



GENDER AND AGEING: QUALITY IN DIVERSITY

Report from an international workshop

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European Women's Health Network
EWHNET

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PREFACE

THANKS TO MANY SPECIAL INTEREST GROUPS, SCIENTISTS, AND NETWORKS, OLDER women's health has begun to find its way into the political agenda on a local, national and international level. This is a positive development. However, the way in which older women are often viewed is not always the way in which all older women view themselves. They are not a uniform group with more or less the same needs and problems. Stereotypes of older women do not apply to the group as a whole.

Moreover, there is a strong tendency to discuss older women's health as a medical issue. Statistics about diseases and health problems are more common than a focus on older women's position in society. With the International Year of the Elderly coming soon, the organisations involved in the European Women's Health Network, EWHNET, felt that it would be good to present other ways of dealing with the issue of elderly women's health. Taking a gender specific approach to health care, new questions can be asked, other models and criteria developed.

What is this 'gender specific health care'?

Over the last twenty years, women scientists, health advocates, health workers, doctors, and others have developed views and methods that do justice to gender differences in health, health experience, and health care. These views and methods are based on a number of criteria:

- Gender specific aspects, such as gender socialisation, are taken into account in the interpretation and treatment of complaints and disorders,
- Societal and situational factors are taken into account,
- Unnecessary medicalising, trivialising, and psychologising is avoided,
- Patients are approached with respect,
- The patient's own strength and responsibility is reinforced,
- Material requirements such as the availability of good information material and referral possibilities, are met.

This approach, together with the notion of customised care, leads to questions about how differences between groups of women/men can be dealt with in the (health) care for the elderly. It implies that important factors such as socio-economic position, cultural background, life style, and generation should not be overlooked.

But how can we bring this into practice? Or, in other words: how can both quality and diversity be realised in older women's health care?

This was the central question at an international workshop organised by EWHNET in May 1999. Experts on gender and ageing and on specific target groups within this field attended the workshop.

On the basis of a number of case studies, and the following discussions, they have succeeded in identifying the conditions required for good gender sensitive customised care.

The results of this group are presented in this report. As we shall see, the diversity is reflected in the shape, contents and setting of the papers presented, showing a picture resembling the colourful mosaic of elderly women as a group.

The framework of the discussion is outlined in the keynote paper by *Maria van Bavel*. In this paper she discusses the notions of old age, femininity, and diversity, and shows how these notions can be brought together. She develops an interesting idea: While diversity is often interpreted as simply identifying target groups (e.g., immigrants from various regions, people with certain impairments), she broadens the notion of diversity to include life style, and basic values during the course of individual people's lives.

Modita Heijnen shows us how new ways are developed of working with older migrant women on a local level, and how networking with different organisations and policy makers generates a better understanding of the needs and wants of these specific groups. Thus, her paper provides ideas about strategies for bringing diversity into the agendas of organisations and governments.

The contribution of *Mariet Paes* is also concerned with local health work. The main topic of her paper is community health and elderly women. Starting with the story of an individual woman, Bea, she goes on to describe the very unique approach to (elderly) women's health in the neighbourhood of 's-Hertogenbosch-Oost. Although the papers of both Heijnen and Paes describe local practices, the impact of their contributions reaches far beyond. These practices are exemplary for customised care for elderly women of different backgrounds. The strategies described by Heijnen, and the woman-empowering community approach shown by Paes, will certainly provide inspiration for new strategies and models elsewhere.

Providing room for women's own ideas, needs and wants can result in unexpectedly large successes. This is clearly demonstrated in the paper by *Gisela Kurtz* from Germany. A small, local initiative for women that aimed at possibilities for recreation and social contact, grew in very little time to become a broad organisation with a more political scope, and is now being copied in other parts of the country.

Room for women is also an important issue in *Eva Janes'* paper. She describes the supportive work carried out for older women from a rural area in Austria. Some women have great difficulty in claiming time and space for themselves, because they are lay caregivers in their homes, looking after disabled or sick relatives or neighbours. Janes describes how the well-being and health of these women are influenced by their images of femininity and masculinity, and by images that live in their social surroundings. She also shows how women's health initiatives try to help these women gain a little more autonomy.

Scientific research is more central to the last two papers. As a folklorist, *Anne Leonora Blaakilde* introduces new ways of 'listening' to elderly women, that reveal the ideas, feelings and wishes that these women have, and that will otherwise be overlooked. She also uncovers the interplay between the individual level and the collective, 'cultural' level, thus opening possibilities of integrating both levels in the development or improvement of (health) care arrangements. Another new way of looking at elderly women's health is also found in the connection between health and work, as is shown by *Gunilla Carlstedt* and *Annika Forssén*. Work is an important determinant of health, not only for those who are active in the labour market, but also for those who have no paid employment, or who are already retired. Carlstedt and Forssén's analysis once again stresses the necessity to look at elderly people by considering their entire life span, as did Maria van Bavel in her paper.

A number of conditions for customised and gender specific (health) care for the elderly were identified during the workshop, using several working methods such as experiential learning, discussion, and a panel method called 'brain disc'.

These conditions are printed in the last section of this brochure. They are of interest to all those who work on the subject of elderly people, of health care and health policy, on a local, regional, national and transnational level. Perhaps they will be a starting point for customising the care for older women in a gender sensitive way.

Lea den Broeder, editor

GENDER AND AGEING: QUALITY IN DIVERSITY

*Maria van Bavel*¹

ELDERLY WOMEN AND HEALTH: WHAT ARE WE TALKING ABOUT?

What is the meaning of elderly, of ageing? What are your thoughts when I am talking about women, what pictures do you have in mind when I ask you to imagine a room full of women? And finally what is health? Is health an objectively measured status or does it refer to what we feel? And what does health mean to ageing women? Is there a new perspective to approach elderly women and health?

I hope that my lecture offers you some answers to these questions, but I am sure that there are more answers and I am convinced that each of you will bring forward some other answers this weekend.

I will now start with asking you to image a group of elderly women. What do you see? Do you see a lot of grey hair, small deformed women with a wrinkled skin, weak, vulnerable, disabled, lonely, dependent, suffering from illness, such as incontinence, and not a pleasure to look at and to be with? Do you see active, laughing, beautiful, wise, caring, travelling, inventive, nice-looking, gardening, healthy, curious people? Or do you see a mixture of all these aspects: some are grey, and sitting in a wheelchair and telling wise stories and laughing and others have brown hair, are complaining about society and their bodies, and others are black and powerful? Do you image yourself one of them? Or are you the outsider, the one who is looking at the elderly women?

Most of the elderly people don't want to be seen as an old person. They say that others are old, but they themselves are not. Since ageing is surrounded by negative connotations and stereotypes, it has a negative image in our society.

For example: in the Netherlands there is a special department for policies at the ministry concerning the elderly. In their policy there is a dominant image of leeway (= margin of time, money; room for freedom of action) and disadvantage of the elderly, such as societal problems concerning their socio-economic situation and participation, but this department is essentially dealing with health care policy, as if all older people have health problems. By focusing their policy on disadvantages and health problems, stigmatisation of the elderly increases. Health problems and loneliness appear among all age groups, not only among the elderly.

There are other examples:

Research on prescription of medication shows that physicians rather prescribe medications for older persons than for younger ones.

70% of the care providers in nursing homes think that older people are sexually non-active.

Many care providers use baby talk in their communication with the elderly (how do we feel today).

In psychology books the negative aspects of ageing dominate and when you look at health education booklets you see lots of stereotypical illustrations with regard to elderly people.

This negative approach is not fair and not correct. Furthermore, it is not correct and not fair to lump all the elderly people together. Two of the most stereotypical images of old people are wise (wisdom grows with the years) and lacking/defaulting (the ailments of old age). However, the term wise usually refers to older men, while the term lacking refers to older women.

When disadvantages and problems in society and health dominate the policy in a country this policy does not do justice to the meaning and diversity of the elderly women.

For example, a faulty image exists of elderly women concerning their participation in society. Most women are very much socially involved and do a lot of work on a voluntary basis, but they don't categorise their activities as work. Thus, their work is not visible in statistics. For example, it is a standard research question to ask whether people have work on a paid or voluntary basis. In general men give a positive answer, because they see their activities as work, but although women are very busy within the house or caring for neighbours, family and others, they give a negative answer to that question, because they see it as natural, obvious, and as something that goes without saying.

That's why policy makers think that elderly women are participating far less in society than men. But this interpretation of participation is one-sided and biased. It lacks insight into the self-worth and meaning of the social functioning of women. The consequence is indirect age discrimination and gender discrimination.

When we look at the differences between elderly men and women we see that women experience discrimination on the basis of age earlier than men. Age discrimination exacerbates the disadvantages of gender discrimination. Throughout their lives women have to deal with negative images. In the Netherlands there is a journalist who has called women the leak-and-ailment-sex. As babies they use nappies, when they are in the reproductive age they use tampons and napkins because they menstruate and at a later age they again use nappies because of incontinence.

Women are considered old at an earlier age than men. Furthermore, elderly women are perceived as weak, dependent, vulnerable, and lacking in femininity and sexuality. Such

negative images contribute to rendering older women invisible and negate their significant diversity and resourcefulness.

Such a low status of ageing women is not inevitable.

Not all elderly women have problems and when they are in trouble, they don't have the same problems. Recognition of diversity is necessary.

Ageing does not have a fixed, definite denotation. For most people ageing is not related to biological age, but rather to meaning and significance. The meaning of getting older is found in the reality of daily existence, and this is very different for the many elderly persons, men and women. The meaning of ageing is different for men and women.

For example: most women emphasise the importance of having meaningful relations, while men consider social status more important.

But as you all know, there is a change going on concerning ageing. The obvious view that 'that's the way it goes' is disappearing. Elderly women nowadays are more self-conscious, and they discover their own choices and wishes. This self-consciousness is a source of diversity and dynamics. Older women now can give a better content to a life which suits them.

Restrictions of the traditional existence of women lie behind them. They are now challenged to fill in their new existence. This process of creation is not easy, there are many choices to make, and many of them struggle with all the alternatives.

Ageing is a continuing process, and age is not an objective criterion for health. Since the health of a woman in earlier periods of her life forms the basis of her health in later stages of her life it is essential to consider the health of women within the perspective of a life span; the strategic implication for promoting the health of ageing women is that both primary and secondary prevention initiatives must be taken during the later stages of life.

There is an interaction between grown and developed life circumstances on the one hand and the self-conscious intervention and building of a new existence on the other hand. Social images play an important role in this interaction. We need to break with negative images by showing more positive images and showing more diversity. Some commercials show us new images of elderly women, such as the active, travelling, good-looking lady. But that social image does not fit either, since many ageing women do not recognise themselves in that picture.

The point is that the standard items, the stereotypical images of the elderly must disappear. Many different kinds of images must replace them. We need more diversity.

Health is a fundamental right, according to the WHO. The WHO says that our goal should not be solely to extend lives in the physical sense but to ensure that the added years are worth living, even with diminishing faculties (handicaps or disabilities) and

with a greater degree of health security.

Health is a state of complete physical, mental and social well-being.

That means that we must not focus only on the physical abilities and inabilities of elderly women, but that we must approach health issues in a broad context.

When we use the broad definition/description of health, the social model, we see many important factors, which are in some way related to health and well-being.

Some of these important determinants are:

- Age, generation,
- Social economic status,
- Ethnicity, cultural backgrounds,
- Life style,
- Needs concerning health services,
- Religion,
- Marital status,
- Housing and living conditions,
- Health care services and health care providers.

But other factors are important as well, factors which are not mentioned or used as often, such as:

- Life history,
- Self images,
- Social images/stereotypes,
- Expectations, and finally,
- Styles of ageing or attitude towards life.

According to the WHO health problems of ageing women are readily seen to stem from social factors as well as biological factors. These social determinants of older women's health are:

- Economic: income, food and nutrition, work environment, water and sanitation,
- Social: literacy and education, care-giving, widowhood,
- Political: enfranchisement, advocacy, participation,
- Cultural: attitudes towards ageing, attitudes towards women, self-esteem.

In short, the WHO says: 'Better lives, better health'.

It is required that older women throughout the world be given opportunities to present their own interests concerning health issues and to participate in the development of programmes, in order to address the problems they have identified. It is only through such approaches of defining health that the value placed by ageing women on different aspects of health will be given due recognition.

In addition, it is important to focus not only on the problems older women may have, but also on strengthening and emphasising their power and their possibilities.

I now want to talk about the cultural determinant, this attitude towards life or style of ageing.

A female scientist in the Netherlands, coincidentally by the name of Trudy Nederland, did research on this subject. She interviewed many elderly women and has written a book about different styles of ageing. She found that more than any other determinant, the attitude of the elderly towards ageing helped them to go on with their daily activities.

T. Nederland used a historical approach. In her view the style of ageing is to be seen as a beacon, which can be moved with the times; by self-conscious intervention a person can adapt itself to the altered circumstances. The attitude towards life or the style of ageing is not a static fact: it is more differentiated and dynamic. Changing of style is possible. This perspective offers more variety, diversity and dynamics.

Trudy Nederland asked the women about their

- Spending time: labour, paid work, voluntary work, informal care, spending of free time,
- Human relations: intimate relations, family, relations based on mutual trust, acquaintances and friends,
- Coping with important living conditions: income, health, housing accommodation.

She distinguished five styles of ageing:

- Autonomy,
- Reflection,
- Carpe diem,
- Helpfulness,
- Self-development.

She describes those styles as follows:

- The core of the style of autonomy is to feel free and to be an individual. Most of these women are financially independent, work on a paid basis and have built up a career. They are emotionally independent, live alone and have no intimate relation or a lat (living-apart-together) relationship, and they choose their friends carefully. Other key-words are: a healthy life, paying attention to food, diet, and staying active, doing exercise. Most of them have a well-designed house, and focus on the present.
- Typical for the reflection style is contemplation and consideration; these women take enough time to think things over. Most of them have no intimate relationship and no extensive social network; they often spend their time alone and have a few good friends. Their income, housing and mobility are well organised. They adapt easily to their circumstances, are not focused on improvement, but on sustainment. Sometimes

they are in bad health, but they know their restrictions and adapt to these limitations. They focus on the present and the past.

- The keyword for the carpe diem-style is enjoyment: they enjoy every new day, they do only things that they like: nice and pretty things, such as going out for dinner, shopping, visiting a museum, seeing a movie, travelling, etc. Most of them have many friends and relations; they seek company for going out or for sex. Good living conditions are very important, but when they have less money they are very creative. They are also very inventive where their health is concerned. They focus on the present.
- The style called helpfulness is suitable for those women who are always willing to help and to be there for others. They take care of their family and the community. They often work in the health care sector, on a paid or voluntary basis. Most of them do recognise their own needs and limits, but no-one else notices, because they are busy and because of their willingness and readiness to help. The needs of others prevail both in social respect and concerning their living conditions.
- The keywords of the self-development style are curiosity, self-fulfilment, keeping up with the times, cultural, political and societal interests. Most of these women take courses, lead a more profound life and broaden the meaning of their life. They have no priorities in their personal relations, their social network is fit into the activities; that's why they have many and changing contacts. Their living conditions are not the most important aspect in their lives.

So far a short explanation of the five different styles of ageing according to Trudy Nederland.

When you look at elderly women in this way, you cannot see a grey mass anymore, but you only see differences. The variety in attitudes towards life is dynamic. Life histories, experiences and important events, in connection with present life, can change the style of ageing.

These styles of ageing give us the opportunity to break down with the stereotypes, and they would be very useful in health care and in policy.

After all: stereotypical images are learned and acquired, and thus we can transcend them and cure ourselves of these prejudices.

One way to do that is to ask yourself questions, like the question: What kind of picture comes into your mind when you think of elderly women? How did this picture arise?

After you have answered these questions you can confront elderly women and face reality yourself, and check your images of real people.

Two examples:

- Compilers of the grandma-book went to look for stories about grandmothers in literature. They were very surprised that they could hardly find conventional, traditional and conservative grannies. On the contrary: they found more picturesque and colourful types, or mean and nasty bitches. They concluded that elderly women

do not only develop wisdom and self-sacrifice, but also witch tricks. After all there are sweet, awkward, priggish, pedantic, nagging and brave grandmas; grandma is not limited to one particular cliché.

- A schoolteacher asks the children to draw an older woman. The teacher tells the children to think of their grandma. One child draws a woman aged about 55 in a short skirt and high-heeled shoes. The teacher is astonished and asks: is that an old woman? Yes, that's my granny, the child says, my grandma is a director of a commercial centre and she always looks that way.

Health care providers and policymakers should use these methods more often. They should go to ageing women and ask them what they need, instead of using stereotypes and filling in the needs and problems of ageing women. I think that it is very necessary that policy makers and health care workers do more research on the needs and wishes of ageing women and that they spent more time and money in developing methods of self-assessment and self-evaluation. Let elderly women judge their own lives, their power and their problems and let them say what can be done to solve their problems or to make them easier to cope with.

Health care providers and health care policy need to see more diversity to offer customised care.

1 Maria van Bavel MA has been one of the founders of Aletta, Netherlands Centre of Women's Health Care, and worked for many years as a senior staff member and unit coordinator at this centre. Since the closing down of the centre in January 1999, she has been a staff member at TransAct, National Centre for Gender Specific Care and Prevention of Sexual Intimidation.

CARE FOR BLACK, MIGRANT AND REFUGEE ELDERLY WOMEN

*Modita Heijnen*¹

THE NUMBER OF BLACK, MIGRANT AND REFUGEE ELDERLY WOMEN IN THE CITIES OF THE Netherlands is growing fast. When developing care policies for elderly women it is very important to take these groups into account. If we don't, we will miss a very important challenge to create diversity in the care for elderly women, or, in other words, to create the best possible quality of life for the elderly in our country.

Just as in the case of 'white elderly women' there is a big diversity between the groups named above. Of course, in this context it is not possible to do justice to all the practical, diverse issues that are important to them. However, since we are still in the learning stage concerning these groups, a few general remarks and strategies are most important at this time.

Because ethnic diversity in policy making for the elderly is quite new in Europe, professionals, institutions and policy-makers are poorly equipped to deal with these groups of elderly: it's just not 'part of their system'. Working on the diversity issue on different levels is a spearhead at the SARA/Riet Hof Centre. Therefore (bottom-up) activities are developed on:

- 1 the grass-roots level,
- 2 the research level,
- 3 the policy of institutions, and
- 4 the policy making and politics.

1 First and foremost, we need to know more about the people concerned and their specific issues. In gathering this knowledge, it is important to 'have an eye' for diversity as well as for the general needs of all elderly people. It is important that women's organisations invest in working with different groups of elderly women. This can be done by organising meetings where the elderly, as well as the organisation, can learn more (health issues are a good point of entry). When it's a 'double-edged sword' it will motivate the elderly to keep coming. Creating an informal atmosphere will help to gain insight into a variety of issues that are important to these women. Moreover, it is very important to train the workers in care of the elderly, in order to help them get ethnic sensibility into their way of behaving and working.

- 2 Only after gathering information on the grassroots level, and in combination with other research and general (migrant) literature, is it possible to gather information systematically on specific issues. Such information then provides a legitimate basis for consultation and co-operation with other parties.
- 3 When we know more about the friction between the needs of the elderly and the ways organisations and institutions work, we can set up a lobby to influence the institutions in the field of care for the elderly, preferably in co-operation with a network of specialised organisations. Many of such institutions are beginning to realise the importance of new developments for their future survival, especially in multicultural cities. By focusing on the common interests of institutions and their clients with their specific needs, we can create a 'win-win' situation. The SARA/Riet Hof Centre proposes clear cut and practical solutions. Home care service, for instance, needs more workers; we propose to choose these workers from a variety of ethnic backgrounds and co-operate with them in developing a method to find, prepare and work with these ethnic people in a 'white' organisation. In this way the elderly can choose a home care worker who speaks their own language and who is sensitive to their cultural codes and habits.
- 4 Institutions cannot always be motivated to pursue ethnic diversity in care without a political back-up. The SARA/Riet Hof Centre is therefore investing in meetings with policy makers to introduce them to new information about a variety of groups that need attention in policy making. We present the reactions of target groups to law proposals on a local as well as on a national level, in order to give policy makers first-hand information on the 'target groups' they only know on paper. The SARA/Riet Hof staff members are like 'spokeswomen' who pass on the messages of these elderly. They work on showing the 'faces' of ethnic elderly women to the people who decide about the quality of their elderly care.

Their faces are diverse, sometimes showing the traces of 'a hard life'. Faces who have encountered many different situations in their lives. Faces with different tastes and styles.

And also... faces who can relativise, laugh and enjoy, sometimes quite a bit more than autochthonous elderly. Who wouldn't want to have this humorous black grandma as a neighbour in their home for the elderly?

1 Modita Heijnen MA. is a staff member of SARA/Riet Hof Centre for emancipation and innovation of care, Rotterdam, the Netherlands.

COMMUNITY HEALTH AND ELDERLY WOMEN IN 's-HERTOGENBOSCH-OOST

Mariet Paes¹

- 1 Bea; an individual portrait of a woman
- 2 Samen Beter, the health centre
- 3 Hulpsector Oost, the network of community organisations in the neighbourhood
- 4 De Stroom, a program for women
- 5 Bea again

1 The portrait of an individual woman: Bea

BEA IS ABOUT 50 YEARS OLD. SHE LIVED WITH HER HUSBAND AND TWO DAUGHTERS IN A town in the middle of Holland. Bea was a mother and housewife. When she was a child she went to primary school, then had some classes of vocational training, and soon she started working in a factory. When she married and got her first child, she stopped working. During her marriage she did not work outside the house.

Bea's marriage was not a happy one: she was ill-treated and abused for a very long time, but she stayed with her husband because of her children. Finally she went to a women's shelter in another town: 's-Hertogenbosch, so her husband would not be able to find her. She made this decision after her two daughters were old enough to live on their own, so that there was only Bea to leave her husband.

Bea is slightly disabled. She cannot walk in a common way, since one leg is much shorter than the other, and she is very overweight.

Bea is shy; she does not trust people easily. It is hard for her to tell what she wants and needs. Since she has been humiliated for a long time, she has little self-confidence.

Bea received the benefits for disabled people. Not a big amount, but her first income after a long time. When she left the women's shelter and got a house for herself there was no money to buy furniture. Bea had to borrow money.

So there was Bea in 's-Hertogenbosch: she had a house, but no friends or family, she had an income of her own, but also debts. After a while Bea got a message that she had to go to work, that she was no longer entitled to receive the benefits for disabled people.

She was frightened that she would have to go to work in a factory at her age and with her handicap. Bea became a very tense person.

Bea is a woman with little education, no work or career, alone, 50 years old, with financial, emotional and physical problems. How do we try to help her get control back over her own life?

2 The health centre Samen Beter

The name of the health centre is a play on words meaning that working together is good and working together is good for your health: 'Together Better Together well'.

Samen Beter is based in a working class area of 13.000 people containing a higher percentage of elderly, unemployed and migrants than the national and municipal averages.

The centre was set up as a result of community concerns about local general practitioner services and is one of a whole network of community development initiatives in the area. Some qualified health workers, including doctors, together with the community, opened the health centre (initially in a house) in 1980. At that time the establishment of general practices was not controlled. From this initial concern and idealism a health care service has developed which is a fully integrated part of the community. Since 1980 several organisations of Primary Health Care and independent working disciplines joined Samen Beter.

The central aim of 'Samen Beter' is the attempt to enable people to gain more control over their own health; this is also the focal point of the World Health Organisation.

Samen Beter wants:

- To allow people to function as long as possible and with dignity in their own home,
- To provide the help which is needed at the time it is needed,
- To encourage people's responsibility for their own health,
- To provide wellorganised, accessible, diverse and user-friendly facilities.

Samen Beter tries to realise these aims by:

- Offering an integrated service of primary health,
- Supporting cooperation between professionals of several disciplines,
- Encouraging the use of the experience and abilities of the people in the neighbourhood.

Structure of Samen Beter:

Samen Beter is a democratic association with about 60 members. The members are the health professionals and the volunteers (local people) working in the health centre.

The democratic union chooses the executive committee of 7 independent members, who have different duties (financial, juridical, health care policy etc.) Two members on the

committee represent the local people/volunteers.

The manager implements the policy of the executive committee and co-ordinates the professionals, the volunteers and their co-operation.

Professional staff:

3 doctors, 4 assistants, 5 physiotherapists, 1 speech trainer, 1 midwife, 4 nurses, 1 dietician;

3 social workers, 3 prevention workers, 1 secretary, 1 administrator, 1 computer system worker, 1 manager.

Most of the staff-members work part-time. There are 24 women and 5 men. Most of them are autochthone Dutch people, but 5 have a different ethnic background.

23 of the professional workers are employed by the health centre; the others are employed by other primary health care organisations and they rent rooms in the centre.

Volunteers at the centre:

At this moment there are 30 volunteer members in the democratic union. They are involved in the management and day-to-day activities of Samen Beter, organised in working groups:

- Hostess group:
the group keeps the centre ‘feeling cosy’ and puts people at their ease. By chatting with people while they are waiting, the hostess hears about problems in the local community. These can then be fed back to the health professionals. The hostesses are seen as an important channel between the local community and the health professionals and as a means of identifying community needs,
- Magazine group: The group makes the magazine for users of the centre with information about activities, on diseases etc.,
- Health care and migrants: A group of patientmigrants discusses ways of meeting their needs and provides information for the migrants,
- Documentation group: This group provides information folders, leaflets etc. on health topics in the waiting room of the centre.

The volunteers are women and men from the local community. Some have extensive networks in the community which help them in their work. Others suffered from problems themselves with which they have been helped by the centre and have since progressed to become volunteers. Many of them have experienced great changes in themselves through the involvement in the centre.

Financial information:

The funding of the centre come from different sources. In a way this makes the health centre independent and able to make their own policy.

The funding comes from:

- The payments for the treatments of the medical and paramedical professionals by the compulsory or private insurance of the patients,
- Rents from the organisations which have professional workers in the centre,
- Contributions for some activities,
- Subsidies from the National Insurance Scheme for co-operative activities,
- Several subsidies for projects and specific activities from the national, regional or local government, and
- Grants.

3 Hulpsector Oost

Samen Beter is part of a complex network of community organisations, health care organisations, social work organisations and educational organisations. As the definition of health is taken broadly, all these objectives can be seen as contributing to primary health care in the community.

Samen Beter is the pivot of an entire network in the area called 'Hulpsector Oost' (Help Sector East).

Hulpsector Oost provides chains for co-operation between:

- Local people and professionals,
- Professionals from different organisations, and
- Managers from different organisations.

There are meetings at three levels:

- Help Sector Evenings: local people and professionals discuss common issues and aims,
- 'WorkerHelp Consultation': professionals from different organisations meet once every 2 months and discuss the inputs and needs from the local people,
- 'OrganisationHelp Consultation': representatives of the agencies and district residences meet once every 2 months to discuss their policy and enable co-operation programs.

Co-operation programs:

Hulpsector Oost initiates many examples of integrated programs in which the local people participate.

Some examples are:

- A group of volunteers helps disabled and elderly who need care.

- A group of volunteers runs a place where psychiatric patients can meet each other and activities are offered.
- A female therapy program: ‘De Stroom’ (see below).
- The ‘eating together project’: elderly can have a meal at two places in the area: eating together prevents loneliness and they get a wholesome meal cooked in the kitchen of the elderly home.

In these projects an integrated multi-sector approach is realised in which participation of the target group itself is a main concern.

4 De Stroom

Samen Beter and Hulpsector Oost are no projects, since a project is limited in time. Samen Beter and Hulpsector Oost are organisations based in the community, trying to make flexible programs for specific categories of people and patients.

De Stroom for instance is a program for all the women living in the area of ’s-Hertogenbosch-Oost with severe psycho-social and psychiatric problems.

With the program of De Stroom we try:

- To help and support these women to function with dignity in their own environment,
- To prevent, if possible, admittance to mental hospitals or rest homes,
- To enable these women to gain more control over their own health and over the health of their children, and
- To strengthen the social networks of one-parent-families and multi-problem families.

The principle interventions:

We employ an integrated approach, using the professional expertise of several health and social care services and welfare and educational agencies, as well as the experiences and abilities of the women in the neighbourhood who have had problems themselves and overcome them.

An individual program is made for every woman with different kinds of interventions. These could include, for example: shelter, support, self-help, buddy-help, recreation, education, or therapy. If needed, there is also a day-nursery and kindergarten in the neighbourhood so families can stay together in their own environment. The day-nursery and kindergarten are run by volunteers (grass-roots women) and professionals. This combination guarantees the accessibility and the adequate use of these facilities.

The staffing of De Stroom consists of:

- A part-time co-ordinator,
- A staff member, and
- About eight volunteers (grass-roots women).

This staff is part of the health centre Samen Beter and co-operates intensively with the professionals of the health centre (doctors, social workers, physiotherapists, community nurses, prevention workers, midwives, infant welfare centre staff) and with professionals of welfare agencies in the neighbourhood. The staff of De Stroom also co-operates with other volunteers from community-activities in the neighbourhood, especially with the day-nursery and kindergarten and with the health extension programs.

The women helped by the programs of De Stroom have a poor health status according to their socio-economic situation. Their problems are a combination of financial, emotional, physical and psychological problems. Since social inequality is often seen as an important environmental determinant of children's health and well-being, improvement of the ecology of the families, especially with the involvement of the mothers, will have a great influence on development and upbringing of their children.

The method of De Stroom can be described by the concept of empowerment. Empowerment is the process by which women gradually emerge from a situation of powerlessness through helping each other with professional support.

The volunteers and the women in the programs help each other in this process. A lot of these women become volunteers (grass-roots women) themselves in community-activities. In this process of empowerment they increase their social network and support.

De Stroom was set up as a result of community concern about women with severe problems and is one of a whole network of community development initiatives in 's-Hertogenbosch-Oost. The health centre, the day-nursery, the kindergarten are other initiatives set up by the community with the help of professionals. Local people are fully integrated into the management and the day-to-day activities of the services in the district and so are the women in De Stroom. That is the way De Stroom started and continues to operate today.

De Stroom has existed for seven years. There have been a lot of problems because of the focus on a specific neighbourhood and because of its interdisciplinary nature. Both aspects seem to be incompatible with the logic of (public) financing. However, due to creativity and good results De Stroom continues to do good work and has become a model for practical application of the ideals on community involvement.

Each year there are about thirty women in the program of De Stroom. During the eight years De Stroom has existed, only two or three of these women had to go to a mental hospital temporarily. All the other women stayed in their own environment, stayed with their children and families and gained control over their own health and the health of their children. Some of them became volunteers, some started to improve their education, some started a career and all of them became healthier and happier.

5 Bea again

Bea is one of the women who participated in the program De Stroom. Her companion at the women's shelter contacted De Stroom. Bea completed the program, but most important of all she got to know other women who lived in her neighbourhood. One of those women introduced her as a volunteer at the health centre. Bea became one of the host ladies and also became more and more involved in all kinds of activities in the neighbourhood.

When Bea had to accept work to earn her own living she made a plan with the other women of De Stroom. Bea liked to be a host lady at the health centre. Being very shy she had to overcome many restraints in contacts with other people. At the health centre she felt good, so she made a proposal to the manager. She wanted to work at the health centre as a host lady and assistant in all kind of things: making copies, filling up the bandages and so on.

Now she has an additional workplace in our health centre and I think Bea has many more qualities. I think she is a good organiser and in a few years, she will possibly do other things in our health centre. I don't think Bea would be able to work in a regular job. She is aged and disabled and it is hard for her to deal with surroundings that do not appreciate her.

So Bea has found her place at the health centre, and has become friends with some other host ladies and their families. She is able to pay all her debts, she is less tense and laughs more, and she showed her daughters the place where she is working and felt proud.

Other women who take the program of De Stroom find their place in some of the other community organisations in our neighbourhood, make friends, start improving their education, or start working.

There are many examples of women who made a career in one way or another. They are helped by the program of De Stroom. Each of them has their own individual program, because their problems, their age, their needs and wants, and their possibilities are different.

They find strength in themselves and in their neighbourhood. They learn to use their qualities for themselves and for the community.

1 Mariet Paes MSM. is the director of the health centre Samen Beter, in 's-Hertogenbosch, as well as a senior staff member of the National Centre of Community Work (LCO) in Zwolle, Netherlands

WITH COMPETENCE TOWARDS ACCEPTANCE –PROJECTS WITH AND ABOUT OLDER WOMEN

Gisela Kurtz¹

Introduction

FIRST OF ALL, I WOULD LIKE TO INTRODUCE NATIONAL NETWORK OF ELDERLY WOMEN (Näf). The network is still a young organisation, founded in March of 1995 in Münster. Starting point was an initiative by the Federal Ministry of the Family, Senior Citizens, Women and Youth in Bonn, Germany. In preparation for the Forth World Women's Conference in Peking, a working group 'Women and Ageing' was convened. Women from Eastern and Western Germany discussed the living conditions of elderly women in reunified Germany on the basis of their diverse life experiences. The variety of experiences and opinions led to a praxis- and problem-oriented approach.

The result of this dialogue was that committed women from this working group decided to continue the work, primarily in order to contribute personally to the implementation of the formulated tasks for elderly women in Germany, and, secondly, in order to develop the co-operation between women from Eastern and Western Germany further. What is more, many exemplary networks for elderly women had already been established at the European level.

Some of the highlights of our initial activities:

- Our conference in Frankfurt in autumn of 1995 'From a divided past towards a common future',
- The entry of the National Network of Elderly Women Germany into the Older Women's Network Europe (OWN Europe).

The OWN was founded by groups of older women in Europe who pursue the same goal, namely: *'The reinforcement and recognition of older women's needs and the acknowledgement of their capabilities and their role within society.'*

The member countries of OWN on the basis of its constitution agreed upon in Brussels are the networks for elderly women from Belgium, Denmark, Germany, Great Britain, Ireland, Italy and the Netherlands.

The chairwoman of the OWN is Maria Marziali of Corciano (Italy). We should mention that the interests of elderly women were taken into consideration on this level for the first time during the Fourth Women's World Conference in Peking.

In its programme, the National Network of Elderly Women pursues three main goals:

- Developing self-help offers for older women and supporting their participation in public life,
- Preventing health deficits caused by the loss of roles (as a mother, a wife or as an employee) by developing initiatives for elderly women,
- Establishing connections with other networks that deal with the issues of age, in order to increase the impact of our actions.

At the moment, we inform and communicate through the internet – the articles on our transnational work can be found there.

The German offshoot of the International Network, the National Network of Elderly Women (Näf), works with groups and individual members in almost all federated states. There are groups in Münster, Regensburg, Marburg and Leipzig, among others.

‘Gender and Age-Characteristics of the Diversity’

Women's experiences

As an introduction of our work I would like to introduce a woman from the theatre project of the network from Saxony – Karin. Karin was born in 1941. If it had been her choice, she would still be working. Her work, she said, was her life. Through her work she had established manifold contacts and had acquired a relatively large circle of friends. After unification, the company where she had been working was closed down. The company was a leading delicatessen company in East Germany, in which she had been responsible for the entire food inspection department for years. Her occupation as a qualified food inspector and her financial independence were of great significance to her. She spent her scarce spare time with a theatre group and with her friends. The quality of life she had attained was especially valuable to her. Because Karin has an inherited disease (Usher syndrome), is distinctly hard of hearing (she didn't learn to speak until the age of 9) and because her eye sight declined starting in her mid-thirties, Karin had to work very hard for everything she achieved. With the unification of Germany, she faced hard facts: she lost her job, her contacts with people decreased, her financial security diminished and she battled with breast cancer. That much about her difficulties.

Her strengths were her indestructible courage to face life, her optimism, her curiosity to try out new things, a very sociable nature and no self-pity. In 1991, shortly after unification, she started to learn belly-dancing and occasionally appeared in small shows for the handicapped.

Our Network of Elderly Women introduced Karin in our conversation series 'Women just like us'. She is celebrated with enthusiasm!

The Activities of the Network of Elderly Women

'Women- just like us' –a conversation series

In our conversation series we present women who in many respects give new impulses and stimuli to other participants of the discussion circle. Successful entrepreneurs introduce themselves, as for example the owner of several hearing-aid stores, a hearing-aid acoustics craftswoman, experienced artists, as for example the theatre photographer Helga Wallmüller, but also the committed government committee representative on social equality. Especially interesting was the meeting with Ingrid Graf, a prominent judge who stems from West Germany but who has settled in Leipzig. A large number of visitors to the meetings indicates that the presentation of competent women is of great interest. These women convey competence and encourage new paths and ideas. This helps us to realise one very important aim of our project.

Our project: Meyersdorfer Breakfast –a building block of our network

In autumn of 1995, we began to organise conversation circles for elderly women which tackled current topics, and very quickly noticed an increasing interest in them. We tried out possible forms of organising this circle and we found that morning hours were more suitable for elderly women than the afternoon, evening, all-day or weekend events. Thus it seemed obvious to call these meetings: 'Meyersdorfer Breakfast'. It has quickly become known in Leipzig that this is a women's conversation circle with fighting spirit. Those who visited the circle once just to enjoy a nice 'breakfast', did not appear again, as this circle is neither peaceful nor leisurely. The reasons why women come, participate and discuss are diverse. There are reasons such as a desire to impart one's own experience, to speak one's mind, to gain courage, not to put up with everything etc. There are women full of frustration, who are driven to despair because of injustice, women who want to overcome their isolation, women who are in the process of self-discovery within our society, women to whom the common experiences give new courage, women for whom the new contacts are of great importance, for whom it is again possible to open themselves up to others. Trust and confidence in oneself results in trust in others. To date, the conversation circle for women from age 45 onwards –the Meyersdorfer Breakfast– has been carried on successfully.

The breakfast has been well attended continuously and is popular for many reasons. The most important of these is surely that the topics discussed are of current interest, as well as women-related, such as 'Why do battered women need shelters?' or 'How do the Bulgarian women live today?' or 'Our desires for the new millennium –network women and their dreams'. On this last topic, we carried out a survey among women from East and West Germany.² A second important reason for many women to become involved in this conversation circle is apparently that they themselves can contribute to the discussion. We do not exclude any problems in the discussion, everybody gets a chance to speak –and even to get her frustration and problems off her mind. As a third reason for participation, we have also noticed a growing bond and increased friendship between the network women.

A high point of the conversation circle was the 'last' breakfast of 1998, on December 1st, which we broadened into an entire network day. Attended by more than 50 women, this day was a successful end to the conversation series of 1998. As it was so successful, we would like to organise one every year.

On this day we presented a wide range of activities. We showed what had been achieved (e.g. via a photo-collection) which gave us courage and mutual support.

Our principle is to awaken the joy in participation and co-production through our example. It is very important to encourage women to become more active. Some of these women have become members of our network, while some of them are only linked to us through our mutual activities. The goal of our work is to build up networks which radiate, which connect women, which build up smaller or bigger groups and which join together women who pursue common interests.

The project: Development of a revue with the working title 'Women's wishes and frustrations'

This project takes up and reflects the joys, difficulties and wishes of women over 45. It was realized using the following steps:

- An call for texts on this subject,
- Conceptual work, including the development of a story and variations on the topic,
- The translation into a music, dance and drama performance.

At the same time a working group was founded in Leipzig, including a literary and an artistic director, a choreographer, a musical expert, writers and potential actresses.

Two workshops were carried out: 'Writing for the stage' and 'Going onto the stage in old age'. Opening night was at the end of 1998. First successful performances took place. Karin was there as well, performing a speaking part, a show-dance and a belly-dance. She received a special applause every time.

Her comment: 'It was an experiment, a challenge for me as a handicapped person, to play in a theatre group of healthy women. Today, I can say that it has become my new purpose in life. Now, in my third stage in life, I have realised wishes and dreams, which was not possible during my working life. I am enjoying it very much. We are like a big family.'

Four of the thirteen participants in this theatre group belong to the Network of Elderly Women.

In the mean time, there are new projects by this theatre group:

- Project 'Tests of courage' 1999,
- Theatre –women– group of regulars.

Other projects:

- A painting and writing event for children with the title: 'Everything my granny can do' with exhibitions, presentations, an awards ceremony, and many other things..
- The social project Meyersdorf: care for elderly people in the foundation Meyer Houses
- a special highlight of our work in 1999 (the International Year of the Elderly): EUROPEAN CONFERENCE WOMEN 'Welcome to the third stage of life – post occupational areas activity for older women in Europe' (11.05-15.05.99 in Leipzig) Women from 10 European countries participated, of which six were Eastern European countries. The National Network of Elderly Women was the organiser of this event. The conference included workshops, discussion groups and a conference of experts with more than 60 participants.

Summary

The activities of the National Network of Elderly Women in Germany focus on encouraging women to think about their own competencies, to awake their positive attitude towards life in order to improve their general quality of life.

The notion that society does not need older women any more should be countered with a positive construction of the social life of older women. This 'self-construction' also includes problematic topics of elderly women. In October of 1999, the OWN is planning a conference 'Older Women and Social Exclusion' in Amsterdam. At the conference, this exclusion should be made visible from the perspective of elderly women, including a wide range of its aspects in various areas of life, as for instance in advertisement, at work, in the family and in many other fields of public life.

The activities which are developed and carried out within the Network, should be offer models for imitation, should stimulate curiosity and invite participation, they should improve the quality of life of older women and strengthen their ability to enjoy life. They should make older women's voices heard and facilitate their presence in politics and public life.

- 1 *Gisela Kurtz is the chairperson/member on the board of several German networks for older women. She is involved in the organising committee for the international year of the elderly in Germany.*
- 2 *The National Network of Elderly Women (registered organisation), 1999.*

RURAL WOMEN: WOMEN'S HEALTH CENTRE IN LEIBNITZ/ AUSTRIA

Eva Janes¹

Introduction

THE WOMEN'S HEALTH CENTRE 'THE SPIDER AND THE WEB' IN LEIBNITZ, SOUTHERN Styria, Austria, was founded on the initiative of the Graz Women's Health Centre. Funding for the project is provided by the Styrian Government, the Department of Health, the Department of Social Security and the Social Aid Association of Leibnitz, the Federal Ministry of Women's Affairs and Consumer's Protection, and the City of Leibnitz.

Supporting women working as lay caregivers as well as professionals

The project is focused on a specific rural area, offering itself as a health promotion initiative for women working as lay care-givers within the family and also for professionals who, in various health-related environments, cater to the needs of disabled patients suffering from acute or chronic diseases. The demography of Austria demonstrates that women from 40 to 65 years old in particular are responsible for the majority of work within this field, most of whom work without adequate pay or social security. These women need support. This support is to be achieved through social intervention in this rural area.

The overall objective is to make fuller use of the existing resources within both the lay and professional areas, and to ensure more focused networking between existing care providers. The Women's Health Centre Leibnitz was opened on January 28, 1998.

One woman who has gained strength through our activities is Gerda Stienetz, from Heiligen Kreuz a.d. Waasen, a rural community in the district of Leibnitz. She was born in 1944, the eldest child in a Catholic family of six brothers and sisters. Her parents owned a farm, and during the harvests she had to work instead of going to school. Altogether Gerda has had only seven years of formal education.

Gender status and the social contract of behaviour between the genders constitute the foundations of Gerda's living conditions. These foundations can be described in terms of the basic meaning of being male or female in a specific historical/cultural context. In the ideology of the culture in which Gerda grew up, the unexpressed moral code for a woman could be defined as follows: A woman's expectations for matrimony, for example, included: monogamy, romantic love, a house of her own, a husband who earns enough, a husband

who takes care of his family. Once married, a woman's code included: giving birth to children, being responsible for the household, being present and available for the family, keeping the family in harmony with love and understanding.

To be a man within this same moral code could be described like this: to prove 'real manhood', i.e. to be a strong man and the dominant part of the family, to provide for the family as the 'bread-winner', to compete with other men, to be a 'lady-killer', to go out regularly with the boys for a drink, to have many children.

These separate ideologies meet on the micro level of real individual lives. In her real life, Gerda experiences a deep ambivalence about the collision between her own individual needs and the selflessness of her expected role.

Today, at the age of 55, Gerda has been living with her husband on his parents' farm for many years. The cultural contract between her husband and his parents involves one important obligation: to take care of his parents when they get old. For two years Gerda has been taking care of her bedridden mother-in-law. The old woman has the ability to pay for her care through a government allowance. This money, however, is being put into a deposit. Gerda hasn't had the chance to take out an insurance policy for herself in order to 'collect years' on her own pension plan. Her in-laws are not easy personalities, but Gerda endures them without complaining. Throughout all the years of her marriage Gerda has had to prove herself acceptable to her in-laws.

Gerda's children are either grown or in their teens. None of them wants to take over the farm. Two of them have already been employed for some years and the youngest is an apprentice.

During the last few years Gerda's husband has been unemployed for long periods of time. Most of this time he spends just sitting around. Gerda alone has been almost entirely responsible for the care of the farm, with its forty pigs to keep and four hectares of land, even when her husband was out of work. In general, he expects her to solve all his problems.

Gerda's financial situation is insecure. Her husband never gives her regular 'house-keeping money'. Gerda hasn't seen her friends very often since she got married. She meets them in church on Sundays or when she shops in the village during the week. Traditional family celebrations, like birthdays, are the only occasions when she comes together with her relatives and neighbours. Her lifestyle is rather simple. There are few possibilities for her to make demands for herself. When she looks back on her life, she sees that she hasn't had much 'free' time to spend. When she assesses her own health, she overrates herself and works too much, although she admits feeling exhausted after a day of work. Gerda pretends that everything is okay, and pretends to be healthy.

Gerda has religious faith and goes to church once a week. She also has a good relationship with her mother.

Because Gerda has had little time to think about getting older, she is not worried about her future old age. In her position as a farmer's wife, an official 'retirement period' does

not exist. She will work as long as she is able. She will care for her future grandchildren when they come to visit her, and when her children need financial support she will provide it.

We came into contact with Gerda through her parish, which organised a meeting with our project around the issue of 'health promotion in lay home care'. She became interested in the exchange of experiences and skills, and now visits the meetings regularly. As a result, we have had the possibility to stimulate her with ideas about different possibilities in life and to empower her.

How does the project work?

The advice and information available in the Women's Health Centre Leibnitz prompt women to establish their first contact.

At the same time, structural policy changes have been initiated by the Health Centre to improve co-operation and communication between all sectors of health care providers. This is to ensure the sustainable development in the field of health care services offered in this region.

The project is based on the following guidelines:

- The 1986 Ottawa Charter of the World Health Organisation redirects seniors towards simultaneous intervention on different social levels. The project is thus linked to international declarations and models.
- The Vienna Declaration of the World Health Organisation of 1994 deals explicitly with the question of women-related health care. Investment in health, enabling strategies, as well as women-friendly and needs-oriented health services are of particular importance in this model project. Continuous development of women-related and women-specific care services will be ensured by the Women's Health Centre Leibnitz.
- The model of Integrated Health and Social Districts developed by the Austrian Federal Institute for Health Services is used as a model approach for our networking between existing care institutions in the medical and psychosocial areas. Because the project takes an interdisciplinary approach, it can easily be linked to national care models.

Description of the activities

The project acts as an independent contact, initiator and intermediary institution in the following fields:

- Work with relatives: enhancing their own initiatives, strengthening those concerned and coaching them to acquire new skills,
- PR to foster an awareness of care as both a lay and a professional concern,

- Awareness and the promotion of social networks and co-operation within the district,
- Management of interface between the target groups, care givers and care providing institutions to ensure political advocacy and continuing contact with the media,
- Interface management between out-patient and in-patient care.

Our top priorities include lobbying and advocacy on behalf of the relatives concerned. We provide these services while necessarily remaining sensitive to informal power structures, a prerequisite when working within a rural area. From the start of the program, we have successfully fostered a regular exchange of information and feedback. We have also networked extensively by establishing direct contacts: We recognise and respect the services provided in the district. The relevant initiatives and parishes have been contacted. We also integrate local experts in work groups, panel discussions and as speakers at seminars, workshops and conferences.

It has thus been possible to make use of the existing resources and to intervene by pointing out the potential for new ways of organising co-operation and networking between existing resource organisations.

Our public relations work includes a wide range of activities: the regular publishing of a programme magazine; planning and conducting events, lectures and press conferences; writing articles, press releases, and letters to the editors of regional and national newspapers. The PR work and the resulting acceptance of this usually invisible work delivered by women within the district has boosted the importance of the project.

In spite of the enormous size of the district (which comprises 72.000 inhabitants within 48 rural communities), the project has already been widely accepted. One sure sign of this acceptance is the co-funding of the project by the Social Aid Association within the first 5 months of our existence.

Activities that the Women's Health Centre Leibnitz carried out from its beginning have included:

- Counselling for care-giving relatives,
- Initiating and accompanying self-help groups in the communities,
- Enhanced planning and implementation of training and support in co-operation with existing institutions, as well as with active members of the community,
- Public relations measures to boost public awareness of care services provided within the family,
- Interface management between out-patient and in-patient care, including the drafting of guidelines for discharge criteria. In order to accomplish this, an interdisciplinary working group was established,
- The establishment of one structural working group intended to sensitise citizens to the topic of 'care allowance,' aiming to work out solution proposals using the existing resources,

- The implementation of a talent-exchange without money,
- The establishment of contacts with parish communities, social workers and active community women to foster communication between voluntary and professional helpers. This has enabled us to plan and implement events and counselling measures to meet actual needs,
- Continuing PR by means of a regularly published programme magazine, press releases and newspaper reports, as well as seminars and workshops organised throughout the region,
- The presentation of the project at several scientific conferences,
- Several articles about the Women's Health Centre were published in books, making the project accessible to a wider circle of professionals.

Conclusion

The intervention of women-related care is based on the diversity of women's intrinsic needs and requirements. The project offers both support and inspiration in the promotion of health, as well as guidance in how to make use of one's own personal and structural resources.

The innovative aspect of the concept lies in the intention to work out a sustainable structure for the district, bringing together both the lay people concerned and the professionals. Existing resources are interconnected within a network which thus ensures their complementary, enlarged and more targeted use.

People tend to seek professional help when objectively informed and when the services offered are easy to understand and readily accessible. Information on the nature of services offered are tailored to the requirements and needs of the people concerned. To reach several groups of women, we are working together with the parishes and with many active individual women, institutions, organisations and initiatives. The talent-exchange is another way in which contact occurs. As a result, women can afford products and services that were previously out of their price range. Providing advocacy for women is the Women's Health Centre's major impetus and objective.

Evaluation

The model project *The spider and the web* is carried out with the scientific support of the Institute of Social Medicine of the Karl-Franzens-University of Graz, which also evaluates of the project scientifically.

In this context, aspects of program and strategy development will be documented and evaluated for further implementation.

Regular, ongoing monitoring and evaluation of services provided is required in order to enable the identification of emerging issues. This will involve a process evaluation to ensure guidelines, procedures and policies were well planned, evidence based and responsive to emerging information about their feasibility, appropriateness and effectiveness.

Working groups with experts and lay care-givers will develop protocols which will secure quality assurance in this field. Development of care-giving protocols by providers will add quality assurance measures in this area. Furthermore, the main area in which service responsiveness and quality improvements in care-giving can be achieved is the consultation with consumers and the community in all aspects of protocol planning, policy, purchasing and provisions of care-giving.

At the end of the project, a manual will be produced to help ensure successful implementation of similar intervention projects carried out in other regions.

1 Eva Janes is a staff member of the Graz Women's Health Care Centre, and runs the Leibnitz Women's Health Care Centre.

ELDERLY WOMEN: A DIFFERENT FOLKLORISTIC INTERPRETATION¹

Anne Leonora Blaakilde²

THIS PAPER IS BASED ON MY FIELDWORK AMONG OLD WOMEN ON A SMALL DANISH ISLAND. 'Fieldwork' here means repeated, long conversations with these women as I lived on the island during two summers. The old women were born on this island, and they have lived there all of their lives. Mary, 89 years old, told me about her childhood: 'We did not have the white-cold heat they have today.'

The 'white-cold heat' is a trope, a metaphor, and a defamiliarised combination of words implying ambiguity and is enigmatic to me. I need to interpret this trope in order to find meaning in the words. First and foremost I construe 'heat' to be a metaphor culturally connoted with cosiness, social relations and secure feelings of a valued identity. This is a widely accepted interpretation, I believe, and I find Mary to imply this connotation as well, because she returns to the topic of warmth and heat several times during our conversation, always related to the cosy fireplace from her childhood, where all of her family were gathered, occupied with nice activities. I do not doubt Mary is referring physically to the modern grey or white metallic installations on the walls, radiators, as opposed to the black stove from her childhood and youth. But there is one more contrast in her words: 'white-cold heat.' Normally, heat and warmth is supposed to be red and warm, so when Mary picks this tense antinomic constellation of 'white-cold heat', it is a contrast to the black stove, the red fire, and of course a contrast to the expected cosiness and social relatedness connected with heat. Interpret the sentence: 'We did not have the white-cold heat they have today' as an expression of dissatisfaction in Mary.

The temporal placement of this disappointment is situated in the present time contrary to what she experienced in the past: This is read through her grammatical word-choice 'did not have' versus 'have today.' Furthermore, Mary emphasises her message by a clear distinction between 'we' and 'they', referring to cultural identity rooted in temporal coherence. Interestingly, Mary does not perceive herself to be part of 'today', she narrates her own discursive representation to be in the past, regretting the coolness of today.

Thus, the contrast set up in the statement about 'white-cold heat' is pointing to three levels of difference:

- To social relations and values,
- To temporal differentiation, and
- To a distinction between different cultural groups.

Mary represents the 'we'-group, which is born and has lived for many years on the same island. The conditions there were what I would call a 'rural' life, involving farming, tough work and little income, during a historical period with increased mechanical progress, – which these islanders only partly accepted. These are the common conditions of life as experienced by most old people on this island. Verbally, they all narrate themselves as 'we' in first person plural, whereas young people, and urban people in general, would say 'I' in first person singular. So in daily speech, these islanders confirm their common identity by weaving their history and culture together into a stable cultural identity. This has been found to be true in general for groups with a strong feeling of 'togetherness' (Goffman 1963, Lalive d'Epinay 1985, Scott 1990).

Contrary to urban people, the islanders are not very individualistic in their orientation. In Mary's eyes, I presume, I could easily be seen as a member of several of the discursive representations to which she is opposing herself. It is interesting to hear, therefore, that she elegantly avoids including me in her narrative, using the term 'they' instead of 'you,' when she refers to the discursive practices, as opposed to what 'we' used to do. This is a verbal feature of narrative ambiguity: If I myself feel affiliated with what she is saying, it is up to me to make that interpretation. I could also construe the way she 'neutralises' me to be caused by her intention not to include me in the discursive representation, because she perceives me differently, as a stranger, who is unusually interested in listening respectfully to her experiences and narratives. I can interpret this ambiguity and indeterminacy in her cultural tropes the way I want. She is not responsible for my interpretation. She is free.

This freedom is due to our meeting point where intertextuality takes place. We each represent different cultures, and our interpretations of each other depend on this representation. Clearly, when I enter Mary's living room and obtain a conversation with her, both Mary's and my own presence provide the intertextual sphere of similarity and difference. Hence, it is possible, by way of interpretation of certain spoken words and narratives, to try to grasp and understand perceptions of life as seen from the perspective of elderly people.

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ELDERLY WOMEN'S WORK, HEALTH AND ILL HEALTH – DIVERSITIES AND COMMON EXPERIENCES IN A LIFE- COURSE PERSPECTIVE

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Introduction

IN THIS PRESENTATION WE SHOW HOW ACADEMIC RESEARCH CAN BE USED IN THE framework of the programme set up by the EWHNET. The intention of the inquiry described below is to influence different actors – such as health-care workers, politicians, trade union members and, not least, women in general – in promoting better health for women. The results are applicable to both older and younger women of today.

Background, method and theoretical tools

As practising doctors, we have found that many women's experiences of work and ill health do not quite fit into available medical frames. Practitioners like us and the public medical service as a whole have also had limited knowledge of the factors that build up women's resistance to illness and benefit their health. These circumstances were the point of departure for our research.

In the initial aim of our inquiry we chose to describe and characterise the work and the experiences of well-being and pain of a selected number of women. The under-lying purpose is to make women's experiences more visible, and to create knowledge of activities and contexts that influence women's state of health. Our approach has been to focus on prerequisites, content, expressions, and characteristics of women's work, health and ill health.

The study is based on interviews with twenty women born in the 1910s or 1920s – most of them in Sweden, one in Hungary and one in Estonia. A criterion for the selection of interviewees was that they should represent a range of experiences of life and work. In order to acquire knowledge about their outlook and their perspectives and also allow the multiplicity, diversity and detail of their lives to emerge, we used qualitative methods. The interviews were shaped in close co-operation with the women, a co-operation that influenced our lines of inquiry and, at times, brought our previous ideas into question. In this way, the women participated actively in the research process.

We selected women in general rather than patients or women who represent a particular category of illness. This choice, as well as our focus on work, emanates from a wish to view women's good and poor health in relation to their circumstances, prospects and actions. Thus, we did not try to find links between specific symptoms or diseases and work. Instead, we acquired knowledge of women's work and of the processes – in social, professional and private life – that cause ill health or malaise or are conducive to good health and recovery.

The research was based on feminist theories. Different ways of viewing gender and the meaning of gender were discussed, as well as other issues in the theory of science that are related to feminist medical research. In order to understand the causes of women's poor health and identify ways to recovery, it was useful to apply a historical perspective. By selecting older women for the study, we were able to view women's experiences in a long-term perspective. The interviewees' history of work, health and ill health were studied in relation to changes in society, individual patterns of life and accidental occurrences. In addition, we integrated knowledge from other scientific fields with our medical experiences and ways of thinking.

The women's work, health and ill health

Conditions, norms and civil status

Each individual woman's work history, health and poor health was shaped and influenced by a number of circumstances. Confrontations arose between the women's own wishes, strategies and actions and the expectations of them as women, as well as the power relationship between women and men. Legislation, social norms, class membership, varying degrees of education and civil status are other factors that were of consequence.

As they began their adult lives, the women bore an inner experience and consciousness that work is distributed according to gender, and that men and men's work is valued higher than women and women's work. Their freedom of movement and liberty to choose their education and profession was also more restricted than it was for boys and men. Moreover, they learned that, as girls and women, they were responsible for the wellbeing of others, not least that of men. Taboos and the stigmatisation of women's bodies, genitals and sexuality were conveyed to many of them.

The period during which the women worked most intensively was from the 1930s to the 1960s. At that time, the favoured way of life was the heterosexually constituted family with the man as the main provider. The general view was that women's most important tasks were at home, as housewives and providers of care. Some women in our study fit into, and were happy with, such a pattern of life. Some felt an obligation to adjust, since they saw no alternative. Others opposed the expected pattern of life, created

opportunities on the side, or managed to achieve compromises. Some broke the norm decisively, and thereby proved that the restraints that normally surrounded women could be pushed back or transcended. Both the single women and the married women that held on to ideas of a career of their own encountered resistance, though of differing forms. The unmarried women were often directly insulted for contravening the norm. One of the married women made an agreement with her husband that neither of them wished to take responsibility for a child. This was also an infraction against existing norms.

The women who married did so for various reasons. For some, marriage was a matter of course, the role as a housewife was taken for granted and higher education was therefore considered unnecessary. Others had an education, fell in love and got married more 'accidentally'. Yet others were forced to marry because they were pregnant. To some, marriage was the only way to have a home of their own and thereby achieve independence, for example from their parents. It was nearly impossible for unmarried women with low-paid jobs to live in homes of their own. All the women expected their marriages to be based on sharing and mutuality. No woman in our study lived in partnership with another woman.

Work and health in the family

Regardless of their position in the labour market, all the married women ended up assuming the main responsibility for housework and providing care in their families. They were responsible for the survival and wellbeing of their men, children and other relatives. Many of them had already acquired the knowledge needed for these tasks during childhood and adolescence. Those who lacked such knowledge experienced difficulties in their adult lives - but acquired it along the road when needed.

The workload in the home and its demands on time were closely related to the size of the family and the available financial resources. Large households with poor finances were self-subsistent to a great extent. In such families the production of essentials at home and the pursuit of cheap merchandise demanded a lot of time. Housing standard and housing environment were of great consequence; dwellings without modern conveniences or dwellings situated far away from public services entailed heavy physical work and longer working-days. Compared to more educated and well-to-do women, women with low-wage occupations often carried out heavier work both 'at work' (i.e., the place of paid employment) and at home. Many women found housework monotonous and dull, even if certain aspects of it were enjoyable.

In addition to efforts to improve the standard of living of the household, other central tasks that the women at home had to provide were physical and emotional contact, keeping the family together, mediating and creating a sense of sharing and belonging. Social contacts, also on behalf of husbands and children, likewise belonged to the women's field of responsibility. The care of children (both their own and others) demanded a physical presence and a constant attention to the safety and needs of the children. Rearing children and planning for their future were other necessary tasks.

Work related to the needs of healthy husbands mainly had to do with personal service, which in some cases included sex as a service. Some women had to contribute considerably to their husbands' work; this was the case for those who married farmers or men whose work included entertaining (a vicar and a headmaster). Many women nursed seriously ill or disabled men, sometimes for long periods of time, even when they themselves were old. A few were responsible for the care of old and ailing parents and parents-in-law. The care of children and the sick was often a night and day occupation, regardless of the women's own age.

The women's work for the family as a whole, and for individual members of the family, demanded considerable adjustments in their own lives in respect of their choice of occupation and occupational activities, their social contacts, other work of their own and their civil status. Despite this fact, they relate many positive experiences –not least of all from the period when they had children to look after. They were needed, and speak of the feeling of 'being rich', of physical and emotional contact, of being useful and of feeling proud. Responsibility for the totality gave them strength and enabled them to extend themselves and their abilities. At times, however, they extended themselves too far. Many of them describe feelings of never being left in peace and not getting enough sleep, as well as feelings of insufficiency, worry, guilt and loneliness. Fatigue, sometimes to the point of physical and mental exhaustion, was often a part of their everyday lives. Several of them sustained injuries from the physically and mentally strenuous work of caring for their families. Some consider themselves responsible for wearing themselves out.

Despite the fact that the distribution of work at home was arranged in a similar pattern for all the women, their feelings about their work differed greatly. This is also the case concerning their adjustment to, and relationship with, their husbands. Those who viewed the care of their children and husbands as their most important task were usually rather content with their situation. A few who were not very interested in housework as such, considered it a natural task for women and therefore accepted it. Those who wished to achieve a more even distribution of work at home, but failed, found themselves in a state of conflict. This was the case for the women of higher education, whose position in the labour market was similar to that of their husbands. These women sought to balance their lives between adjustment –often for the sake of the children– and protest.

Some women experienced the joy of sharing work, as well as mutual consideration and respect, in their relationship with their husbands. Several describe feelings of love, friendship and sexual desire. Those who never experienced the joint responsibility and the sharing that they had expected express great disappointment. Attempts to change the balance of power and the distribution of work at home meant that the women deserted their role as peacekeepers. Alcoholism, mental abuse and sexual pressure made the everyday lives of some women difficult. Anxiety, loneliness, powerlessness and shame tormented them.

In other words, the relationship with their spouses greatly influenced the women's working life and state of health. The degree to which the men made use of their position

of superior power in married life decisively influenced the wellbeing of the women. Sooner or later, many of them questioned their husbands' demands for attention and adaptation to their needs. In some cases, this resulted in divorce. Since two of the women whose marriages ended in divorce were divorced while they still had children to care for, they were left in a financially and socially difficult position, and this in turn caused both physical and mental illness. Nonetheless, single life was experienced as a relief, and in the long run, they see it as having improved their health. Those who chose not to live together with a man all along in order to be able to devote themselves to a career of their own also express contentment. This in spite of the fact that their choice excluded the prospect of having and caring for children of their own.

The sharing of work that some women missed in their marriages, as well as in their rather isolated existence as mothers of small children, was in some cases compensated by working together with others; mothers, daughters, neighbours or friends. Furthermore, those who were full-time housewives describe an organised co-operation; women gathered and carried out work such as baking, laundry, child-minding and sewing together. Sharing of thoughts and experiences took place in the course of this work.

Relatives provided the women with a fundamental sense of belonging. At the same time, some of the women felt used in these relationships. Those who lacked close relatives express feelings of abandonment.

Several women thought of friendship, usually with other women, as 'an absolute necessity'. Such friendship, however, was quite frequently set aside for the benefit of husbands' and children's needs, and because of the social rule that says that couples should mix with couples. Certain matters could not be discussed outside of the family, even with close friends. This was especially applicable to problems arising in married life and experiences connected to childbirth. Many derived enjoyment and higher self-esteem from membership in organisations, clubs and associations, but others, mainly single women, were also humiliated in such contexts. Some, but not all, were able to find a particular freedom within groups consisting exclusively of women.

Gainful employment

The women in our study had many different occupations. About half of them had compulsory or upper secondary school education. Most of these women also had professional training – in the fields of nursing, teaching, engineering or administration. Two women, a physician and a teacher, had an academic education. All women, except the physician and a few housewives, were gainfully employed most of their lives, up to their retirement.

The women who only had a limited school education often used knowledge and skills acquired during childhood and adolescence in their working life. These mainly domestic skills made it possible for them to work within a great number of vocational fields. Many of them worked as kitchen staff and cleaners as well as in health care and municipal home-help service. Others were industrial workers, and acquired competence within

their branch of occupation over the course of time. As is typical for women, competence through life experience has also proved useful in industrial work.

The employment of the non-formally educated women was characterised by low salaries, low status and physically strenuous work. Today, these women have low pensions. Women with professional training were generally better off. However, those who were married had lower wages than their husbands (with the exception of the teacher). In some cases, they also have a lower pension than their (male) colleagues, for instance because of maternity leave.

Most of the women enjoyed their paid work and would not have considered a life without it. This is also the case for those who had heavy and strenuous jobs. Employment made it possible for them to have a life outside the home; it provided them with money of their own, a sense of purpose, recognition and appreciation, and sometimes also gave them power. The feeling of doing a good job gave them a sense of self-respect. To work in spite of illness or to cope with excessively heavy work or too many tasks was sometimes conceived by them and others as part of doing a good job. On the other hand, inability to meet such demands could induce a sense of failure.

The women who worked as nurses or administrators describe difficulties connected to being in an intermediary position at work. Some of them also found that their professional careers were questioned after they married. All women, regardless of their position in the labour market, describe experiences of discrimination and vulnerability due to gender. The professionals, as well as those who had industrial, domestic and nursing or care sector jobs, all encountered inequality in the form of lower wages and fewer career opportunities than men with equal or less education and competence. Many of the women felt that they were scrutinised and used. The engineer and the doctor found that they had less authority than their male colleagues and that information was at times withheld from them. At least half of the women had been subjected to sexual harassment and other forms of harassment.

However, being a woman was sometimes also an advantage in the pursuit of a profession. This was especially true for those who worked in the health care sector. Paying particular attention to the needs and interests of female patients gave these women a special sense of fulfilment in their work. At the same time, this meant that they risked over-exertion and could incur feelings of guilt, particularly when the responsibility for the work was greater than the power to influence it. Women in other occupations also felt needed as women in relation to customers, pupils, work-mates and others.

Childbearing

The work of childbearing, in which we include contraception, pregnancy, childbirth, the time of confinement and breastfeeding, emerged as a particularly important aspect of the women's work. They describe the burden of the mental and physical work that a pregnancy involves, as well as the strain of simultaneously carrying out other work. Fatigue was a dominant symptom during pregnancy. Giving birth was a positive

experience to some of them, but to most, memories of feeling exposed are permanently attached to it. Many met with indifference and felt humiliated in their encounters with the medical service. Some describe physical and mental abuse.

Breastfeeding was a natural, simple and enjoyable experience to some. A greater number than we expected, however, experienced breastfeeding as painful, uncomfortable and tiring.

Pregnancy and childbirth involved risks to the women's own health, and in some instances, even life-threatening illness. Many of them sustained permanent injuries that resulted in conditions such as backache, urine incontinence and haemorrhoids. At the same time, childbirth was, in different ways, health-promoting for many of them.

Self-determination in childbirth was constrained by factors such as legislation, prohibitions of knowledge and contraception, sexual pressure and exploitation, prevailing attitudes towards women in the health care sector, and professional opinions of the time. Mothers or other close relatives with experiences from pregnancy and birth-giving were therefore influential in helping the women gain some control over this work. For most of them, memories of carrying and giving birth to children have remained very much alive over the years.

Being well and handling illness

Most women describe illnesses that they have suffered from earlier in life, as well as illnesses they suffer from now. Yet most of them think that, generally speaking, they have been 'healthy and well'. The actual meaning of the statement is usually that they have not been confined to bed and that they have coped with their work in spite of illness. Thus, to be well has at many times been synonymous with coping with poor health. The women denied, forgot and got used to their illnesses. When their ailments got the upper hand, they would not infrequently regard themselves as lazy or 'just tired'. For this reason, they sometimes received medical attention late, even when they were seriously ill.

The women usually define physical pain, especially when it is connected to their body movements, as 'cramps' or 'minor ailments'. These were usually considered insufficient reason for being put on the sick list and remained 'cramps', since no other medical diagnosis was usually given. The women have kept themselves well, felt well or behaved as if they were well – because they have been needed, because they have felt the demand always to be there for others, because nobody was there to care for them, or because it was what they themselves wanted to do. They have continued to deal with illnesses and ailments in ways that have made it possible to remain active and outgoing.

When seeking medical care, they often met with disrespect and felt that their own knowledge and judgements had very little credibility. Contacts with gynaecologists produced a particular sense of exposure, accompanied with feelings of shame and humiliation. However, the women also met with good treatment, sensitivity and concern in their medical contacts. These experiences helped them to manage better than they might have expected.

Most of the women felt a need to create room for a life of their own in order to secure their physical and mental well-being. Late in life, many of them enjoy a much longed-for solitude. Many have also developed an ability to 'see the good things in life'. Some describe a constant struggle against the feeling of not being 'good enough'. Fear or consideration for others sometimes kept these and other women silent in situations when they now feel that they ought to have spoken. Some women feel guilty about shortcomings and wrong decisions in life. Many are anxious about the future, afraid of being left alone, exposed, ignored or neglected when in need.

One woman who had experienced war feels that this has ruined her whole life.

Between responsibilities and power

In the following we discuss a few concepts and expressions that reveal the character and essence of the women's work and experiences of ill health, as well as some prerequisites and strategies for health.

Creative work

In most cases, the women's work required experience in a range of different areas as well as giving them experience in several areas. Their work history generally consists of many different types of work and forms of remuneration, and covers most of their lives. Domestic skills and skills in caring for others were a prerequisite for most of their working lives. Practically all types of work, gainful or otherwise, required technical skills.

Most of the work had a strain of creativity. The biological way to create is to give birth. A common feature of childbearing and other work directed towards others or carried out in co-operation with others, is the creation of relationships. Most, but not all, women in our study displayed such ability and knowledge.

Nurturing, in the sense of feeding physically and mentally and fostering health, is also creative work. In order to create and maintain something, for instance health, it is necessary to identify and satisfy needs, above all the needs of those who are not able to take care of themselves.

The women also created order, in their homes and in their working life. To this can be added the creation of beauty. The study of how they used, created and co-ordinated their time triggered many reflections on the complexity of women's everyday lives and on the amount of planning that is needed to make everyday life function. Planning ahead, planning for the future, was also identified as a particular task.

However, material things, relationships and order must be maintained; everything had to be recreated. Washing, cleaning, tidying up, repairing and shopping all constitute the work of recreating order, and are necessary for upholding a certain material and sanitary

standard. Recreating work also includes comforting, being the one who listens to problems and worries. The concept of reproductive work is often used for all work that takes place in a home, while in the medical field the term refers to the work of childbirth. If the concept is to be used at all, it should be limited to include only the type of recreating work that is described above. What we have described as creative work above should then be considered productive work.

Much of the women's work was heavy, both physically and mentally. This contradicts the common idea that women's work is generally light. Women with low-paid and often heavy jobs had heavier and more time-consuming housework because they had limited economic resources. Responsibility formed a major part of the women's total workload. For those who had families, the total responsibility was considerable. Some experienced a high degree of self-determination in their housework and the care of their own children. Others, for example some of the women who combined housework and employment, had less freedom of movement because they had so many duties and so little time. Many felt similar restrictions in their marriages, because of unvoiced demands from their husbands for personal service or assistance in job-related entertainment.

The responsibilities for nursing and the care of children in the home can be said to be both self-imposed and dictated. Most parents want to take responsibility for their children. At the same time, the state has the right to take measures if the work is not carried out in the 'right' way.

In their paid work, the women experienced a high degree of self-determination in teaching, engineering and artistic professions. Those who worked in the health care sector give examples of what might be called 'compelled or subservient responsibility'. By this we mean that responsibility and acts based on ones' own knowledge and experience had to be reconciled with instructions from superiors, sometimes resulting in a state of conflict. Women with low status occupations often worked under supervision and great pressure.

Almost all women were, during some part of their working life, subordinate to men –even in work counted as traditional women's work.

The women's work can thus be said to have been carried out in a dimension of creation and recreation. At the same time, their work moved along a continuum between compulsion and personal responsibility. Other characteristics of the work are that it required knowledge, that it was a physical and mental burden, and that it was strongly related to time.

Being sufficient and adequate

The women's struggle for survival and health can be formulated by expressions and strategies such as: a room of one's own, self-determination, pride, to be working and creative, belonging (for instance with relatives), mutuality (for instance in the marriage), beauty, a sense of humour, comfort and reconciliation. These aspects became crucial to the women, due to the often very extensive responsibilities that they were assigned and

took upon themselves, due to the closeness to others that they developed in this work, and due to social norms applying to them as women.

Many of the experiences of well-being and health were associated with the women's success in living up to expectations. At other times, the struggle to assert their own values and consider their own needs was more important. Joy and pride over the female body was not a matter of course but was important, nonetheless, and is expressed especially in connection with the ability to give birth.

The women's experiences of suffering and pain change or nuance the meaning of some well-known and frequently used expressions in medical practice and research. Worry, fatigue and guilt emerged from the same responsibilities, physical and emotional contacts, and social norms that could also be causes of well-being. Again, we have found that the women's position as women is essential. Their situation was formed by existing social rules for how 'good women' should be, as well as by their exposure to other's –not least men's– exercise of power. The women's feelings of shame and loneliness are even more clearly related to exercise of power, violations, norms and taboos affecting them as women with female bodies.

Some women experience a compulsive sensitivity to the needs and wishes of others, and feel this to be painful. We view this as a sign of weariness, and as a work injury. It is the result of years of extensive responsibility for the care of others. The sensitivity of these women has caused them, continually and even at old age, to feel physically and mentally compelled to exist for the benefit others. People around them also took advantage of their sensitivity.

The expressions that we have focused on are examples of how the women's health and ill health has, to a great extent, been produced within relationships. This is taking place at different levels – personal, institutional, and social. The discussion of what it is that characterises these relationships is based on three themes that we identify in the women's narratives: power and possibilities, responsibility as meaning and as an impediment, and the idea of 'managing'.

The women were forced to handle the limits of power and possibilities that have been set for them as girls and women. Many of them strove, and succeeded, to acquire power over their own lives –not least in relation to men and male dominance. Successful acquisition of power was beneficial to their health, while futility taxed their strength and resulted in poor health.

Those who tried to achieve greater freedom and opportunity were forced to weigh the prospect of freedom with the responsibility for others. When weak as well as strong individuals were, or had made themselves, dependent on the women, this sometimes gave the women a power they did not want, for instance in the nuclear family. If the women responded to the demands and needs of others, it gave them confirmation, strength and a sense of meaning, but simultaneously, it could hinder them from acting in their own interests. Loss of a desired responsibility could lead to poor health, in their gainful employment as well as in their unpaid work.

The women's struggle to 'manage', in the sense of responding to their own demands and the demands of others, summarises their general attitude and mode of behaviour. To manage has often been synonymous with being healthy, strong, adequate and responsible for others. This could be either a positive or negative experience, depending on the women's prospects for self-determination and the respect and consideration of others.

To most women in our study, health and ill health were largely determined by constant negotiations on responsibility and power and a continual balancing and reconciliation of the two. On the whole, the meaning that the women and those around them attached to the concepts of femininity and masculinity had a determining effect on the conditions for health and risks of poor health that were created for them.

Elderly women still work

We have shown how different the lives of the interviewed women were, with various circumstances, wishes, and strategies for 'managing'. At the same time, some conditions are common to all. Changing situations in the labour market, political reforms, war and military preparedness have altered the conditions for their total workload. We must also be aware of the expectations that have been directed towards women, formerly as well as today.

At the time of the interviews all of them took care of their homes. Many helped and nursed members of their families and had different tasks in society. Some had been, or still were, responsible for the care of sick husbands at home. Sometimes this was a constant, round-the-clock task – just like work with small children used to be, though more physically demanding.

When meeting an elderly woman in the health care system we accordingly have reason to ask: How much has this woman worked in her life, with what and under what circumstances? How much of her work has she been paid for? Does she still work and is she still needed by others? Can she find time and space for her own needs? What makes her feel well?

What can we learn from the elderly women

When we chose elderly women for our research we saw the possibility to relate these older women's experiences to younger women's lives and work today. One way in which living conditions of today differ from those of an earlier period is that the norm of being a housewife is replaced by the demand for all women to earn their own living. Reforms and political ideas have also contributed to a more equal division of work between women and men. At the same time, in most families, women are continually expected to assume the main responsibility for getting the necessary house- and care work done. Women who have children still face the problems of catching up with time, and a lack of time of their own. The feelings of 'guilt' and inadequacy are also shared across the generations.

Today many women have greater opportunities for higher education and attaining higher positions in gainful work than women of an earlier generation. At the same time there is a

tendency for large groups of women to remain in strenuous and low-paid work without any chance of gaining influence over their own work situation. Accordingly, there is a risk of increasing class differences among women.

Furthermore, the gender division of work persists. The fact that more women than men 'choose' to work part-time in gainful employment is partly due to the fact that women are still lower paid and have poorer working conditions in the labour market than men. The wish to preserve the power-balance in the family may also come into play. This can easily become a vicious circle. When women spend more time at home (than men) they gradually take on, and receive, a greater responsibility for what is going on in the home, while at the same time, men gain a greater advantage in the labour market. The division of work between women and men, in couples and in gainful work, thus remains unchanged. The result of this is that economic inequality is perpetuated and reinforced over the years.

On the other hand, many women choose to work part-time in paid work in order to avoid stress and attain qualities in life that might otherwise be unavailable to them. This possibility is, however, restricted to women who have sufficient economic resources, either through marriage or high salaries. This option is not open to the majority of single mothers: they simply cannot afford it. Instead, their workdays tend to be unreasonably long.²

A problem for women, today as well as earlier, is that only gainful employment is considered a relevant basis for eligibility in the health insurance system. Ill health caused by unpaid work, together with the effects of the total and combined responsibilities of work, is not considered. The recent application of the Swedish law regarding injuries at work also treats women unfairly. Injuries typical for women, as for instance those caused by monotonous work, are no longer regarded as injuries related to work.³

Another persistent problem for women, that has also been a health risk for the interviewees, is the occurrence of sexual harassment. Sexual harassment attracts more attention today and is acknowledged as a work environment problem.

Seeking help when ill

In light of the stories of the women interviewed, the focus of medical care on women's biology and mind (mentioned in the beginning of the article) is of no relevance. Several women in our inquiry were prescribed tranquillisers or hormones when seeking medical attention for problems that could not be cured by these drugs. In their accounts of encounters with the medical profession they talk about not being heard when describing their symptoms. They also remark that doctors often lacked knowledge of the work they had to perform. Other researchers have shown that women are treated this way far more frequently than men.

Women, especially women who have reached menopause, are also prescribed medicine without any demonstrable reason. Thus, there is a risk that women, especially those who

have passed middle-age, are either not being given due respect concerning their complaints, or are ascribed problems they do not have, mainly of a biological nature. In this way women are deprived of power regarding their own health.

When women's diseases and suffering are viewed instead in relation to their work and responsibilities, the causes of ill health will be made more visible. This also enables us to identify elements in women's lives that are health-promoting.

Responsibilities and power

Questions of responsibility and power appear in our inquiry as central to the women's work, health and ill health.

How the power relationship between the sexes was shaped has not only influenced the women themselves in their private and paid work, it has also been of importance for how medical and other knowledge about women is created. This, in turn, has been of consequence for political decisions.

Women have gradually obtained civil rights in society. The women in our inquiry have taken part in this struggle. Their experiences show that women's struggle for increased power regarding their own lives and work is significant to their health.

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2 In Sweden there is a legal right for parents (both women and men) to work part-time when they have children under the age of twelve. This law has the heterosexual family in mind. The limitations on how the law can be used in practice keeps promoting this kind of family situation.

3 During a period from the mid-1980s to the mid-'90s injuries caused by monotonous work were approved as injuries related to work. Due to a worsening of economic conditions in the labour market, this application of the law is no longer valid.

REQUIREMENTS FOR GENDER SPECIFIC CUSTOMISED CARE FOR THE ELDERLY: SOME FINAL REMARKS

THE WORKSHOP 'GENDER AND AGEING: QUALITY IN DIVERSITY' RESULTED IN A NUMBER of requirements that must be met in order to realise customised care for the elderly, taking into account that there are gender differences, but also diversities within the group of elderly people, women and men, as such.

Of course, the general principles of gender specific health care also hold for elderly women:

- Taking into account gender specific aspects,
- Taking into account societal and situational factors,
- Avoidance of unnecessary medicalising, trivialising, and psychologising,
- Respectful approach,
- Reinforcement of the patient's own strength and responsibility,
- Material requirements.

But for elderly women some specific requirements can be identified. Thus, gender specific customised care:

- *Breaks through stereotypical images of elderly women/men*

It is important that new images are provided, which are more realistic, more respectful and more recognisable for elderly women themselves. This is needed both in interaction with clients/consumers and in the media. Moreover, it also means that more attention must be paid to the aspect of life style.

- *Can only be realised by listening to women themselves*

The needs and wants of elderly women need to be thoroughly assessed. Methods, developed from research under the supervision of elderly people, should be made suitable for this purpose. Aspects of life style and life history need to be included in these assessments.

- *Means continuous evaluation*

The work is never 'finished': after realising care arrangements these must be evaluated on a regular basis, assessing if they are what the clients/consumers need or want. This is even more necessary since we know that old age is not a static state of being. Changes in central values of women/men may occur, as well as changes in physical, economical and social position, causing changes in needs and wants.

- *Is interdisciplinary*

Elderly people may have a need for different types of care. It is necessary that the care arrangements provided do not interfere with one another in a negative way, but that they are attuned to each other as well as to the needs of the client/consumer. This concerns not only the individual client/consumer: In development, policy-making,

and research concerning gender and ageing, interdisciplinary work pays off as well. In our workshop for instance, we saw how fruitful it can be to connect work and the sociology of labour with the medical field of health.

– *Involves different levels*

It does not suffice if an individual care provider works in a customised and gender specific way. Gender specificity and an open eye for diversity in elderly women (and men) should also be present on an organisational, scientific, and policy level.

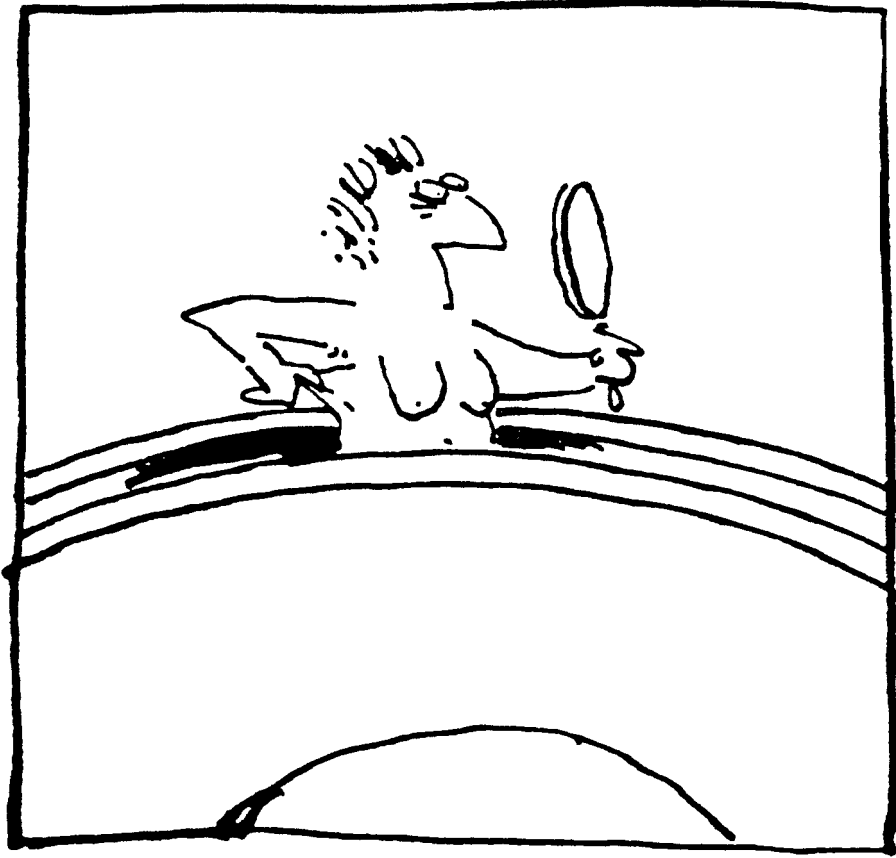
– *Brings about dialogues*

Involvement of elderly women themselves in shaping the care they need is necessary. In addition to such dialogues between care providers and consumers, dialogues between grassroots women/volunteers, professional care workers and other levels in care organisations are needed as well.

– *Provides examples of innovation and 'good practices'*

There should be an exchange of these good practices between organisations on a regional, national, and certainly also an international level. International networks could be of use here.

How all this could be put into practice depends on the field. In the contributions to our workshop we have seen considerable variety: policy, science, (health) care work and so on. It is recommended that people working in different settings develop ways of dealing with diversity in ageing specific to their particular work. A lot of work still has to be done before gender specific customised care for the elderly will be realised. We hope our workshop report may serve as a starting point for thinking about gender, ageing and diversity.



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