people's emotional needs differences arose mainly around the issues of communication and dignity but not regarding trust and relief from loneliness.

### *Communication*

When participants talked about communication, they described the need for an ongoing dialogue within and between services, between services and service recipients and between the carer and the person needing care about individual preferences, needs, and entitlements, for example:

> When my mum first came out [of the hospital] they assessed her. She was wheel chair bound, they said oh don't worry we will get a ramp up. They sent some builders up within three, four weeks of mum coming out of hospital and we had this construction in the back yard. I looked at it and thought, one it's in the backyard, two it looks like you can launch a space rocket off this thing […] Mum was already apprehensive about being in a wheel chair never mind being pushed four foot in the air, totally unacceptable […] So the assessment was done, they ticked their boxes when they provided the ramp, but they didn't mention that it was access to the back […] Well common sense would have

told you to have some kind of discussion with the client, that seldom never happens

(Male Afro Caribbean British carer, 46).

Both carers and older people considered it crucial to address communication issues at group/community/cohort level as well as at the individual, face to face level of the caring relationship:

> If I gave her a meal on Tuesday and she ate it, it would be oh she likes that I will give her that Wednesday, Thursday, Friday. But come Wednesday and it's like: "what's wrong? I thought you liked that? "But you can't give it to me everyday!" Now I tell her what's available and it makes my life a lot easier […] I think it is just [a matter of] understanding and compassion and communication. I think that if you have those three things you get on with anybody you have to care for (Male Afro Caribbean British carer, 46).

At the group or cohort level, the study participants' cultural and spiritual backgrounds played a critical role in determining the specific issues that they considered important in the communication process. Although all study participants shared a common 'abstract expectation' regarding the role of communication in the caring process, the specific issues, their 'pragmatic expectations', differed from group to group. For example, White British older carers suggested that their parents' generation often did not like to receive help from non-family members, and argued that these attitudes and expectations had to be recognised when planning and providing care and support for this cohort of much older people:

> My mother was like that, she didn't want any strangers come in at all, she didn't even want the carers […] My dad was ill and he had to have the nurse three times a day to see him and she didn't even want them. It right upset her. I used to have to stop at night until they came so that she could go to bed before they came […] My mother's age group

> were all sort of family things like that and they didn't go out that much. Our generation
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> mix more, so you might have in years to come like us we won't do that (White British
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> older woman, 68, living with husband)

Polish carers commented that their parents' experience of never having cared for their own ageing parents, as they were left in Poland, together with their experiences of occupation and deportation during the Second World War, had shaped their expectations of care and support in old age in two ways. Firstly, their parents expected to receive support and company from their children at all times during the day. Secondly, their parents did not want any external help, as they had often developed a strong fear of 'officers' as a consequence of their experiences during the Second World War:

> My mum doesn't want any external help. If there were two of me and one could be with
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> mum all the time and the other person who does their own thing all the time that would
>
> be great, but mum only wants me (Polish carer, 56, living with husband)

> When the mail came and my parents saw a brown envelope they used to be terrified
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> because they thought "who is it?" My mother, even today, she is eighty three, she thinks
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> that at some point they are going to be sending her back to Poland and she has nowhere
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> to go, as her village no longer exists. They are frightened of bureaucracy; assessments on
>
> them to see what they have got, how are they going to manage, it smacks of
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> bureaucracy… (Polish carer, 54, living with husband and mother)

Another common 'pragmatic expectation' concerning communication was related to older people's need for increased time to process information, which had a major impact on face-to-face interactions with care staff, such as assessments. Many interviewees suggested that social workers should allow more time for older people to process the information and to share it with their next of kin, as illustrated by these quotes:

> When professional carers say to older people, regardless of what nationality they are, "Do you understand?" I think they should err on the side of caution, because older people can have dementia or a bit of Alzheimer's and when they say "yes" today, tomorrow it means "no" […] I object to social workers talking to my mum when I am not present, because I know that my mother would say things to please them, but she is not telling them the truth (Polish carer, 54, living with husband and mother)

For older migrants who were not fluent in or able to speak English access to interpreters was also linked to effective communication. The removal of language barriers was often the first step towards trust and a greater understanding between the older migrant and those who provided services.

*Trust*

The issue of trust was mainly raised in two ways: trusting care staff and personal safety. Several older people mentioned that they had to have confidence in their care staff before they could trust them with those tasks that were important to their quality of life, but which they could no longer do themselves. Trust took time to develop, but the presence of some form of previous connection between the older person and the care worker facilitated the development of trust. Importantly, these connections did not necessarily imply a common ethnic background between the carer and the older person:

> There was a black carer who came here and she realised that I was good friends with her brother and that level of trust actually built, I was reliant on her, mum developed a relationship and loved it. Then there was a white carer who came in and I actually went to school with her and she was now caring and it was a case of well I know you from school and mum developed really good relationships with them […] (Male Afro Caribbean British carer, 46)

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For many interviewees having 'strangers' visiting them, raised issues of personal safety. Although none of the people we interviewed had felt threatened by their care staff, they worried that they might be deceived or robbed. Older people and their carers, regardless of their ethnic background, had common 'pragmatic expectations', regarding the factors that could help to build and maintain trust in caring relationships. These included having meetings between older people and care staff preceding the start of care services to get to know one another, consistency in the care staff who made home visits, and appropriate information regarding the time of visits and identity of the care workers.

*Dignity*

Dignity was described as having a caring relationship based on respect. In other words, they expected to be listened to and taken seriously, and as one Bangladeshi woman said: 'not being hurt in any way'. Dignity, therefore, meant that both their bodies and their feelings were respected.

Dignity was a common 'abstract expectation' for all older people in the care relationship. However, their 'pragmatic expectations' emerged in the practices that older people and carers associated with maintaining dignity in older age. Some differences were evidently related to older people's and carers' specific cultural backgrounds. For example, for Afro Caribbean older migrants, dignity in the care of their bodies meant having their bodies moisturised on a regular basis in a culturally responsive manner, a factor which did not appear in other groups. For Pakistani and Bangladeshi older migrants their religious identity as Muslims was a strong guiding factor in their expectations of care. A critical factor for them was, therefore, to have care staff of the same sex. For White British older

people, the ability to maintain independence was a central, strong issue associated with dignity. However, some differences were also related to specific individual idiosyncrasies. For example, for some White British older people the question of dignity was also associated with the ability to maintain their house to a certain standard of tidiness:

> When a person has been house proud all their life and they sit there and they're looking round their home and they're thinking "oh that wants doing", if they can't get jobs done that they used to do, that could do more damage to their health than anything else (White British woman, 82, former home carer)

*Relief from loneliness*

Loneliness was consistently described as spending long periods of time in solitude without talking to or having meaningful social interaction with anyone. It often seemed to be the final outcome of a process of loss, one after the other, of valued companions until the point when no companionship was perceived as available. Missing the contact with close family members, such as partners, sons and daughters was frequently the first element in the participants' descriptions of loneliness. Older migrants often described the unavailability of members of their own community of origin with whom to interact socially as a significant loss.

Most of the suggestions for ways to relieve loneliness were based on older participants' 'pragmatic expectations' of what might alleviate loneliness in later life. Some suggested visits to day centres or community centres as ways to ease older people's loneliness:

> The day centre where my husband goes all day Monday, Thursday and Friday morning. Today they are out for the day trip. That is the best thing [speaking of how to ease loneliness]. (White British woman, 83, living with visually impaired husband)

> They know a woman who now attends the centre and who they knew was used to spend long periods of time alone, feeling lonely. So, they invited her to come to the centre and spend time with them [referring to group of woman attending focus group]. So she started to come and she felt a lot better (Focus group with Bangladeshi older women, through interpreter)

## *Access to services needs*

Participants expressed strong views about what constituted 'good practice' in the way services were delivered. This expectation was related to the needs of trust and communication discussed previously and had a major impact on decisions about retaining services or not. The notion of 'good practice' was associated with perceptions of professional and ethical standards in the delivery of services.

Examples of perceived poor professional and ethical practices included:

- care staff not washing their hands on arrival, for each new client;
- using the same cloth to wash the older person's face as well as the rest of their body;
- not following basic hygiene practices such as cleaning the bowl used to wash the older person and re-using it dirty the following day;
- not tidying up after completion of care tasks;
- not respecting the dignity of the individual.

There were similarities between study participants in their request for high standards of good practice, their 'abstract expectation', and mostly in the specific issues that were

considered as important elements of good practice, their 'pragmatic expectations'. However, some older migrants and carers stressed the relevance of specific practices within their culture. For example, African Caribbean carers stressed the importance of hygiene in their culture:

> When my mother had her car accident […] we had home care coming, but I had to keep
> an eye on what homecare were doing, how we care for ourselves is not how the English
> would take care […] (Female Afro Caribbean British carer, 34, living with family)

Pakistani and Bangladeshi study participants stressed the importance of their identity as Muslims. In their words, it was important to acknowledge the practices and behaviours related to their religion in service provision, for example, halal food, same sex care staff and prayer rooms in housing services. However, some older Bangladeshi women said that they did not expect care staff to replicate all behaviours associated with cultural or religious beliefs, such as feeding with the hand. They simply expected that staff talked to the older people about their desires, that the tasks were executed properly whilst at the same time respecting older people's dignity.

**Discussion**

This study set out to investigate the needs, experiences and aspirations of care and support among older people and carers from a range of migrant and White British communities across Bradford in the UK. Ideas for the development of culturally sensitive services were also explored. Our findings showed that, despite different experiences and cultural backgrounds, the study participants shared a number of common 'abstract expectations'. Most differences in the study participants' views emerged at the level of their 'pragmatic

expectations'. Interestingly, these differences could not always be explained as an outcome of different cultural backgrounds, but were rather linked to individual characteristics and life experiences.

The literature on older migrants' needs of care and support and on culturally sensitive practices in health and social care services emphasises the importance for professionals and policy makers to acknowledge the wider cultural expectations, and the individual expectations of older migrants and their carers. However, to date there is a lack of understanding of the interaction between culturally based expectations and individual expectations and of how the views of care and support and access to services across different groups of older migrants and between older migrants and national majorities are shaped. This lack of a theoretical framework has often resulted in an over-emphasis of the importance of cultural factors or of individual differences, whilst ignoring the interaction between them. This study identified two distinct types of expectations in older people's views of care and support services: 'abstract expectations' and 'pragmatic expectations'. Our analysis has shown that, despite their different backgrounds, the study participants had a significant element of similarity in that they shared a number of common 'abstract expectations'.

Although our study did not identify significant differences with regards to older migrants' 'abstract expectations' of the issues investigated, it does not necessarily imply that all older people share one common cultural knowledge system. However, the similarities found at the level of 'abstract expectations' support Yu's (2009) conclusion that researchers cannot take for granted that older migrants' expectations are necessarily informed by a different and monolithic cultural knowledge system. If and how older

migrants' different knowledge systems inform their expectations should be object of investigation rather than taken for granted. Taking the example of loneliness, the solutions suggested by the interviewees were based on their knowledge of available services rather than on cultural expectations. However, currently there is insufficient evidence to demonstrate if there are cultural or ethnic differences in the factors that impact on loneliness or in the interventions that might prevent or alleviate loneliness in later life (Cattan *et al.* 2005, Victor *et al.* 2005).

Exploration of older migrants' knowledge systems may help us to understand if older migrants' expectations differ with regard to *what* they expect to receive from a certain service, their 'abstract expectations', and/or *how* they expect to receive it, in other words their 'pragmatic expectations'. This information should help to identify if different communities require different culturally competent interventions and of what type: interventions at the organisational level, e.g. more representativeness, at the structural level, e.g. interpreter services, or at the clinical level, e.g. training interventions for care providers.

Our findings have shown some of the complexities of the cognitive and meaning-making processes that form older migrants' expectations of care and support. The two types of expectations that were identified through the analysis have allowed us to identify a continuum of similarities and differences in older people's expectations. However, our study only focused on one limited area of influences on older people's service expectations. There is, therefore, still need for theoretical frameworks that would help to disentangle ethnic processes from non-ethnic processes in the interpretations. The concepts suggested in this article and Wimmer's (2009) suggestions regarding how migrants' experiences and

actions should be accounted for without *a priori* assuming ethnicity as an *explanans* can help researchers to investigate how and why diversity and similarity arise across and within migrant groups.

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Table 1. Breakdown of the study participants by ethnic group

| Ethnic group | N | % |
| --- | --- | --- |
| White British | 37 | 22.16 |
| Pakistani | 34 | 20.36 |
| Italian | 21 | 12.57 |
| Bangladeshi | 19 | 11.38 |
| Polish | 15 | 8.98 |
| Indian | 13 | 7.78 |
| Ukrainian | 12 | 7.19 |
| Hungarian | 9 | 5.39 |
| African Caribbean | 7 | 4.19 |
| Totals | 167 | 100 |

Table 2. Breakdown of study participants by age group

| Age groups | N | % |
|---|---|---|
| 25-35 | 5 | 2.99 |
| 36-45 | 7 | 4.19 |
| 46-59 | 21 | 12.57 |
| 60-65 | 14 | 8.38 |
| 66-70 | 40 | 23.95 |
| 71-75 | 27 | 16.17 |
| 76-80 | 26 | 15.57 |
| 81-90 | 22 | 13.17 |
| Missing values | 5 | 2.99 |
| Totals | 167 | 100 |