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“Medicine doesn’t cure my worries”: Understanding the Drivers of Mental Distress of Older Nepalese Women Living in the UK.

Abstract

The mental health of migrant communities is an important public health concern. A growing body of literature suggests that wider social determinants significantly contribute to the mental health and wellbeing of older migrants in their host countries. Despite the increasing population of Nepalese migrants in the UK, there is little research exploring the mental health needs of this community. This article explores older Nepalese women’s experiences of drivers of mental distress in London. Data was collected using in-depth interviews with 20 older Nepalese women living in the London Borough of Greenwich. Grounded thematic analysis of women’s narratives identified six overarching factors contributing to their emotional distress that pose significant risks to their mental health: absence of family, language barriers, housing problems, physical illness, lack of appropriate support, fears of death, and inadequate financial resources. In many cases, the impact of these factors was felt in combination rather than isolation, often influenced by cultural dynamics. Findings highlight that re-settlement in the absence of family is at the heart of emotional challenges for older Nepalese women. The paper concludes with a series of recommendations for supporting processes of settlement to mitigate this risk among older Nepalese women in the UK.

Key words: *Women’s Mental health, migration, Nepal, social determinants of mental health, United Kingdom*

Introduction

The number of Nepalese migrants settling in the UK has increased significantly since 2004 due to settlement rights enacted by the British Government for the ex-British Gurkha army and their family members (Sims, 2008). The UK census (2011) recorded 60,202 people of Nepalese origin living in England and Wales, a rise of over 1000 per cent since last census. Other estimates have placed the number higher, with The Centre for Nepal Studies UK (CNSUK) suggesting closer to 80,000, and local Nepalese community organizations presenting estimates beyond this (Adhikari, 2012). According to Adhikari (2012) three quarters of the Nepalese population in the UK live in South East and Greater London. The London Borough of Greenwich has one of the largest Nepalese communities in the UK with around 5.5% of total the population identifying Nepali as their first language (Greenwich Council, 2007).

The process of migration, where individuals move from one place of residence to another for permanent or semi-permanent periods (Bhugra and Ayonrinde, 2004), poses many health risks to individuals as they settle in the host country (Lassetter and Callister, 2008). Many migrants may be unfamiliar with the norms and practices of a new country where sociocultural and geographical circumstances can have huge impact on their health (Carney, 2015). Bhugra (2004) argues that interrelating biological, psychological and cultural factors are particularly important drivers to mental health and wellbeing for migrant populations. Women are at particular risk for mental distress due to migration (Halpern, 1993; King, 2002; Sardavar, 2015), which increases in old age (Casey, 2010; Gubernskya, 2014).

Furthermore, poor mental health and wellbeing is related to outcomes of lower socio-economic circumstances, such as poverty, unemployment, social isolation, exclusion, gender inequalities, injustice and discrimination (WHO, 2012), the same contexts that shape many experiences of migration. For example, recent studies from the US confirms the importance of structural inequalities such as housing and economic stability to migrant mental health (Arevalo, Tucker and Falcon, 2015). Experiences of racial discrimination and identity crisis may lead to social isolation and exclusion,

while the loss of emotional support from family and relatives can exacerbate poor mental wellbeing (Williams and Williams-Morris, 2000; Yip, Gee and Takeuchi, 2008; Casey, 2010). These determinants may interact with each other to create further marginalisation (Crenshaw, 1989, Nightengale, 2011) affecting their health and wellbeing.

Few studies have reported on the mental health needs of the Nepalese population in the UK. In a health needs assessment of the Nepali community in Rushmoor (England), Casey (2010) suggested that very low levels of mental health problems are identified within the Nepalese population. This is linked to potential cultural differences, stigma attached to mental health issues, and difficulties in diagnosing mental health problems by health professionals due to lack of clarity about the perception mental wellbeing in this community mental (Casey, 2010). An older study by Jolly (1999) identified that western healthcare providers had little understanding about traditional Nepalese concept of non-physical problems, such as home sickness, spiritual and religious concept of feeling unwell. This was confirmed in reports from an outreach project conducted in the UK Nepalese community (Amani, n.d.) where a lack of awareness about availability and low accessibility of mental health services, and stigma associated with mental health illness within the Nepalese community were associated with poor mental health outcomes.

Other studies have confirmed stigma as being deeply rooted within Nepalese community (Jha, et al., 2012; Regmi, et al., 2004;), which may also contribute to low-levels of diagnosis. A study conducted in Nepal found that individuals are more likely to seek help for mental health issues in the form of social support from friends and family, rather than seeking professional help (Jha, 2007). While strong local social networks among the Nepalese may provide a protective factor against mental illness (Fiori, Antonucci & Cortina, 2006), and social support has been identified as a positive coping strategy for women in many contexts (Burgess & Campbell, 2014), it can also discourage people from seeking available mental health services in more serious cases (Scheppers *et al.*, 2006), meaning more serious issues may go unidentified for some time (WHO, 2013).

Increased waves of immigration from Nepal in recent years have been linked to policy changes around settlement. In 2009, the UK government allowed widows of ex-British Gurkha soldiers to settle in the UK (UK Border Agency, 2010), establishing a new dynamic of transnational household who's impact on well-being needs to be explored (Graham, Jordan, Yeoh et al., 2012). Globally, women are twice as likely to experience depression, risks that are exacerbated by vulnerabilities such as low income, inequality, low social status and access to resources (WHO, 2016). The needs of older Nepalese women are further complicated by their status as ethnic minorities in the UK, who are known to have poorer mental health outcomes and disproportionate access to mental health services (Simkhada, et al., 2015). As older Nepalese women in the UK exist at the intersection of multiple vulnerable identities there is a need to fully understand how the realities framing their existence place their mental health at risk, in order to organise appropriate mechanisms of support. Given the paucity of evidence focusing on this population and their mental health, this qualitative research study reports on the drivers of emotional distress among older Nepalese migrant women to answer the following research questions: *What are the contexts framing older Nepalese migrant women's mental distress? How do older Nepalese women experience these contexts as part of their everyday lives?*

Methodology

The study used in-depth face-to-face interviews, informed by a narrative approach, to explore everyday drivers of mental distress among Nepalese older migrant women living in the London Borough of Greenwich. The study used naturalistic purposive sampling to select Nepalese-born women aged 60 years and older residing in the Royal Borough of Greenwich. Participants were randomly approached by the first author in a local park where older Nepalese women are known to spend time, and invited to participate in the study. Exclusion criteria included male participants, and women under the age of 60.

Given the high levels of stigma attached to mental health conditions among Nepalese communities (Jha, 2007; Casey, 2010; Thake, 2014), the study collected women's accounts of their lived experiences and explored how these were linked to emotional distress. Current trends in critical mental health research highlight the value of this approach among groups with low levels of biomedical health related knowledge about mental illnesses (Burgess and Campbell, 2014), as it enables the researcher to gather an understanding of mental health risks facing participants, without imposing a new knowledge paradigm on individuals in uncontrolled settings, where the implications of links to a stigmatised identity may be distressing to individuals.

20 interviews were conducted (see table 1). In-depth interviews suit the target population because it enables attention to the intersections between multiple factors such as race, social status, age and gender in the interview processes (Seidman, 1991). Furthermore, the method provides a sense of flexibility that encourages participants to develop and expand on the issues in their own ways in order to reflect on emotions, beliefs and experiences (Gill *et al.*, 2008).

Interviews were conducted by the first author (a Nepalese woman in her 30's) in Nepali, were recorded using a digital recorder, and lasted an average of 50 minutes. Given the strong gender norms that organise Nepali culture and society, we are confident that gender parity between the participants and the interviewer helped to support women's engagement with sensitive material in the production of their narratives and life histories (Oakley, 1981). Women preferred to be interviewed in the informal setting of the local park. A quiet corner was chosen to increase the level of privacy for the interviewees. Participants completed oral and written consent, preceded by discussions on the use of audio recordings, participants' rights in terms of withdrawing from research, and confidentiality. Following interviews, the first author continued a casual discussion to ensure comfort, and provided participants with a list of mental health and other support services in the area.

Interviews were translated and transcribed verbatim into English language by the first author. Translations were validated in a two prong process. First, a sample of

interviews were validated by the third author who also has experience conducting research with Nepali populations. Second, following the completion of 11 interviews, a focus group discussion was conducted with 4 participants (2 previous interviewees and 2 new participants) lasting approximately 2 hours. The aim of this discussion was to present emerging themes and initial findings to confirm that interviewees were in agreement with English translations of the past interviews. This gave research participants authority over the research aiming to speak on their behalf (Davis, 2006). Whilst the inclusion of two new participants could potentially have influenced their later interviews, we are confident that the open-ended nature of the interview schedule, designed to promote naturalistic conversation and the creation of individual narratives and histories, would have limited the influence of the broad themes discussed in the focus group. The data collection process continued until saturation (Mason, 2010) of emergent themes was achieved.

Data Analysis

Data was analysed using a grounded thematic network analysis (Burgess 2013; Attride –Stirling, 2001) in Nvivo software (version 10). Since there was limited pre-existing information about the mental health and wellbeing of this particular group of women, the aim of this analysis was to identify the range of factors that contributed to older Nepalese women's distress (Burnard *et al.*, 2008). This approach is useful in summarising themes from raw descriptive qualitative data and analyse data to produce reliable and valid findings (Thomas, 2006), and avoids the a priori imposition of themes within research about women's experiences of mental health, which is often critiqued by feminist scholarship in this area (Burgess, 2017). The first 11 interviews were analysed by the first and second author to derive a set of emergent themes. Six global themes linked to women's emotional distress were identified, each informed by two or more organising themes. These were validated by the third author. Analysis of the remaining 9 interviews served as further internal validation of emerging themes and expansion of themes where relevant. A second coding framework linked to women's coping strategies was also identified, and is reported elsewhere (Authors, under preparation)

Findings

Of the 20 women interviewed, nine were widowed. All were Hindu, and 18 participants migrated from rural villages in Nepal, where life is dependent on agriculture and marked by poverty, deprivation, illiteracy, poor health, low social status and restricted socioeconomic mobility (Geriatric Centre Nepal, 2010). Life in Nepal is particularly difficult for older widows, where gender inequality and discrimination is part and parcel of society (Geriatric Centre Nepal, 2010; Ramnaraian, 2016). In our analysis all women identified the same factors as problematic, and we did not find consistent differences between the accounts of widowed or non-widowed participants, or across different ages. As such our findings report on a range of experiences that led to emotional distress among our population, and seeks to map out the diversity of drivers of mental distress across this group of women as a whole.

Findings highlighted six over arching global themes that described factors contributing to women's emotional distress: *absence of family; language barriers; housing problems; physical illness; absence of appropriate support; psychological impact of death; and inadequate financial resources*. It is worth noting that many of these themes intersected in the accounts of distress presented by most participants, and the impact of cultural norms and traditions reflected throughout all narratives. Pseudonyms are used to protect the anonymity of participants.

Absence of Family

The absence of family was identified as one of the major reasons behind women's daily emotional distress. Eight participants lived alone with immediate family members living in Nepal.

I have to live alone in my room. I am living alone in a sharing house. In one moment I am good (feeling well) and in other moment I am ill. (Radhika, 65)

In the absence of family members, women felt they lacked sources of moral support and a sense of security at older age. Nine participants identified as widowed. Living alone in a foreign country where they cannot speak their native language appeared to isolate these participants further, as Kabita described:

Women who have (a) husband they walk together, talk to each other. I don't have husband. It's hard for single women because they don't have anyone.... It's scary to walk alone...(people) need families... friends. (Kabita, 70)

The importance of families and friends were highlighted by many of the participants, who linked a sense of happiness and satisfaction with the presence of children or wider families.

What to say? It is not possible to be satisfied here. I am not satisfied, because I cannot bring my daughter or grandchildren here. (Maya, 61)

Laxmi reported that her daughter lives in the UK but they were unable to live together because of structural limitations, such as the need to ensure income from the state, and limitations of her daughter's visa status.

One of my daughters lives in this country. But we are unable to live in the same house. She is (on)a domestic visa. There is not flexibility at her work. If I go to live with her, I can't get room rent from the state in the UK. That's the problem. She comes to visit me weekly. (Laxmi, 75)

Cultural norms also create barriers for engagement with families, as the typical cultural practice within Nepalese community does not accept parents living with their married daughter. As noted by Mayabati

We are living separately from children. They are daughters. They are married and living in their own family. They are renting house and working to live here. (Mayabati, 73)

Language Barriers

As alluded to previously, all women in this study faced language barriers, which restricted their communication with their immediate neighbours and the wider community. This resulted in a lack of independence and social isolation, which limited access to emotional support.

There are non-Nepalese people in my neighbourhood. But, I do not have any communication with them because I don't know their language. They also don't know my language. So we don't talk. No contact at all. (Laxmi, 75)

Language barriers were described as inhibiting women's independent mobility. As women were unable to communicate with members of their community or public service providers, they live in fear of needing to ask for help.

We can't go anywhere as we are uneducated, we might be lost. We visit near this area, but how many times can we visit the same place. (Chanta, 61)

After lunch I come to this park and I see all sisters¹ from Nepal and talk to them. I need to walk to come here because I don't know where this bus goes. I can't speak the language, so it's hard to buy things to eat. (Radhika, 65)

As alluded to by Radhika above, language barriers were also identified as limiting basic survival strategies to fulfil daily needs, such as shopping for food:

I pick what I can see in the supermarket and I pay on the counter. They return if I give more money, if it is not enough they show sign like forwarding hand for more money, and then I give more money. (Ambika, 68)

¹ Any women from any parts of Nepal

Housing Problems

Housing issues created daily struggles for many participants. For example, many struggled to find good quality affordable accommodations due to socioeconomic hardships. Maya highlighted how restrictions set by her landlord affected her eating behaviour.

Now we (living with spouse) are living in the house of an Indian family. There is problem with fungus in my room and it smells. They (Landlord) are vegetarian, they say it smells when we cook meat. They have different religion.... In our culture we eat meat...Here, when we search for accommodation, we cannot rent a house like we want. (Maya, 61).

Poor housing conditions, overcrowding and restrictions in use of facilities, can have a huge impact on the eating behaviours of these older women. Many reported being unable to cook food at times of their choice, and sometimes going to sleep without meal:

There is not enough space in the kitchen to cook. Sometimes it's too late to cook. They (housemates) cook one after another.... Sometimes, I sleep without eating anything. (Radhika, 65)

Many women felt that the lack of power they had over their housing created insecurity in many women's lives, and was a source of distress. As noted by Mayabati:

I don't feel like this is my own home in the UK. We don't have our own home in the UK and that is the problem; if we had our own home we could live peacefully and securely. (Mayabati, 73)

Physical Illness and Absence of Appropriate Support

Many participants highlighted that they developed chronic diseases while living in the UK. Deteriorating health and development of chronic diseases made the lives of many participants very challenging, in the absence of support systems.

I had good health in Nepal. After coming to the UK, I have sugar (diabetes) and my husband has high blood pressure problem in last 2 years. As we are too old, if suddenly we cannot move our limbs and our children are not here in this country (UK), who will look after us? (Chanta, 61)

Women in this study felt concerned about the support they needed to address their health conditions. Difficulties in accessing healthcare due to a lack of clarity about the operation of National Health Service (NHS) created barriers to support, and created distress in women's lives

I cannot go to GP at any time I wish, [as] translator is not available all the time. I take someone with me who can speak the English language. I cannot say what I want to say from my heart because I don't know the language. (Santi, 65)

GP gives medicine if I say I have pain. They give me only medicine, but that medicine does not cure my worry. (Maya, 61)

Psychological fears of Death

Women's fears of death were linked to the importance of family, and financial insecurity. Older participants highlighted the importance of cremation, a cultural ritual after death, and the critical role of sons in these rituals.

If we don't go to Nepal and we die in the UK, what will happen? I have a son and daughter-in-law in Nepal. In the UK, I have a daughter and her husband, what to do? At last, don't we need a son to attend all the ritual things when we die? In Nepal, once people die they are burnt. The UK does not allow burning the dead body or need lot of money to burn. We save the money that will help to burn the body in case we die in the UK. (Yamuna, 70)

The financial costs linked to death rituals and absence of sons in the UK caused worries and distress among all participants. Women were also worried because they had little or no family in the UK, which is considered very important for rituals after

death. Due to a lack of resources, it would be impossible for relatives to travel to pay their respects appropriately.

If I die here, my relatives and family will have to suffer more. I have many children. If I die in Nepal, my children who are living abroad will come to Nepal. If I die here they will have problem to come here. (Laxmi, 75)

Inadequate Financial Resources

All participants reported serious concerns about the availability of financial resources in the UK, where daily living costs were high, and arrangement of family visits to Nepal were often unaffordable. This was particularly distressing as many moved to the UK for the sole purpose of gaining access to larger pensions, which never transpired:

We would be happy if we could get the same amount of pension in Nepal as we get here. I would live with my children. But they (government) don't do that. We are living in the UK and getting money, but our children are in Nepal. I feel sad for this. We don't get the same amount of pension in Nepal as we get in the UK. We get very little amount in Nepal that was not enough to live, that's why all ex-army and their families came to the UK. If we could get the same amount, as white army pension scheme is available in the UK, we could live in Nepal with our children. I would be happy in that case. Although we get money to live here in the UK, we miss family. (Nirmala, 68)

The money we get is just enough to eat and buy clothes. We need to go [to]Nepal because if something happens in family, people expect us to be there, such as someone dying or being sick. This money is not even enough to buy good clothes because we are on benefit and pension. How is it possible to buy tickets with this money? (Babita, 70)

Families are integral to the lives of participants. Many expressed their desire to visit home and compromised their everyday comfort to save for travel, often in ways that posed health risks. For example:

At whatever cost, I must go to meet my children. I have to manage to buy my tickets even if I need to eat half meal. (Laxmi, 75)

Discussion

Findings in this study highlight the intersectional nature of the social determinants of emotional distress for older Nepalese women in the UK. For all women in our study, it was the interaction between multiple social drivers that drove emotional distress. For example, women not only identified housing challenges as distressing, but pointed to how limitations in access to housing interacted with their cultural positioning (namely, differing levels of restriction within vegetarian diets) to create vulnerabilities and emotional distress. Financial struggles emerged due to the importance of securing resources to fund visits to Nepal, and support expensive burial rituals. Isolation, a typical challenge for older women (Panagiotopoulos et al., 2013), was compounded for women in our study by their migrant status, and further intensified among widows.

Whilst widowed and non-widowed women in our study did not identify different factors behind their distress, the impact of factors varied. Findings from other studies suggest that women who are widowed may be at risk for increased distress when faced with the same factors as their non-widowed counterparts. A recent study of older Greek migrant widows in a similar high-income country highlighted that women's non-English speaking background and identification with a non-indigenous culture may have intensified the detrimental emotional effects of their widowhood (Panagiotopoulos et al., 2013). Lenette's (2014) narrative study on refugee widows suggests that widowhood can have a negative impact on emotional wellbeing due to lack of financial assistance and increased resettlement issues. While Mand (2005) suggests that Britain is a relatively better place for widows because of state benefits and pension systems, for widowed women in our study, their presence in the UK and

access to pensions and benefits did not significantly improve their financial positions. For some women, ongoing financial challenges in spite of support seemed to deepen emotional distress linked to financial and housing instability, supporting findings that poor socioeconomic situations may put migrants at risk of poor mental health outcomes (Tinghog, Hemmingsson and Lundberg, 2007).

The disparities in access to pensions was one of the major reasons driving older women to move to the UK. The amount received in Nepal is inadequate to support a decent living, driving many to migrate. There is an ongoing legal campaign to claim equal pension incomes for the ex-British Gurkha Army (BGA) (Thurley, 2014), as currently ex-BGA soldiers residing in Nepal receive less than British Army and ex-BGA residing in the UK. Recently, the Department for Work and Pensions (2015) has made changes to the pension credit, allowing the receipt of payments for up to 13 weeks while pensioners are temporarily abroad. Whilst this policy enables individuals to keep access to their pensions while visiting home, it does not increase the value of pensions, which based on our findings would be needed to enable access to support the purchase of flights in order to visit home.

The ongoing separation from families causes a huge strain on women's emotional wellbeing given women's desire to maintain family. The need to live with children and expectations of support from families are common among the Nepalese community, as seen in other Asian communities (Mui, 2000; Shibusawa and Mui, 2002). Findings from this study suggest that a strong sense of family obligation among older Nepalese women establishes a need to be closer to families and relatives in their old age, that when not met, establishes distress. Given the cultural tradition and expectations for children to support older parents, living alone leads to feelings of loneliness as it fractures this expectation and, a norm which linked to good motherhood. The immigration policy of Gurkha settlement has created challenges for older Nepalese women who seek to bring their children to the UK. Earlier UK Border Agency policy (2010) stipulated that children of the ex-BGA under the age of 18 years were allowed to be granted settlement on the condition that both parents are present and settled in the UK. In 2015, changes to the immigration policy allowed adult children of ex-BGA, aged 18 to 30 years, to settle in the UK (UK Visa and

Immigration, 2015). However, traditions of early marriage and pregnancies among girls in Nepal (Alejos, 2015) means that the policy change is unlikely to be beneficial for the majority of older women (60 years and over) residing to the UK, and thus not helpful for many of the women at the heart of this study.

Much evidence shows that poor standards of housing may have negative impacts on mental health (Curl et al., 2016; Evans, Wells, and Moch, 2003; Hopton and Hunt, 1996). Findings in this study highlighted that difficulties with adjustment to life in the UK linked to the need to share housing with people of different cultures and religions. In this study, all participants were Hindu. Vegetarianism is an integral part of the religious tradition where meat is preserved for sacrifice in presence of the priests (Spencer, 1996). Nepalese older people who eat meat as part of their dietary requirement may challenge other positions on this doctrine, which may create conflict with others. Beyond this, many participants live in poor housing conditions marked by overcrowding, inadequate communal spaces and limitations to their personal agency in use of facilities (i.e access to kitchens, or cooking desired meals), which was distressing to most women, inline with previous studies (Buhgra, 2004).

The behaviour of landlords towards women in this study make it difficult to live in rented accommodation. Financial limitations often locked women within housing situations they have little control over, given the shortages of affordable housing across greater London (Thompson et al., 2017). Recent research conducted in the Royal Borough of Greenwich by Simkhada, *et al.* (2015) identified that two-thirds of Nepalese people live in a rented accommodation that has very poor standard of housing, and cited evidence of abuses and discrimination from landlords, especially towards older Nepalese women. In a divergence from other studies, experiences of discrimination faced by women in our study were only reported in relation to housing challenges. Previous studies from other parts of the UK also identified that women from different castes had different experiences of their environments (Metcalf and Rolfe, 2010) suggesting differential experiences of distress. However, in our study, women did not identify caste as a driver of discrimination or distress in London. In fact, women in this study described the ability for groups to come together despite

caste as a positive coping mechanism in their everyday lives (see Authors, under preparation for full discussion of coping strategies). Such findings suggest that discrimination linked to caste may be minimized in larger multi-cultural cities like London.

Additionally, this research demonstrated the negative impact of poor language skills on day-to-day lives of the older migrant women. Participants were isolated as a result of their language limitations, locking them into a very small geographical area trapped by fears of getting lost and being unable to ask for support. Low social integration in social networks, low levels of perceived social support and fewer close relationships are all linked to poor psychological wellbeing (Kawachi and Berkman, 2001; Barnett and Gotlib, 1988; Cornwell and Waite, 2009). Our study corroborates findings from Tran's (1990) seminal study of older Vietnamese migrants in the US, who struggled with daily survival strategies such as asking for help due to language barriers. Later work by Ding and Hargraves (2009), and Panagiotopoulos and colleagues (2013) confirmed that migrant and older widowed migrant populations may face disadvantages in accessing to health services and social environments, largely due to their immigrant status and language barriers, which establishes a reliance on others for access to critical information and support.

Numerous studies support the impact of language barriers on mental health and wellbeing and access to health care services for migrants and minority ethnic groups (Ding and Hargraves, 2009; Ponce *et al.*, 2006; Pippins *et al.*, 2007; Kim *et al.*, 2011; Scheppers *et al.*, 2006). Findings from this study highlight the ongoing language related barriers to health care services in the UK. Despite policy that theoretically makes translators available in NHS services, women in this study reported waiting many days to access health services due to a lack of translators.

Even in the presence of translators, women in this study find it challenging to use them effectively due to difficulties in expressing emotional concern through translations. Nepalese older women's inability to fully express their needs and concerns about their health status to doctors increases risk of poor health outcomes due to ineffective treatment encounters. Temple and Koterba (2009) assert that people

present themselves differently in their own language than if using a translator and mental health issues are highly sensitive and access of the services are determined by the need of its client.

Narratives of women in this study highlight a common belief among migrants that previous local realities of marginalisation could be exchanged for improved wellbeing in a new host country (Bal & Willems, 2014). Instead, women found the disparity between imagined futures and their new realities as a source of distress, particularly in relation to their physical wellbeing and the management of chronic disease. Recent evidence has highlighted the differential impacts of chronic disease among migrants in the UK, where prevalence of conditions like diabetes is five times higher among South Asian migrants than the local population (Montesi et al., 2016). For women living alone, fears and emotional distress linked to physical illness are often exacerbated (McInnis and White, 2001). Participants across a range of older ages were worried about being looked after in their old age, especially in terms of increased needs for physical support in their day-to-day activities, including transport to medical appointments. This fear sits in harsh contrast to the belief that if they were living in Nepal cultural expectations would ensure the availability of family to support and care for them in later life (Mui, 1996; Mui, 2000), despite difficult financial circumstances.

Most literature published on mental health and wellbeing of older migrants has overlooked the psychological impact of death as a determinant of mental health (Jolly, 1999; Thake, 2014). Our study highlights psychological risks created by fears of death among women in this study that differs from studies on similar ethnic groups. A hypothesized path model by Cicirelli (1999) has discussed how increasing age, low socio-economic status, being female, and belonging to minority ethnic status may escalate the fear of death. However, findings from this study highlighted that age did not create differential fears, and emphasised a new dimension to a potential model; the impact of absence of kin (particularly children) and, economic burden associated with death. For women in this study, the strong desire to die in the presence of family, particularly sons who are needed to perform rituals after death were concerns that occupied women's fears and distress. The ability to afford certain rituals, such as

immediate cremation of the body, and the attendance of children and family from abroad at ceremonies, are dependent on access to financial resources, which all women identified as insufficient.

Findings also support existing cross cultural studies that highlight the importance of male children for women's identity and wellbeing. For women in our study, sons create the opportunity for care and pathways to the completion of important rituals linked to a 'good' death. This cultural norm is supported in the work by Coward and Sidhu (2000), who argues the importance of the son's role in Hinduism where the eldest son is required to preform the rituals for the wellbeing of parents in the next life. Moreover, in Asian cultures more broadly, sons are seen as the head of the family, and as such, has a moral obligation to protect the women in the family (Coward and Sidhu, 2000). Although some women have daughters in the UK, they do not accept being dependent on daughters in terms of financial and physical support, especially if daughters are married. The importance of sons and children is particularly important for widowed women, as they often face excessive control and social scrutiny in terms of freedom and independence (Houston et al., 2016; Ramnarayan, 2016). Widows often look to sons for social and financial supports in Nepalese (Ramnarayan, 2016) and other Asian communities (Martin-Matthews et al., 2013). Continued adherence to these cultural norms has been argued as important to maintaining a positive sense of self, particularly among non-English speaking older migrants (Panagiotopoulos, Walker & Luszcz, 2013). Furthermore, the presence of children may have a moderating effect on experiences of exclusion from wider community events, and abuse from in-laws that widows in Nepali communities often face (Houston et al., 2016, Uprety and Adhikary, 2009). In our study, widowed women did not identify experiences of cultural exclusion within their new lives in London, suggesting that migration may serve as a protective factor against some of the more negative consequences of gendered norms surrounding widowhood that dominate life in Nepal.

Findings also suggest the importance of understanding the often complicated dynamics of transnational households and their impacts on mental health. Nearly all

participants in this study reported separation from their children as the main source of their distress, with family members scattered across the globe. Many studies discuss the importance of maintaining connections with family as a way to promote well-being within migrant (Panagiotopolous, Walker and Luszcz, 2013) and older populations (Fiori, Antonucci, and Cortina, 2006), though less has focused on the needs of those who are at the intersection of these groups. In our study, while we were not able to engage with family members back in Nepal, it is likely that the nature of these relationships pose mental health risks for family members on both sides of this transnational network, as suggested by Graham and colleagues (2015). Although some work has begun to explore transnational dynamics of Nepalese families (Low, 2015) there is little analysis of how these dynamics specifically impact on emotional and mental wellbeing within the literature. Our study begins to highlight how separation from family intensifies some social drivers of emotional distress for women in our specific population, but the need for further research in this area among Nepalese and other migrant populations is evident.

Limitations

This study represents only a snapshot in time of the needs facing older women in the UK. As such, social and relational drivers of mental health and wellbeing among older Nepalese women living in the UK could change overtime in line with policy and economic shifts. Furthermore, as this study is focused on older women (60 years and over) in one London Borough, findings cannot automatically be generalised to all Nepalese women living in the UK. Whilst a plethora of research focuses on socioeconomic factors that determine mental health and wellbeing of the general population (Delara, 2016), there is less research recognising that the processes of migration itself can be a determinant of mental health and wellbeing (Ingleby, 2012), and even less on older migrants. The findings in this study highlight that the wider social contexts around processes of settlement – such as housing and learning a new language, establish a particular set of mental health risks for women in this population, across a range of social categories. Though our study begins to point to

how social issues impact the mental health of older migrant women in one setting, there remain large gaps in our understandings of mental health needs among the Nepalese population, particularly among men who are likely to have different experiences of similar challenges. Notwithstanding, there is great importance in this research, given the need to understand burdens of illness among aging migrant populations in the UK and globally.

Conclusions and Recommendations

Findings from this study suggest that interventions to support the mental health of Nepalese women needs to consider both structural and relational drivers of emotional distress. It is worth noting that in our study all participants had no prior knowledge of mental health services in their area, signalling a need for access to information and support in accessing such care. However, findings also confirm that bio-medically driven mental health care would provide limited relief from the worries that older women face on a daily basis. Critical mental health theorists such as Summerfield (2008) have argued that insufficient attention is given to the impacts of fractured social worlds on mental wellbeing, with treatment options for women instead offering biomedical solutions to social and political problems (Burgess & Campbell, 2014). For women in this study, it is clear that migration in search of a better life has left them in a position where their most important world – family - is fractured. Women’s concerns indicate the importance of support addressing challenges in the world beyond the body, through the provision of ‘social’ medicine to promote mental wellbeing.

Currently the Nepalese population in Greenwich receives support from the local community empowerment network², who run services such as training programmes on digital skills, healthy living, and housing and benefits schemes. Such training would go a long way to helping women feel more confident in managing health crisis,

²see: <http://cesi-uk.org/programme/>

as well as contacting family members around the world in an effort to maintain ties despite physical distance. In terms of reducing isolation, recent evidence highlights the value of befriending schemes (SCIE, 2015). These could be adapted to also include opportunities for women to build confidence in their use of English, and mechanisms for widening community participation (i.e. teaching women how to navigate transport systems). Women who struggle with landlords are likely to do so in the absence of an understanding of their rights as tenants in their new home. Increasing access to public services such as local Citizens Advice Bureau's could also be included as part of a widened 'befriending' programme of supports, so women could be helped in addressing problematic landlords and unsafe housing conditions. Small changes of this nature would make large inroads into addressing some of the complex risks facing older Nepalese women's mental wellbeing, in an attempt to provide additional forms of 'medicine' to solve wider range of women's concerns.

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