

Sorties d'une marginalité multiple : les femmes d'âge mûr s'affirment sur le plan des soins de santé

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Cette étude phénoménologique féministe explore le sens des expériences vécues par les femmes d'âge mûr au fil de leurs négociations avec le système de santé. Plusieurs entrevues réalisées auprès de divers groupes de femmes d'âge mûr (immigrantes, autochtones, canado-japonaises et les femmes qui adhèrent à des groupes communautaires et sociaux) ont révélé que les négociations qu'elles devaient mener pour obtenir des soins de santé correspondant à leurs besoins constituaient un processus difficile qui nécessitait l'apport d'un soutien mutuel. Des facteurs liés à l'accès aux services, au pouvoir et à la pauvreté influençaient sur leurs expériences en matière de soins. Les entrevues axées sur une approche interactive ont stimulé chez plusieurs participantes des prises de conscience, un désir de militer et une réflexion. Les résultats suggèrent que de telles réflexions peuvent aider d'autres femmes à comprendre le concept de « marginalité multiple » (être d'âge mûr, être femme, être membre d'une minorité visible) qui contraint et rend difficile leur accès à des soins de santé.

Mots clés : femmes d'âge mûr, accès, pauvreté, féministe, phénoménologie

Out of the Multiple Margins: Older Women Managing Their Health Care

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This feminist phenomenological study explores the meaning of older women's experiences as they negotiate health care. Several interviews with diverse groups of older women (immigrant, First Nations, and Japanese-Canadian women and those involved in community and social clubs) reveal that negotiating to have their health needs met was a challenging process requiring mutual support. Their health-care experiences were influenced by issues surrounding access to services, power, and poverty. For many participants, the conversational interview format served to inspire consciousness-raising, activism, and reflection. The findings suggest that such reflection may help other women to understand the "multiple margins" (being older, being a woman, being a member of a visible minority) that constrain and challenge their access to health care.

Keywords: older women, access, poverty, feminism, phenomenology

Background

This study continued a program of research initiated by the first author to explore older women's health-care experiences and how older women manage their health and health care. The program of research is intended to ultimately enhance the accessibility to health care for underrepresented and marginalized groups of older women, including poor women, lesbian women, women of colour, and disabled women. Future studies must include these groups to ensure that their voices are heard and their needs are met.

In the course of previous research interviews (Kinch, 1997, 1999) and in clinical nursing practice, many older women recounted that their specific health-care needs had not been addressed. Older women are rarely included in the planning of their health care or in the planning of health-care reforms. In fact, their health concerns are often trivialized. In the research interviews (Kinch, 1997, 1999) they expressed the view that they were not listened to when they gave their reasons for seeking care. Older women bear the burdens of invisibility and inaudibility as they journey through the health-care system (Blow & Barry, 2002; Hunt, 2001; McCormick, 2002; Sharpe, 1995; Worcester & Whatley, 2000). The difficult relationships that older women develop with health-

care providers stem largely from the way in which women have been socialized to be passive and submissive (Baslow, 2000; Smith, 1999). The feminization of aging and poverty is well documented (Fukuda-Parr, 1999; Gonyea, 1994; Harman, 1999; Weitz & Estes, 2001; Worcester & Whatley), and it is fair to say that older women are at heightened risk of receiving less than optimal health care (Blow & Barry; Hunt; McCormick; Rosser, 1994).

While women in Canada are living longer, as they grow older they experience more chronic disabilities than men, use health-care services more often than men, spend more time in hospital than men, and are more likely than men to end their days in a long-term-care facility (Ratcliff, 2002; Statistics Canada, 2003; Trypuc, 1994). As well, many women use alternative therapies such as chiropractic, massage, herbal remedies, and acupuncture (Kinch, 1997).

Kinch (1997, 1999) found that many older women experienced lack of trust in a health-care practitioner, often because their long-time physician had moved, retired, or died, and that many spent long periods accessing health care because of a shortage of physicians and long waiting lists. As well, many people are known to access the health-care system through the “illness door,” seeking care only when they are ill, as opposed to seeking preventive or health-promoting care. Sharpe (1995) found that older women’s “disadvantaged status” (p. 9) within the health-care system has contributed to the combined forces of sexism, ageism, and racism that have led ultimately to “patronizing care” in the form of programs that are ill-suited to the needs of this neglected population. Hunt (2001) asserts that, while some biologic measures have been developed in recent years, subjective accounts of older women’s health are still elusive. The present study was intended to add to our knowledge base concerning the subjective world of older women’s health.

Purpose of Study

Conversational relationships with older women occur in many contexts — social, personal, and professional. Questions brought to this study from conversations between the first author and older women in social, personal, and professional contexts were: *How do older women manage their health care? How do they access health care, and for what reasons? Who do they ask for advice and assistance in meeting their health-care needs? What are the barriers that prevent them from receiving the care they want and need?*

The purpose of the study was to engage with older women in a peer-group setting in order to explore the meaning of health and health-care issues in their lives, how they manage their health, and the health-care challenges they face. The ultimate goal was to give voice to older women as they suggest ways in which their health status might be managed dif-

ferently, in order to recommend ways to facilitate and enhance their health care.

Design

A feminist phenomenological approach was used to elicit the meaning of health, health-care issues, and challenges in the lives of older women. We sought to involve women in a discussion of how they met their health-care needs and to learn from their lived experiences with the health-care system. Such experiences are considered unique and context-driven. Phenomenology explores the lived experience of human beings as they go about their daily lives (van Manen, 1990). Feminist research is that which is about and for women, usually conducted by and with women (Chinn, 1995; Gustafson, 2000), reflects issues in women's lives that are central to the feminist concerns of power, change, and domination (Campbell & Bunting, 1991; Hedin & Duffy, 1991; Hekman, 1999; Reinharz, 1992), and pertain to the centrality of women's experience (Chinn, 1989; Mohanty, 1995). We met with small groups of older women who were interested in sharing their health experiences and needs using a collective approach. Such an approach is consistent with feminist methodology (Chinn, 1995).

Method

Consistent with van Manen's (1990) approach for exploring lived experience and Munhall's (1994) guidelines for exploring human life, the participants were interviewed in small groups by the principal investigator and/or a research assistant. Conversations were initiated by the participants, with the interviewer playing a facilitative, participative role.

Sample

The sample comprised 32 women aged 65 years and over who spoke English well enough to understand and be understood in a group setting. The women lived within a short driving distance of a large western Canadian city.

Recruitment was initially carried out by publicizing the study through a letter or poster in locations where older people tend to congregate, such as seniors' centres, social centres, agencies, or churches, and through word-of-mouth, or "snowball effect." An attempt was made to ensure the inclusion of women from diverse cultures and ethnicities and women of compromised socio-economic status by advertising in diverse newsletters and at diverse centres. Formal and informal presentations were then made at two seniors' centres. These sessions, together with the input of seniors' activity coordinators, succeeded in attracting women from five seniors' groups. Those who agreed to participate, after hearing a

description of the study, were invited to meet with the researchers in small groups of their peers in order to discuss their experiences. All participants chose to be grouped with their acquaintances and to meet in their own social environment, thus expressing a desire for familiarity and convenience. The result was five self-selected groups meeting in five venues. Table 1 provides a profile of the sample.

Group	Number	Age Range (Years)	Ethnicity	Site of Interview
1	5	66–76	Caucasian	Common room, community pool
2	11	65–83	Ismaili	Subsidized apartment building
3	9	68–74	Caucasian	Community seniors' centre
4	3	65–74	Aboriginal	Health centre on Native reserve
5	4	66–83	Japanese	Seniors' centre

Morse (2000) recommends that the number of participants be based on the scope of the study, the topic, the quality of the data, and the study design. For a phenomenological study in which interviews are expected to generate large amounts of data, Morse suggests groups of 6 to 10. Reinharz (1992) suggests that feminist groups (similar to focus groups) consist of fewer than 12 people. Krueger (1994) holds that 6 to 10 people is ideal but that a range of 4 to 12 is acceptable. Our group sizes were within these guidelines.

Ethical Considerations

Ethical requirements were met through approval by the Conjoint Health Research Ethics Board and through informed consent. The participants were assured of confidentiality and anonymity. They were informed that no names would be used in any document, transcript, report, or article submitted for publication. Pseudonyms were allocated in all documentation. The women were reminded of the need for respect of privacy and confidentiality within the group setting. They were informed of their right to withdraw from the study at any time, without penalty. There was no financial reward for participation.

Data Collection

The principal investigator and/or a research assistant facilitated each group interview of 1.5 to 2.5 hours, at a time and place convenient for the participants. Most interviews were held in a private room at a seniors' centre, community centre, or health centre. The interviews were audiotaped with the participants' permission and later transcribed by a qualified transcriptionist. Relational conversations were initiated, with the facilitator generally discussing concerns that are often raised by older women and then inviting the participants to share stories about their health, health-care experiences, and health-care management. Conversation flowed with occasional prompts from the facilitator, such as "How did that feel?" or "Can you tell us more about that situation?"

At the request of a seniors' representative at one of the organizations, a follow-up meeting was held with five members of a group that had originally consisted of nine women. The women had requested this meeting as they were compelled to continue the conversations they had begun. This follow-up meeting represented an opportunity for the researchers to present some of the study's findings. It also yielded further insights for analysis, which are reported in the Findings section.

Data Analysis

The researchers read the transcribed data and then read them again while listening to the audiotapes. The researchers met regularly to review the tapes and transcripts, seeking the occurrence and recurrence of common and diverse themes. When data are analyzed by more than one person, it is crucial that agreement be reached on the essence of the experiences. Through qualitative phenomenological analysis, one seeks meaning, commonality, and difference, rather than statistical relevance. In the present study, analysis was guided by the approaches recommended by van Manen (1990) and Munhall (1994).

Findings

Themes identified within and across the interviews were: *femininity, relationships, and means of support; health information and the politics of access to care; the supportive role of faith, religion, and tradition; and abuse and power.* Two general concerns identified were: not being taken seriously or not being listened to, and the need for advocacy, including self-advocacy. Every interview highlighted the power of collective advocacy, such as women getting together to strive towards a goal.

Femininity, Relationships, and Means of Support

Many of the women reported that while they had been meeting with friends and in social groups for years, they had never before been asked to participate in an organized discussion. They were intrigued by the concept of sharing their stories in this way. Thus the notion of women supporting each other at new levels was evident in the interviews, and meaningful data were generated on how women perceive their relationships and roles. In this research approach, the group interview is both a data-collection and an advocacy/support intervention (Banister, Tate, Wright, Rinzema, & Flato, 2002; Banks-Wallace, 1998). It became clear that this supportive approach was beneficial for the participants during the group meetings, where statements such as the following were the norm:

We always get together and we sit around and talk, but never discussing the things like this...the personal things. [Irene]

It might be that “personal things” do not get discussed during encounters with health-care providers, for example, because the providers simply do not ask the right questions or listen to the responses.

During a discussion of what they considered “personal” matters, the women spoke of the loneliness they endured after spending years in various relationships, in both their working lives and their personal lives. Having experienced dramatically changed roles and multiple losses (of parents, children, partners, friends), some of the women described a state of loneliness and a drastically altered sense of self in relation to others. They clearly empathized with those experiencing extreme loneliness and made a connection between this social phenomenon and that of widespread depression.

Health Information and the Politics of Access to Care

Two areas stood out under the theme of health information: technologies of support and isolation, and access to health care. These women had grown up in an era when technology was relatively primitive. Personal computers were unheard of, and most Canadian homes did not even have television sets until the mid-1950s or early 1960s.

Technologies of support and isolation. Some participants used computers and other technology such as television to mediate support in the face of their isolation. Assistive technology and the Internet are new means of increasing contact and support and providing a sense of camaraderie (Bradley & Poppen, 2003). While all of the women had access to television, several also reflected on the resources, both social and informational, offered by the Internet:

I do miss having someone to do things with...but as far as being on my own in the house, well, I've got my computer and I've got different things to keep me company. [Louise]

But technology cannot replace human contact. The women repeatedly described a sense of loneliness and pervasive sadness. Margaret explained:

Living alone, you get so lonely and you get attached to your TV and it's much easier to stay at home than get out and explain to people what's going on in your life.

Roberta added:

I used to have a lot of people, but now I keep moving around and around. No one for me to help...no one to help me.

For other women, however, friends were central to the management of their health. Eileen described the community support given to a friend who had recently died at home:

She didn't go into hospital, everybody was there... We looked after one another, then we decided we would be each other's advocates and we would be there for one another...and we have been.

While many women were sustained by a sense of community support, others were overwhelmed by their own loneliness and that observed among their acquaintances, which the medical community often "treated" with anti-depressant medications. The descriptions of depression and extensive prescribing of anti-depressants was notable in some of the group discussions. Margaret spoke about a sense of malaise and disconnection among her peers:

I think depression is rampant; maybe it's just an attitude toward life.

While Margaret regarded the treatment of depression with pharmaceuticals as useful in certain circumstances, social isolation in general is increasingly being medicalized. The needs voiced by the participants in this study echo Michael Ignatieff's (1984) notion of "the human gestures money cannot buy" (p. 13); these needs extend beyond the medicalized interpretations of isolation. Our "society of strangers" (Ignatieff, p. 18) simply cannot meet the needs of many older women (or indeed others).

Access to health care. Many of the women seemed to lack knowledge about how to access services (where to go, whom to ask, how to navigate the system, how to avoid long waits in the emergency room, etc.), as well as specific health information. This lack of access was compounded by poverty issues and environmental factors. For example, many

of the Ismaili women did not know that a public health nurse was available in their apartment building. Other than their friends, they had no one to call if they had health questions or concerns, and therefore either went to the emergency room or kept their illness to themselves. The situation described by Kassa, an Ismaili participant, seemed to be a common one:

Mostly I don't talk to anybody because somebody said we are sick too much, so I don't tell anybody that I am sick.

Two issues, transportation and reliance on family and cultural groups, serve to illustrate the lack of information, support, and access. One of the Ismaili women summarized the transportation issue:

If I am sick and know in advance I can book the handicap system, but what happens if you are sick just this very minute and need the transportation? Then we have to go in our own private taxi or car and pay for that...some people don't go because they can't afford it.

For many of the participants, family and cultural groups were their means of accessing health services. While dependent on such support, these women may also, paradoxically, have been silenced by it, in that health-care providers might have assumed that because they had apparent support they knew how to access whatever health services they needed.

The reliance on family members/cultural groups as translators and the institutional practice of allocating cultural groups as "support" instead of providing real access to services (Brotman, 2003) were particularly notable among the Ismaili and First Nations women. For example, Sunara was accompanied to her regular physician's appointments by her daughter, a working mother. The families of hospitalized immigrant women were immediately called by health-care professionals to serve as interpreters and to assist with care. The lack of access was closely linked to the poverty experienced by many of the participants. In addition, according to Das Gupta (1999), systemic racism places many immigrant women in the role of "victim" (p. 167), due to their lack of cultural and language skills in the new environment.

Advocacy is essential for many older women attempting to navigate the health-care system. Some of the participants had family or friends interceding for them, but others had to advocate on their own behalf, seek out the specific resources they needed, or do without appropriate care (Boyle, 2003). For example, Soshan was sent home from hospital after surgery even though she was unable to look after herself; if her daughter had not stayed with her, she would have been on her own.

The Supportive Role of Faith, Religion, and Tradition

The women consistently reported faith and religious affiliation as central to their health. Josephine described her support system:

It's the F's — not a bad word at all — it's your family, friends, and faith, and not necessarily in that order.

Many participants reflected on the significance of faith and religion in the management of their health. Shirley said:

Doggone it, you know, sometimes you have to believe that a prayer has made a difference.

The women placed a remarkable degree of emphasis on their faith in times of sickness and adversity. Patricia commented on the comfort she received from her faith during her husband's illness:

My family and friends would come. I am Christian so I also have faith in God, who is able and comforting and ever present, and I have friends who would come and pray with me, so the peace of God was there even though the pain was unbearable.

Religion and community were found to be mutually strengthening for the women in the study. McIntosh, Sykes, and Kubena (2002) similarly affirm that “religious ties of the elderly may strengthen community links and attachments” (p. 110).

The participants reported that in times of need “prayer letters came from all over,” or “it's the traditions, the incense I turn to.” Those from the First Nations community relied on traditional remedies. Some First Nations women consulted with elders concerning their health. Helen confided:

For a long time I just stayed home...then I met with the elders and advisors and it's been help for me to go to meetings and start making myself get a living, to start again.

Jennie, also a member of the First Nations community, described her use of prayer:

Praying is good [as a source of support in managing one's health]. I always pray in the morning and at night. That's it. And we pray together — that's the most important.

Jean, from another group, said:

I care for my parents and husband, but no one looks after me...only God...otherwise it is me alone.

The participants also spoke of traditional cultural values (e.g., respect for elders, self-reliance) that had been instilled in them during childhood and through traumatic experiences such as living through war or in residential schools or internment camps. First Nations women cited health concerns such as poverty and the politics of poverty. In the face of their health challenges, they turned to the traditions (gendered and neutral) of persevering, coping, and surviving. They also discussed the experience of collectively and consciously passing on cultural expressions, healing traditions, and traditional health practices. Florence commented:

Our health changed in the residential school. Now I take seven pills, for diabetes, hypertension, and arthritis... We never used to take pills. We used Indian medicine.

The rituals of the Ismaili participants were clearly a means of traditional collective support (evident even during the group interview, in the form of food-sharing). In times of need these women relied on their mosque, their family, and their friends.

The participants' faith and traditional values both sustained and supported them in managing their health care, but at the same time may have obscured the needs of older women from the health-care system. Church, philanthropic, and social organizations, both formal and informal, offer stopgaps for the health needs of older women. While these human connections broke through the loneliness, they may have also served to keep the real needs of older women from reaching the radar of decision-makers (see Lauder, Sharkey, & Mummery, 2004).

Abuse and Power

Three subthemes of abuse and power were identified: historical tensions; unspeakable stories; and lack of understanding, poverty, and the politics of poverty.

Historical tensions. Underlying currents of tension were evident at the beginning of some of the conversations. We were aware of the historical and cultural nature of distrust of outsiders and attributed the tension to the fact that we were the outsiders. However, as the women became more comfortable with our presence, the tension decreased and the topic of abuse and misuse of power emerged.

The First Nations and Japanese-Canadian participants spoke about historical abuses matter-of-factly, explaining that traditional knowledge and practices had helped them to persevere and overcome injustices of the last century. Women's poverty of access to health care was manifested in a broadly experienced form of abuse that many of the participants had endured most of their lives.

The residential schooling endured by many First Nations children took a toll on the physical and mental health of the three First Nations participants. The removal of children from Aboriginal families and their placement in residential schools at seven and eight years of age by the Canadian government is well documented (Wasekeesikaw, 2003). The women retained memories of their ill treatment well into their later years (for example, they were forbidden to speak their native Cree language, were required to wear hand-me-down “white” clothing, and were allowed to bathe, in a communal tub, only once a week). Florence speculated about what had made her health change:

I think that what makes it change is the residential school. That's what changed us. I was nine years in the school.

With reference to her arthritis and sore feet, she recalled:

We never wore our own moccasins. We wore those old ragged running shoes to church. Sometimes that hurts me nowadays.

Dietary impositions were also a factor. In place of their customary “eating off the land” and herbal drinks, they were given “white man’s food,” and were not allowed to visit their parents, who might have fed them their usual diet.

The four Japanese-Canadian women endured discrimination and upheaval during the Second World War when their families were forcibly removed from coastal areas (this “evacuation” is well documented; see Ichikawa, 1994; Kobayashi, 1992). Betty said:

There are still people who have the effects of that in their life and haven't learned to get over it. I think everybody knows people who did not.

The four participants had overcome the mental burden of their past through education, family relationships, gardening, reiki, and social activities.

Unspeaking stories. The follow-up interview requested by one group revealed new but related data on abuse and power. This was the first time these five women had shared such “personal” information. The first author’s intention for that follow-up meeting was twofold: to present the data collected so far, and to conceive of new directions for the principal investigator’s program of research into the health of older women. However, the 2-hour meeting, held at a seniors’ centre, unfolded in unforeseen ways. It began as somewhat of a continuation of the research interview, with a discussion of some of the findings. The participants described changes in their lives since the research interview. The dam seems to have burst, as each of the five women shared information about herself that she had never shared with anyone. The women reported

having felt guilty and full of shame for many years over secrets long-held — about unspeakable stories.

The secrets they had kept from each other were startling to them but not surprising given the vast literature on the abuse of women (Johnson, 1998; Thomlinson, 2003). One by one, the women spoke about verbal and emotional abuse during long-term marriages to men considered good husbands and good neighbours. The topic arose during a discussion about the deaths of their husbands and their having to adjust to a new lifestyle. One woman said that although the adjustment had been difficult she found her new, solitary life quite fulfilling. The admissions evolved after the facilitator commented tentatively that many women feel guilty admitting that they experienced relief after their husband's death. Marta looked around at the other women and warned that what she was about to say would shock. She admitted that she had felt stronger and more independent since her husband's death, even though she had loved him and still missed him at times. The other women then contributed stories of powerlessness and submission during their marriages.

These findings are consistent with Johnson's (1998) reported effects of abuse to older women and the many barriers to help/support-seeking. Johnson reports that older women in a support group saw religious views on marriage as a barrier to speaking out against their spouse. Extreme shame and habitual secrecy, as well as the invisibility of older women in Western culture, made it difficult for the women to take their own needs seriously. Like the participants in the present study, they reported depression and consequent prescribing of medications. Also consistent with the present study, the support group had a positive impact. The participants in the present study had little distance to travel, however, while some of the women in that study drove 100 kilometres to attend the weekly meetings. Johnson stresses the importance of support groups to older women in abusive relationships and the need for them to speak out. The present results confirm the need for such supportive interventions. All of the participants in the follow-up discussion indicated that they wished to meet again.

Lack of understanding, poverty, and the politics of poverty. In addition to the institutionalized reliance on social and cultural groups to support elders, in the dominant medical culture women are often pressured into participating in research or complying with health practices that they do not fully understand (Butler & Collins, 1995). Butler and Collins share the results of a round-table discussion during which a group of geriatricians expressed concern about the medical dominance of older women's health care.

The issue of being treated differently arose in all groups. The Ismaili participants struggled the most in their pursuit of health services. They

were hesitant to criticize what they perceived as a flawed system. Many managed to obtain the information they needed by consulting their pharmacists, who apparently played an important role by translating information for them. When their needs were still not being met, many of the women waited until their condition worsened. One woman's comment suggests ageist, cultural, and gendered marginalization: "We are women; we are not allowed to complain." Another expressed the view that some younger physicians

do not listen at all; they don't want to hear...[what I say] because [of] what's in their book, it's in their book.

Some women believed that they had not received the proper treatment because they had not asked, or been asked, the right questions.

Discussion

The participants in this study managed their health care privately, with the support of family, friends, and voluntary organizations (primarily faith-based, cultural, or accessed over the Internet). Paradoxically, the very means they used to access health services kept their issues out of the public and political consciousness. The story of older women's management of their health is one of poverty (in the broadest sense) and neglect. The politics of poverty was particularly evident in the case of the First Nations women. However, the politics of access to information and services, although unnamed, also applied to the Ismaili women. Some of the more educated women with resources and initiative sought information from television, the Internet, and wellness centres in shopping malls (which they highly recommended), but the Ismaili and First Nations women had no such points of reference.

There is a clear distinction between the haves and have-nots, not only in terms of access but also in terms of information. In a study by Grundy and Sloggett (2003), poor health in older populations in the United Kingdom was consistently associated with poor personal capital, social resources, and socio-economic circumstances; childhood experiences were also considered important, particularly with regard to current socio-economic status (p. 942), while exclusion from political/community life and decision-making was a significant marker of poverty, especially for women. These indicators reflect poverty of autonomy in decision-making in ways that traditional indicators of poverty, such as income and social assistance, do not (Fukuda-Parr, 1999; O'Reilly, 2002). Poverty and poverty of participation and access are increasing health concerns for all marginalized people (Grundy & Sloggett).

Not only are issues of poverty and access largely overlooked in the planning of elder care, but many of them are institutionalized. Butler and Collins (1995) report on a round-table discussion that revealed gender gaps in elder medical care in the United States; geriatricians expressed concern about the neglect of women in medical education, gender bias in health insurance and in quality of treatment, and preventive care, particularly in the area of domestic violence. In the present study, several of the women recalled not being listened to, being patronized, and being ignored until their health condition became very serious. Publicizing of the traditionally “private” concerns of older women will help to bring this growing population out of the margins.

Implications for Nursing

Registered nurses are uniquely positioned to care for, educate, and counsel patients regarding their physical, emotional, and spiritual health. They are often sought out by members of the public for information and advice. Relationships of trust develop as nurses relate to patients during assessment and care, often resulting in the disclosure of information that is relevant to safe and appropriate care. Nurses may be compelled by the results of the present study to ask older women more specific questions during assessment and ongoing interventions, and to advocate more fully for *and with* older women. This should result in more collaborative relationships between nurses and their older female clients. Such collaboration is critical if older women’s voices are to be heard and their health-care needs met.

The method of data collection used in this study holds much promise for a pathway outside of the margins for older women. Group-interview and storytelling methods of data collection have been demonstrated to be useful for both research and intervention. As Banks-Wallace (1998) found in her group interviews with African-American women, “group storytelling can create an environment that supports evaluation of experience and promotes problem solving” (p. 17). The participants in the present study consistently commented that meeting in this way was a new and powerful experience for them. Rola said:

We’ve been meeting for a long time now, but we don’t really talk about these personal things usually. It’s been real nice... just the little things we’re sharing back and forth, and I’m wondering if there are groups of people who get together like this.

Future plans are to work with older women to devise strategies for them to take control of their lives, their health, and their health care by becoming active in the political arena.

Implications for Future Research

Health-care planning for older women has been absent from the public and political agendas (Rosser, 1994; Weitz & Estes, 2001). Weitz and Estes propose an agenda in which the complex needs of older women are addressed and include collaboration by all health-care providers interested in both older women's health and issues of ageing. Further research might involve collaborative groups of older women with representation from nursing, other health-care disciplines, social-welfare groups, and gerontologists. The depth and richness of the women's experiences, and the insights and suggestions they offer, should prove valuable in the development of health policies and health planning for all women.

Dialogue among nurses, clinicians, researchers, educators, and older women is crucial in developing strategies to meet the health and social needs of this unique and diverse population. Innovative ideas for prevention and intervention, such as inviting older women to sit on planning committees for new primary-care clinics and to play a collaborative role in all phases of development, should be explored and tested. Partnerships between older women and nurses or other health-care providers could set the scene for appropriate, effective, and sensitive health-care planning, policy development, and interventions.

The next step in this program of research is to meet with the participants in each of the five groups to present a summary of the results. We hope that some of the women will agree to participate in a further study that we would develop together as a participatory action project, in order to set a research/activist agenda that will shift the margins that have constrained the growing population of older women. Through sharing, learning, and becoming more aware of their health and health-care issues, older women themselves might spearhead important changes to the way the health-care system addresses their needs. They will have the opportunity to become activists in their own right, leading the way to health-care policy and health-care reform related to older women and men. Their voices will be raised in concert and will be heard.

Arundhati Roy (2003), in a reference to other activist movements, speaks of a gentle giant who has been silent for too long: "Another world is not only possible, she is on her way. On a quiet day, I can hear her breathing" (p. 4).

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