University of Alberta

Perceptions of healthy aging among Francophone older adults living in Edmonton, Alberta

by

Christelle Marie-Colette Esso

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Master of Nursing

Faculty of Nursing

Fall 2013
Edmonton, Alberta

Dedication

I dedicate my thesis to my family and friends, in Canada and in Africa, for their unconditional love and support throughout my school years. I also dedicate this work to all of the students who are pursuing their studies in a second language.

Abstract

Although many policy frameworks, research definitions and programs on Healthy Aging are available in Canada and abroad, little is known about older adults' perspectives on this topic. Given the steady increase of the numbers of older Canadians, as well as the diversity of their cultural background in Alberta, the present study introduces the healthy aging perspectives of eight older Francophones of French Canadian descent living in Edmonton, Alberta, using Interpretive Description as a qualitative methodology. Three central themes of healthy aging were identified from participants' interview data: protecting health, maintaining dignity, and preserving identity to achieve healthy aging. Study findings were further re-interpreted in the light of available research and suggestions were made to inform current healthy aging practice interventions, research programs, and policies put in place to possibly enhance healthy aging for all Francophone and non-Francophone communities in and outside Edmonton, Alberta.

Acknowledgement

I wish to thank my supervisors Dr. Gail Low and Dr. Belinda Parke for their valuable advice, support, and guidance throughout the completion of my research project. I also want to thank Dr. Molzahn and Dr. Northcott for their support from the beginning of this project and for their thoughtful feedback in writing this thesis. Additionally, I want to recognize Dr. Ross and Dr. Paul for contributing their time and expertise as members of my examining committee. My sincere appreciation goes to Mrs. Phyllis Castelein and the members of the bilingual Nursing program of the University of Alberta for encouraging me to pursue this study in the local Francophone community.

This study would not have been possible without the interest and support of the following leaders of these organizations: Mr. Luc Therrien, from *Réseau Santé Albertain* (The Alberta Network for Health in French); Mrs. Simone Demers, from *la Fédération des Aînés Franco-Albertains* (the Federation of older Franco-Albertans); Mr. Paul Pelchat, from the Saint-Thomas Manor in Edmonton; and Mr. Yannick Freychet, from *la Fédération des Aînés Franco-Albertains* (the Federation of older Franco-Albertans).

Last but not least, I want to express my deepest gratitude to the members of the Francophone community of Bonnie Doon, in Edmonton, for sharing with me their experiences and wisdom about healthy aging.

Table of Contents

List of Figures

List of Appendix Tables

Chapter 1: Introduction

Background to This Study

Approximately 4.8 million Canadians were 65 years of age or older in 2010, and the number of older adults will grow to 10.4 million in the coming 25 years (Human Resources and Skills Development Canada, 2011). In Alberta, for example, the population of older adults is expected to grow from 413,100 to 642,100 in the next 10 years, reaching by 2036 over 1 million (Government of Alberta, 2010a). In response to these demographics, Healthy Aging has become a priority area for the Canadian government, both nationally and within provinces.

In 1998, Health Canada established the first national framework on aging (Division of Aging and Seniors Health Canada, 1998). Successively, provincial governments came up with their own healthy aging frameworks over the years, including *Alberta's Healthy Aging And Seniors Wellness Strategic Framework* (KPMG Consulting, 2002), *Healthy Aging Through Healthy Living Framework* (British Columbia Ministry of Health, 2005), *Healthy Aging Policy And Framework And Implementation Plan 2007-2008 (*Newfoundland and Labrador, n.d.), *Age Friendly Manitoba Initiative* launched in 2008 (Manitoba Seniors and Healthy Aging Secretariat, n.d.), and *Prince Edward Island's Healthy Aging Strategy* (Prince Edward Island Department of Health, 2009). These policy initiatives were developed to shape community and public health program planning oriented towards meeting the needs and concerns of older Canadians.

The Institute of Aging, a branch of the Canadian Institutes of Health Research, in collaboration with a multidisciplinary team of Canadian researchers from various universities launched the Canadian Longitudinal Study on Aging (Canadian Longitudinal Study on Aging, [CLSA], 2009). This long term study will follow 50,000 Canadians aged 45 to 85 years of age in

an attempt to elucidate the contributing factors leading to healthy aging (CLSA, 2009; Raina et al., 2009). Therefore, exploring healthy aging in the present study is timely and will contribute a growing body of knowledge in this substantive area.

Problem Statement

Healthy aging is defined in numerous policy frameworks, health education programs and services, and in research programs in Canada and abroad (CLSA, 2009; Edwards & Mawani, 2006; KPMG Consulting, 2002; The Swedish National Institute of Public Health, 2006); however, little is known about the level of input that older adults have had in the development of these definitions. Others have called for greater input from older people themselves to better establish the social relevance of such policies and programs intended to promote their health and wellbeing (Bowling, 2006; Dillaway & Byrnes, 2009; Holstein & Minkler, 2003).

Locally, healthy aging is identified not only as a strategic policy outcome in *Alberta's Healthy Aging and Seniors Wellness Strategic Framework* (Government of Alberta, 2010b), but also as a goal to achieve for an aging population (Government of Alberta, 2010b; KPMG Consulting, 2002) which translate into public and community health programs and services for all Albertans. Given that Alberta is a multicultural province harbouring a growing population of older Canadians, I am interested in older Francophones' perceptions on healthy aging. In 2006, Francophone elders made up 3% of the older adult population in Alberta (Government of Alberta, 2010a). Although they represent an official language community living in a minority context (Fédération des Communautés Francophones et Acadiennes du Canada, [FCFA], 2009), very few research articles from the French-language and English-language published literature were found addressing Francophone older Canadians' priorities in aging and health. Studies of

older Francophones have examined these priorities in relation to their needs for housing and support services (Gobeil-Dwyer & Doucette, 2004), social participation (Zunzunegui et al., 2004), life satisfaction (Bourque, Pushkar, Bonneville, & Beland, 2005), success in aging (Bassett, Bourbonnais, & McDowell, 2007), quality of life (Baer & Curtis, 1984), but not in relation to healthy aging. Thus, little is known about healthy aging from the perspectives of older Francophones.

Not knowing the healthy aging perspectives of older Francophones is also a nursing practice issue because it could potentially lead to implementing ineffective healthy aging programs and interventions when working with this group. For example, I was involved as a nurse educator and as a graduate student in planning, delivering, and revising health promotion workshops with other English-speaking and bilingual nurses targeting community living older Francophones in Edmonton. After one of these workshops, an English speaking nurse had a concern about how relevant the content of her presentation was for her Francophone audience. Resources to prepare some of these workshops were not specific to older Francophones and relied on general health promotion in older age gathered from a healthy aging nurse working at a local public health center, from the Health Canada website, and from books (Esso & Black, 2011). In sum, the current understanding of healthy aging and the reported practice experiences with older Francophones call into question the relevance of existing policy frameworks, programs and services and research in meeting their priorities on this topic. Therefore, there is a need to investigate the healthy aging views of older Francophones. This study will then address the following research question: What are the perceptions of healthy aging of older Francophones living in Edmonton, Alberta?

Significance of This Study

Overall, the findings from this study contribute to advance knowledge about Francophone older Canadians' priorities in aging and health. First of all, these findings will potentially contribute to improve clinical practice by enabling nurses and other professionals to critically examine existing healthy aging programs and services for older Francophones. In doing so, these professionals can develop more culturally competent and thus meaningful services for this population. Taking into consideration older Francophones' views has the potential to improve the delivery of healthy aging programs that could meet their needs and expectations. It is essential for Canadian nurses to demonstrate cultural competence because they provide programs and services for multicultural and multilingual communities (Stanhope, Lancaster, Jessup-Falcioni, & Viverais-Dresler, 2008). Culture itself is perceived to affect the relationships between people and their understanding of health and illness, choice of lifestyles and health behaviors, and their participation in health promotion and disease prevention activities (Stanhope, Lancaster, Jessup-Falcioni, & Viverais-Dresler, 2008). From Leininger's work, exploring meanings, values, beliefs, and practices of people will support the provision of culturally congruent, safe, and meaningful care and interventions for health and well-being to clients of diverse or similar cultures (Leininger, 1988, 2001).

These study findings will also contribute to the growing body of research investigating healthy aging in Canada and abroad from the voices of older adults. Such knowledge will allow Canadian researchers and policy makers at the municipal, provincial, and national level to begin considering the applicability of their frameworks and conceptualizations to address healthy aging priorities of older Franco-Canadians.

Forestructure

An aspect of conducting a credible qualitative study is to be aware of one's own assumptions as these undeniably influence both thinking processes and perspectives with respect to the phenomenon being studied (Thorne, 2008; Thorne, Kirkham, & O'Flynn-Magee, 2004). This was deemed to be a necessary step to ensure that my understandings of participants' narratives were effectively grounded in their own perspectives, and not in my personal preconceptions on the topic.

The inspiration for this study of older Francophones' views on healthy aging came while providing health promotion to older Francophones in Edmonton in my role as a nurse. As a student, I have completed several graduate courses in community and public health nursing and learned to appreciate the impact of social determinants of health, public policies, health education and health promotion initiatives on older people' health. As a bilingual individual, I am a Francophone of African descent and I acquired English as a second language through my post-secondary education. I am also a young female in her early thirties. Hence, my professional and personal knowledge were instrumental in designing this study. However, I was careful to remain focused on participants' perspectives through the research process by applying several strategies. I used Interpretive Description as a qualitative research design to elicit participants' perspectives on healthy aging and put in place strategies to ensure rigor. I was also conscious about my own personal characteristics, and the need to be careful about the assumptions (or preconceived ideas) stemming from my professional, cultural, and personal background during data analysis.

As the principal investigator in this study, my emphasis on a culture-specific approach to nursing practice with diverse individuals and communities has come from Leininger's work (Leininger, 2001). Considering the multicultural and multilingual Canadian context, I believe that it is important to investigate healthy aging from a cultural perspective. I believe that healthy aging is a state of wellbeing that has cultural roots in the sense that healthy aging reflects to some extent the ability of individuals (or groups) to perform their daily role activities in a culturally satisfying way (derived from Leininger, 1996).

Thesis Outline

This thesis is organized in five chapters. The background information surrounding this study is briefly introduced in the present chapter. A review of the current state of knowledge on healthy aging to place this study in context of what is known is provided in chapter 2. The research methods used to implement this study are presented in chapter 3. The study findings are described and interpreted in chapter 4. And the discussion of key findings, and study conclusions, limitations and implications for practice, research, and policy are offered in chapter 5.

Chapter 2: Literature Review

The purpose of this chapter is to examine the current state of knowledge of the Healthy Aging concept in Canada and internationally. The goal is to establish the need to explore those definitions from the point of view of older Francophones living in Edmonton. First, I will present the context of the study with an emphasis on the increasing numbers of older Canadians and their diverse cultural backgrounds. This is followed by an exploration of healthy aging from policy, community and public health, research, and older adults' perspectives in Canada and abroad. To conclude this chapter, I will reflect upon insights gained from the debate within the literature which led to the research question that I had posed in Chapter 1.

Context

Demographics of older Canadians. In Canada, the proportion of older adults has increased significantly over the years. In 1920s, older adults aged 65 years old and above accounted for only 5% of the population; this number rose to 13% in 2005 and is expected to reach about 22% in 2026 (Turcotte & Schellenberg, 2007). Across Canada, the percentage of older Canadians varies by province. For example, the largest groups of older Canadians are found, proportionally, in Saskatchewan (14.8%), Nova Scotia (14.2%) and Prince Edward Island (14.1%). Comparatively, the smallest groups are found in Ontario (12.8%) and in Alberta (10.5%) (Turcotte & Schellenberg, 2007).

Multiculturalism: Case of the Francophone community in Alberta. Over the years, Canada has become a multicultural and multilingual society based on immigration status, places of birth, and ethnicity of its citizens. In 2001, 29% of older Canadians over 65 years of age were immigrants (Turcotte & Schellenberg, 2007). The most common places of birth of older Canadians, both immigrant and Canadian citizens, were Canada, Europe, Asia, Africa, and North

America excluding Canada (Turcotte & Schellenberg, 2007). And the most common ethnicities among Canadians over 15 years of age in 2002 were British (21%), French (10%), Canadian (8%), a mix of British, French, and/ or Canadian (7%), and other European (19%), non-European (13%) and mixed ethnic heritages (Statistics Canada, 2003).

French culture and language is an important part of this diverse Canadian society. In 1969, the Official Language Act was amended to recognize French and English as the two official languages of Canada (Office of the Commissioner of Official Languages, 2010a). This act recognizes the language rights of Francophone communities in Canada. The term "Official Language Minority Communities" designates both Anglophones living in Quebec and Francophones living in provinces and territories outside Quebec (Corbeil, Grenier, & Lafrenière, 2006). However, those rights are limited to federal institutions and it is not compulsory that they be enforced at the provincial and municipal level (Office of the Commissioner of Official Languages, 2010b).

In Alberta, the Francophone population is very diverse in terms of place of origin and spoken languages. In the last decade, this population has been growing, fueled by migration of individuals from other provinces, as well as immigration (Fédération des Communautés Francophones et Acadiennes du Canada, [FCFA], 2009). About 31% were born in Alberta, 52 % came from other Canadian provinces, and 16% from outside of Canada (FCFA, 2009). Regarding the linguistic profile of Alberta, 2% of the total population had French as their mother tongue compared to 79% who identified as Anglophone, and 19% identified with neither French nor English (FCFA, 2009). Francophone individuals mostly reside in Northern Alberta towns, Calgary, and Edmonton (FCFA, 2009).

In 2001, the Francophone population in Alberta was estimated at 55,645 people (Fédération des Aînés et des Aînées Franco-Canadiens [FAAFC], 2007). There were 12,505 people (24% of the total francophone population) aged between 50 and 64 years old and 7,580 persons (14% of the total francophone population) were above 65 years of age (FAAFC, 2007) . Recent data from the 2006 census revealed that French was the mother tongue of about 3% of older Albertans compared to 65% who had English as a mother tongue; 30.5% of people reported neither French nor English as their mother tongue (Government of Alberta, 2009).

In Edmonton, Alberta, 2% of the total population has French as their mother tongue, compared to 77% who have English as their mother tongue and 19.5% who report other non-official languages as their mother tongue (Government of Alberta, 2008). The Bonnie Doon district of Edmonton, also called the French quarter, is the focal point of many Francophone associations and institutions (FCFA, 2009), along the Marie-Anne Gaboury Street (previously 91 Street) (Heritage Community Foundation, 2004). Some examples of Francophone associations or organizations include Campus Saint-Jean (where some university programs are delivered entirely in French); the Saint-Thomas community health center (which offers bilingual French and English services to all); the Saint-Thomas Manor (which is an independent living residence for French speaking older adults only); some francophone schools; the Saint-Thomas-d'Aquin Catholic Parish; and the Cité Francophone. The latter organization is considered to be the French cultural center, which is home to several more francophone organizations such as school boards, a bookstore, a theatre, a newspaper *Le Franco*, and some youth, family, and older adults' advocacy groups (Heritage Community Foundation, 2004). However, the French quarter represents more than just a set of buildings in a particular location for the Francophone

community. It is rather "an idea, a language and a way of life shared by a group of people" (Heritage Community Foundation, 2004, para.7).

Studies about older Francophones. The priorities in aging and health of older Francophone Canadians have been the focus of a few studies published in French-language and English-language peer-reviewed journals looking at needs for housings and support services, social participation, life satisfaction, success in aging, and quality of life in older age. Gobeil-Dwyer and Doucette (2004) reported that older Francophones in Edmonton considered important to have access to housing and support services that allowed them to grow older in their own homes.

Better self-rated health status was associated with greater levels of social engagement, larger social networks made of family, children, and friends, and higher perceived social support among an appreciable sample of older French-speaking Canadians living in Moncton, New-Brunswick, and Montreal (Zunzunegui et al., 2004). Bourque, Pushkar, Bonneville, and Beland (2005) also investigated contextual factors affecting life satisfaction of Francophone Canadian adults from Moncton, New Brunswick. For older women, social support was an important aspect of their life satisfaction, while income and personal control were crucial for older men (Bourque et al., 2005). Seemingly the factors that contribute to a better life satisfaction in older age differ between women and men. Hence, as Keating (2005) points out, "gendered analysis is an important reminder of the different life-course experiences of women and men" (p.4).

There are some unique elements to what constitutes success in aging from a cultural perspective. When views of success in aging were compared across Canada between two different linguistic older adult groups, Francophones considered life quality and family most important, while Anglophones highlighted individual characteristics such as self-acceptance,

strength of character, and self-achievement (Bassett, Bourbonnais, & McDowell, 2007). Another study examined the differences in values of older Francophone and Anglophone Canadians (Baer & Curtis, 1984). Older Anglophones valued spiritual understanding and helping others. In contrast, older Francophones valued prosperity, independence, economic stability, and church attendance.

In summary, it seems that values and aspirations of older Canadians differ among official language groups. Older Francophones represent a small proportion of the older adult population in Alberta. Nevertheless, they belong to a larger diverse community whose needs, history, values and life ways are promoted locally through many community-based associations, groups, and service providers here in Edmonton. In the context of this thesis, older Francophones residing in Edmonton, Alberta were the population under study. My objective was to examine the views of older Francophones living in Edmonton on healthy aging.

Healthy Aging

Healthy aging is a concept that has been a topic of interest for many stakeholders both in Canada and internationally. There are multiple perspectives on healthy aging that warrant discussion in this chapter from policy, practice, research, and older people themselves.

Policy definitions and frameworks. From a policy perspective, healthy aging could be considered as a government ideology or vision to improve population health (Dillaway & Byrnes, 2009). In Europe, for example, healthy aging has been defined as a "process of optimizing opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life" (The Swedish National Institute of Public Health, 2006, p.16).

In Canada, the term, healthy aging, is embedded in numerous federal and provincial governmental documents to guide policies and program planning targeting older adults (KPMG Consulting, 2002). It is also presented as a framework applicable across disciplines and sectors of government, service providers and interest groups when dealing with older adults' related issues (KPMG Consulting, 2002). Several government publications display Health Canada's definition of healthy aging as "a lifelong process of optimizing opportunities for improving and preserving health and physical and social and mental wellness, independence and quality of life, and enhancing successful life-course transitions" (for example, see British Columbia Ministry of Health, 2005; Edwards & Mawani, 2006; Newfoundland and Labrador Aging and Senior division, n.d.).

Healthy aging has been described as a strategy to promote best practices to support aging well for seniors as long as possible in community and to improve care and practices in continuing living institutions (Prince Edward Island Department of Health, 2009). In particular, the Alberta's Healthy Aging and Seniors Wellness Strategic Framework (also called the Alberta Rose Model [ARM]) focuses on 4 key components of healthy aging: promoting health and preventing disease and injury, optimizing mental health and physical function, managing chronic conditions and engaging with life (KPMG Consulting, 2002). Overall, policy definitions and frameworks introduce healthy aging as a holistic concept to guide development of related government priorities and program planning.

Community and public health perspectives. From a community and public health perspective, healthy aging is about promoting the adoption of healthy personal and lifestyle habits and activities for health promotion and disease prevention in old age (Center for Disease Control and Prevention, 2009). In a study looking at the prevalence of healthy aging among older

Americans, McLaughlin, Jette, and Connell (2012) tested several definitions of healthy aging (derived from Rowe & Khan, 1997) based on a combination of four criteria: freedom from major illness, freedom from disability, high physical functioning, and cognitive functioning. They concluded that less restrictive definitions of healthy aging focusing on the lack of symptomatic disease and a certain degree of functional health status were more helpful to distinguish the "truly unhealthy" from "truly healthy" individuals to prioritize effective public health interventions (McLaughlin et al., 2012, p. 788).

From a different angle, in Australia, healthy aging has been considered a core component of health promotion programming for older adults (Potempa, Butterworth, Flaherty-Rob, & Gaynor, 2010). To successfully support the adoption of healthy behaviors in aging adults, characteristics of this healthy aging model included taking into account (a) a client-centered perspective of their health and illness experiences, (b) a goal-driven approach focusing on clients' priorities, (c) an individualized coaching strategy, and (d) personal health systems which represent the contexts surrounding clients (Potempa et al., 2010). This model appears to be a more comprehensive conceptualization to achieve healthy aging for older adults, which incorporates older adults' perceived needs and resources, as well as health professionals' input in facilitating the adoption of healthy behaviors.

In a national survey of organizations in Canada that are engaged in chronic disease prevention and healthy lifestyle promotion, it was reported that most of their activities focus on tobacco control and healthy eating, and less on other non-medical risk factors of health (Hanusaik, O'Loughlin, Kishchuk, Paradis, & Cameron, 2010). In Alberta, Canada, Anderson et al. (2008) reported that health agencies indicated less confidence in addressing non-medical factors such as poverty and social support through health promotion activities. In contrast, in

Quebec, Canada, Richard et al. (2005) reported that major themes addressed by local community health centres with older adults, through awareness-raising and health education strategies, focused primarily on physical health, lifestyle habits, community, and social issues. In sum, I conclude that healthy aging from community and public health practice is about empowering older adults with resources to self-manage their healthy aging needs focusing on physical health, healthy behaviors and social factors.

Researcher perspectives. Although there is no clear consensus about how to define or conceptualize healthy aging, it is mostly described as a multidimensional concept in the published literature. Hansen-Kyle (2005), an American nurse researcher, presented a conceptual model of healthy aging incorporating all its attributes, antecedents and consequences. Antecedents of healthy aging are compensation and adaptation strategies (which lead to resilience) in dealing with physiological, cognitive/mental, and social factors (Hansen-Kyle, 2005). Achieving healthy aging leads to successful aging (the focus of which is reaching a specific health oriented goal), and then, to independence, and autonomy. Hansen-Kyle (2005) clearly defined healthy aging as "the process of slowing down, physically and cognitively, while resiliently adapting and compensating in order to optimally function and participate in all areas of one's life (physical, cognitive, social, and spiritual)" (p.52).

Other American researchers have focused their attention on physical and mental functioning, surviving to late life, role limitation, vitality, and freedom from bodily pain or from major life-threatening diseases, when investigating this topic (Guralnik, & Kaplan, 1989; Michael, Colditz, Coakley, & Kawashi, 1999; Reed, 1998). In European studies, healthy aging in old age has been conceptualized as longevity and preservation of good health, significantly

influenced by individual life style choices such as nutritional, physical and smoking behaviors (Haveman-Nies, De Groot, & Van Staveren, 2003).

In other Canadian studies, healthy aging is operationalized as aging without disability, dependency, major depression, and with good health (Buckley, Denton, Robb & Spencer, 2004; Martel, Belanger, Berthelot & Carriere, 2005). It is also described (implicitly) as good health when individuals meet all four requirements: good functional health, independence in activities of daily living, positive self-perceived general health, and positive self-perceived mental health (Ramage-Morin, Shields, & Martel, 2010; Shields & Martel, 2006). Similar components of healthy aging described in other studies include cognitive function (cognition and memory), subjective well-being, physical functioning (ability to perform basic and instrumental activities of daily living), and self-rated function (ability to take care of yourself) (Oswald et al., 2007; Tyas, Snowdon, Desrosiers, Riley, & Markesbery, 2007). Less explicitly, Burke et al. (2001) defined healthy aging as staying alive and free of chronic conditions in late years of life.

From a strictly biological perspective, genes are thought to be responsible for the exceptional longevity of some older adults. For example, Danish centenarians who experienced healthy aging, also called healthy agers, were also those who experienced fewer hospitalizations and hospital days, and lived longer than their peers over time (Engberg, Oksuzyan, Jeune, Vaupel, & Christensen, 2009). Looking at cultured cell lines from 104 American adults aged 57 to 97 years old, an increased or decreased expression of specific genes with age had an effect on mortality rate of participants (Kerber, O'Brien, & Cawthon, 2009). In the case of 47 healthy older Canadians, Halaschek-Wiene et al. (2009) established healthy aging as a genetic trait which could be detected through the activity of particular genes regulating aging-related metabolic processes. Criteria to select study participants were adults aged 85 years and above

who have never been diagnosed with cancer, cardiovascular disease, diabetes, major pulmonary disease, or Alzheimer disease (Halaschek-Wiene et al., 2009).

Researchers' findings point strongly toward two key facets of healthy aging. Those are the maintenance of good health and the preservation of functional status as older adults grow older.

Older adults' perspectives. One qualitative study retrieved from the published literature introduced the views of healthy aging from a cultural point of view in a purposive sample of seven (three males, four females) Thai older adults aged 78 to 85 years (Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, & Steckler, 2009). The researchers in this study applied ethnographic methods through a 12 month period of field work in a Thai village to explore participants' ways of life that promote healthy aging. Although these researchers used single in-depth interviews with participants as primary sources of data, they also conducted additional interviews with primary caregivers and neighbors and focus groups with other Thai elders from the same village to confirm, verify and expand data. Two essential aspects of healthy aging were following family practices and being interdependent (Danyuthasilpe et al., 2009). Family practices included those related to culture, namely healthy lifestyle behaviors (eating right, exercise, healing practices) and spiritual acts (giving offerings, worshiping). Being interdependent included elements related to others: accepting support and sharing time with significant others. Hence, Danyuthasilpe et al. (2009) concluded that healthy aging is rooted in the Thai older adults' culture and incorporates physical, social and spiritual facets of healthy aging.

Besides the Dayuthasilpe and colleagues' study (2009), little recent published research was found relating to healthy aging from the perspectives of older adults' themselves as of

September 2011. There is also a gap in the literature about older Canadians' conceptions of healthy aging despite the interpretations of healthy aging from policy, research and practice arenas in Canada. Specifically, it is intriguing that published literature regarding priorities of Canadian older adults is scarce, even though public input is reported in building related healthy aging policies (KMPG, 2002).

Debate within the literature: whose views are relevant?

After reviewing the healthy aging literature, it is clear that multiple definitions and frameworks are used across policy, research and practice fields despite the lack of published work on older adults' views. Therefore, it seems worthwhile to ask whose views on healthy aging are most relevant. Moreover, some researchers emphasized the need for more research to establish social relevance of researchers' definitions (Bowling, 2006; Hung, Kempen, & De Vries, 2010; Peel, Bartlett, & McClure, 2004). This raises the question of how well policy makers, practitioners, and researchers are informed about older adults' views on healthy aging.

Others have questioned the relevance of positive aging discourses such as healthy aging and how well these reflect the diversity among older people and their aging experiences. Dillaway and Byrnes (2009) commented that such discourses were a representation of a mainstream political ideology, which imposes the aging views of few people (decision makers) as societal values. In a similar vein, Canadian advocacy groups argue that 'positive' aging concepts still remain more popular while examining the needs of non-immigrant older adults than those of immigrants and refugees (Luhtanen, 2009). Tornstam (1992) and Ryff (1982) further echoed that the emergence of many aging discourses (theories and definitions), as well as older adults' behaviors, are deeply rooted in cultural and historical contexts. Therefore, aging perspectives cannot possibly fit the experience of all older adults. The perceptions of realities of aging reflect a range of functional status and disability level, and involve a diversity of races and

cultures, socioeconomic status, genetic predispositions, and gender (Holstein & Minkler, 2003). Canadian older adults are not an exception, and older immigrants expand further population diversity (Luhtanen, 2009).

Greater consideration of the sociocultural environment in studying healthy aging is also needed. Despite the sociocultural context in Canada, little information is accessible in the published literature about older adults' views on healthy aging in Canada. Although older Francophones represent an official linguistic minority group, little is known in terms of what healthy aging means to them and what their needs and priorities are to enhance their capacity for healthy aging. Hung, Kempen and De Vries (2010) came to the conclusion that different dimensions of healthy aging have unequal importance based on cultural contexts, although healthy aging research has been limited worldwide. A recent study of British older adults provided added evidence of cultural differences in aging views and experiences when comparing an ethnically diverse group and two groups of older adults of mainly European descent (Bowling, 2009). Indeed, cultural environment may play a role not only in how older adults view their aging experiences (Collings, 2001), but also in what types of lifestyles and activities they get involved in (Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, & Steckler, 2009). For example, culture and immigrant status of sub-population groups of older adults were associated with the quality of their aging experiences (Litwin, 2005). Therefore, I will engage in research that ultimately builds knowledge on healthy aging among older Francophone adults in Canada.

From my perspective, more research is needed to explore the healthy aging views of Canadian subgroups of older adults such as older Francophones and how these views measure up against the perspectives reported in existing studies and frameworks for improved program planning and interventions. Locally, the ARM was developed as a guiding framework for

program planning and interventions targeting older Albertans. However, little is known about the involvement of different linguistic and cultural groups in developing the ARM (KPMG Consulting, 2002). Recognizing that culture (including language) is a determinant of health (Public Health of Canada, 2004) and considering the official bilingual context of Canada, I believe that it is vitally important to investigate the views of healthy aging from the standpoint of older Francophones in order to best tailor existing healthy aging programs and services targeting that population. Reflecting on my own nursing experience, I have provided health promotion education and activities to community living older Francophones. But despite my francophone background, I agreed with Leininger's philosophy (derived from Leininger, 1988, 1996) that being knowledgeable about clients' own expectations of healthy aging would facilitate the provision of adequate and effective programs and services.

In summary, this literature review concluded that the healthy aging concept is well defined in policy frameworks, in health promotion programs and services, and in research agendas to promote better health in older age. However, little is known regarding older adults' perspectives of healthy aging and there are no previous studies in the French-language or in the English-language published literature discussing the perceptions of healthy aging of older Francophones in Canada at the present time. Locally, this information is needed to examine whether existing healthy aging frameworks and conceptualizations, as well as programs and services, address the needs and priorities of this population. To address this gap in the literature, the research question, "what are the perceptions of healthy aging of older Francophones living in Edmonton, Alberta?", was explored in a qualitative study. In the following chapter, the method used for this study is described.

Chapter 3: Methods

The purpose of this third chapter was to outline the research methods that were used to explore and describe the perceptions of healthy aging of older Francophones living in Edmonton, Alberta. In this chapter, the research design, sample, data collection strategies, ethical considerations, steps involved in data analysis and rigor will be discussed.

Research Design

Because qualitative research is appropriate to study research questions that have been seldom investigated (Wood & Ross-Kerr, 2006), Interpretive Description (ID) was selected to conduct this nursing research study. ID was conceptualized originally to build a research method compatible for nursing as a discipline and a profession that is building its own knowledge based practice (Thorne, Kirkham, & MacDonald-Emes, 1997). In other words, Thorne and her colleagues (Thorne, 2008; Thorne et al., 1997) defined ID as a research method to facilitate nursing research and answer practice-related questions within Nursing and other applied or clinical-based health professions. ID is a qualitative method which helps to answer research questions by describing as well as interpreting the phenomenon under study to build meaningful knowledge that can inform nursing practice (Thorne, 2008). Thorne, Kirkham, and O'Flynn-Magee (2004) pointed out that "the foundation of interpretive description is the smaller scale qualitative investigation of a clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding" (p.3).

Therefore, ID was selected because it was an appropriate design to support this small qualitative nursing study as well as to investigate a research question focusing on participants'

experiences and perspectives of healthy aging as a relevant topic of interest to nursing practice. In this case, healthy aging is the focus of numerous health education programs delivered by community nurses targeting older Francophones in the Edmonton area. Because little is known about healthy aging from the older Francophones' perspective, using a descriptive interpretative approach was the appropriate choice for exploring and describing this phenomenon in my thesis work.

Sample

Recruitment activities. I recruited participants from places offering services and activities to older Francophones at la Cité Francophone which is located in the Bonnie Doon area of Edmonton, also known as the French quarter of Edmonton. Specifically, I approached a local older Francophones' organization (Federation of older Franco-Albertans [FAFA]) and I went to a Francophone retirement home, the Saint-Thomas Manor. Both sites are located in Bonnie Doon. This methodological decision was motivated by the fact that the latter two organizations provide services as well as health promotion and social activities for Francophone individuals and Francophone community groups. Thus, I sought approval from administrators at the FAFA and Saint-Thomas Manor to promote my study in these facilities. FAFA administrators also posted study posters in French on their office billboards and distributed study information prepared in French language via email to their members. I was also given permission to present the details of my study at two meetings, one at the FAFA office and the other, at a local church.

Study advertisements were also posted at the front entrance of the Saint-Thomas Manor, and two study presentations were given at suppertime in the resident dining room. During all the presentations, study information letters were distributed to interested older Francophones who

met the study inclusion criteria. All interested and eligible persons were asked to contact me through a dedicated telephone number as stated in my study information letter.

Sampling technique and sample size. Purposive sampling (Magilvy & Thomas, 2009) was used to recruit eight participants. This fitted well with this study as it allowed me to target study participants who had great insight on the topic under investigation and were willing to share their views. Targeted participants were older Francophones involved in health and social activities within the Francophone community. I anticipated that targeted participants would be very highly knowledgeable about healthy aging and provide insights from a Francophone standpoint. According to other qualitative researchers, the ideal study participants must have experienced the topic under study, must have great insight on the topic under investigation, and must have the ability to communicate with and the willingness to share their experiences with the researcher (Magilvy & Thomas, 2009; Speziale & Carpenter, 2007; Thorne, 2008).

This fitted well with this study as it allowed me to target study participants who had great insight on the topic under investigation and were willing to share their views. Targeted participants were older Francophones involved in health and social activities within the Francophone community. I anticipated that targeted participants would be very highly knowledgeable about healthy aging and provide insights from a Francophone standpoint. According to other qualitative researchers, the ideal study participants must have experienced the topic under study, must have great insight on the topic under investigation, and must have the ability to communicate with and the willingness to share their experiences with the researcher (Magilvy & Thomas, 2009; Speziale & Carpenter, 2007; Thorne, 2008).

Consequently, the study inclusion criteria were: : (1) 65 years of age or older; (2) living in the community of Edmonton; (3) self-identifies as a francophone, (4) currently involved in

health promotion and social activities, (5) willing to participate in this study, (6) gives consent independently, (7) willing to participate in a face-to-face interview for one to two hours.

Between the month of December 2011 and February 2012, a total of 8 study participants were recruited. According to Thorne (2008), the sample size should be chosen to provide enough information to answer the research question. Morse (2000) agrees that fewer participants are needed to reach saturation when a question under study is specific and not complex, and when selected participants are highly qualified to discuss the topic under study and share rich information. Therefore, recruiting up to eight participants for this study was adequate to answer my research question.

Participants' characteristics. Eight older Francophones of French Canadian descent took part in this study. Six were female and two were male; they ranged in age from 73 to 93. Six participants were born in Alberta, one in Saskatchewan, and one in Europe; the length of time they resided in Edmonton ranged between six to 57 years. Only three participants reported having only French as a spoken language at home; others used both French and English. Two participants were single, four were married, and two were widows; three had high school as highest education level and five had attended university. Participants' incomes ranged from at least $6,120 to $36,000 per annum, and while three lived alone, one resided with a roommate and four others with their spouses. Two participants have been living at the Saint-Thomas Manor between nine to ten years. The other six participants who were enrolled through a community group (following FAFA referral) have been participating in this group for one to five years. All eight participants reported being in good to very good health, despite having at least one chronic health condition (see Appendix A).

Data Collection

Preparation of bilingual study materials. Prior to recruitment, all study related materials were prepared in both French and English to accommodate all participants' language preferences. These materials included the recruitment poster (Appendix B), information letter (Appendix C), consent form (Appendix D), interview scripts (Appendix E), and participant information sheet (Appendix F). Offering bilingual materials and using participant preferred language during interviews (Fryer, Mackintosh, Stanley, & Crichton, 2012; Squires, 2008; Twinn, 1997) was appropriate. It was important to accommodate language preferences of participants because Francophones living in a minority context may not use their mother tongue literacy skills on a daily basis, despite being attached to their linguistic culture (Corbeil, Grenier, & Lafreniere, 2006).

During the course of this study, I translated all interview data. I thought this appropriate given Squires's (2008) definition of a suitable translator as "a person who has pursued intensive study in language or lived in the country or region of the participant's language" (p.268). As a Francophone graduate student attending an English-speaking institution, I am fluent in French and English and somewhat knowledgeable about the Francophone culture under investigation in the Canadian context. I have also been involved in delivering health promotion activities to older Francophones in Edmonton in the past (Esso & Black, 2011).

Prior to the start of the study in September 2011, an independent nursing scholar performed data translation checks of the French and the English versions of all study materials to ensure correspondence of meaning as suggested by Chen and Boore (2009). This independent scholar was a Francophone and a Master's-prepared nurse who has been advocating for the delivery of culturally competent health-related support services to older Francophones in Edmonton. Hence from Squires' (2008) point of view, this bilingual scholar was an appropriate

choice, particularly given his ability to use words and sentences in a second language appropriately to the cultural context to which they belong. Obtaining this independent scholar's feedback helped me to corroborate bilingual study materials prior to entering the field. This is necessary to ensure the appropriateness of translated study materials as bilingual speakers tend to struggle with the direct translation of some expressions (See Brislin, Lonner, & Thorndike, as cited in Birbili, 2000).

Interviews. Interviews are considered a defensible means to elicit subjective or personal knowledge in ID studies (Thorne, 2008; Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Kirkham, & O'Flynn-Magee, 2004). I wanted to capture what healthy aging meant to older Francophones and, in the process, gain a culturally-fitting understanding of this subject matter. Overall, I performed a total of eight interviews over a three month period (December 2011 to February 2012). Interviews took place at participants' places of residences and lasted between one to two hours each.

At the start of the interview, study information letters were reviewed with the participants in their language of choice and consent forms were signed. A copy of the study information letter and the consent form was left in each participant's home. An interview guide with one open-ended question and prompting questions was used to start the discussion of older Francophones' perspectives on healthy aging (see Appendix E). Each interview began with a broad question: "…What does healthy aging mean to you?" (see Appendix E). This allowed participants to share their own perspectives without tailoring their answers to a pre-existing agenda (Ryan, Coughlan, & Cronin, 2009). I used additional interview techniques to facilitate greater understanding of intended meaning of participants' views throughout each interview. These techniques included listening carefully and seeking immediate clarification by probing or asking for additional

thoughts, paraphrasing, and allowing participants to think through moments of silence (McConnell-Henry, Chapman, & Francis, 2011). After each interview, demographic and health-related data were then collected.

Although a total of eight interviews were conducted, I only interviewed one to two participants on a given day. Opinion questions on specific aspects of healthy aging emerged from interviewing one participant after the other and these questions were added to subsequent interviews to help with probing and clarifications. Doing so is an acceptable method of concurrent data collection and analysis central to ID (Thorne, 2008). In other words, my early impressions from one interview were used to inform consecutive interviews. Therefore, consecutive interviews were informed by early analytical hunches. New questions or probes to clarify data were thus generated as I progressed from one interview to the next. The same method was used by Carlander, Ternestedt, Sahlberg-Blom, Hellstrom, and Sandberg (2011). All eight interviews were audiotaped and transcribed into text in the preferred language of the interviewee.

Note-taking was also part of data collection and offered a platform to support data analysis later. Two types of notes recorded in this study were memos and field notes. Memos were written notes that documented research activities and methodological decisions, analytical reasoning, and personal critical reflections in ambiguous situations pertaining to related-research activities (see Birks, Chapman, & Francis, 2008).

Field notes were defined as personal notes taken during fieldwork (see Friedemann, Mayorga, & Jimenez, 2011; also see Montgomery & Bailey, 2007). I recorded field notes after each interview and included the location of the interview, time of the day and length of the interview, as well as verbal and nonverbal cues from participants, any unusual events, and the

researcher's personal observations and impressions (see Speziale & Carpenter, 2007). Non-verbal cues, for example, consisted of how easily participants' engaged in conversations with the researcher and their emotional expressions. Verbal cues of interest included participants' expressions and ideas that were recurrent during an interview. The utility of these field cues will be further discussed in the data analysis section of this chapter.

Ethical Considerations

This project proposal was submitted to the University of Alberta Health Research Ethics Board Panel B for review and approved on November 9th, 2011. I then sought administrative and organizational approvals from FAFA and Saint-Thomas Manor to recruit participants. Interested and eligible participants received a study information letter and a copy of the consent form. Informed consent was received from all participants that included an explanation of the nature of the study, their involvement, any benefits and risks, confidentiality and withdrawal clauses, and researchers' contact information (see Appendices B & C). Each participant was also informed in the letter and verbally before each interview that his/her name or identifying information would not appear in anyway when the findings of the study were reported. Participant names were replaced by code numbers on all transcripts, demographic and health-related forms, and field notes.

During the research project, each participant was informed that he/she was free to decline answering any questions or discuss any subject matter during the interview. Participants were also made aware that they could withdraw from the study anytime with no consequences whatsoever. Participants were also given a list of phone numbers to be able to contact me, my supervisors, and the University of Alberta Human Research Ethics office in case any questions or concerns arose about the way in which the study was conducted.

All interview materials (audio recordings, original transcripts, and demographic and health-related information) were saved in the password protected computers belonging to Dr. G. Low and Dr. B. Parke, through the Faculty of Nursing Network system. All of these documents will be kept for an additional five years as per University of Alberta research policy.

Data Analysis

Data interpretation is part of the meaning-making activity through the whole analytical process (Thorne, 2008). Data interpretation involved inferring meanings about healthy aging embedded in participants' interviews gained from processing audio recordings to identify themes grounded in the data. Participant demographics and field notes were considered useful to enhance data interpretation (Bailey, 2008). In this study, participant information and field notes were both records of contextual details needed to make sense of the data.

Interview data analysis. The main focus in data analysis was to describe and interpret the meaning of healthy aging from participants' interviews. It was a complex procedure which involved working with translated data. Major steps involved in this process were (1) interviewing each participant in their preferred language (French or English) and transcribing interview data, (2) writing narrative summaries for each transcript, (3) getting a translation check of narrative summaries by a professional translator, (4) coding iteratively between English transcripts and summaries, (5) clustering similar codes into categories, and (6) clustering like-categories into key themes (see Figure 1). Although these analytical steps were described in a sequence to report methodological strategies, they were not executed in a linear fashion as all interviews were treated individually and collectively through constant comparison analysis.

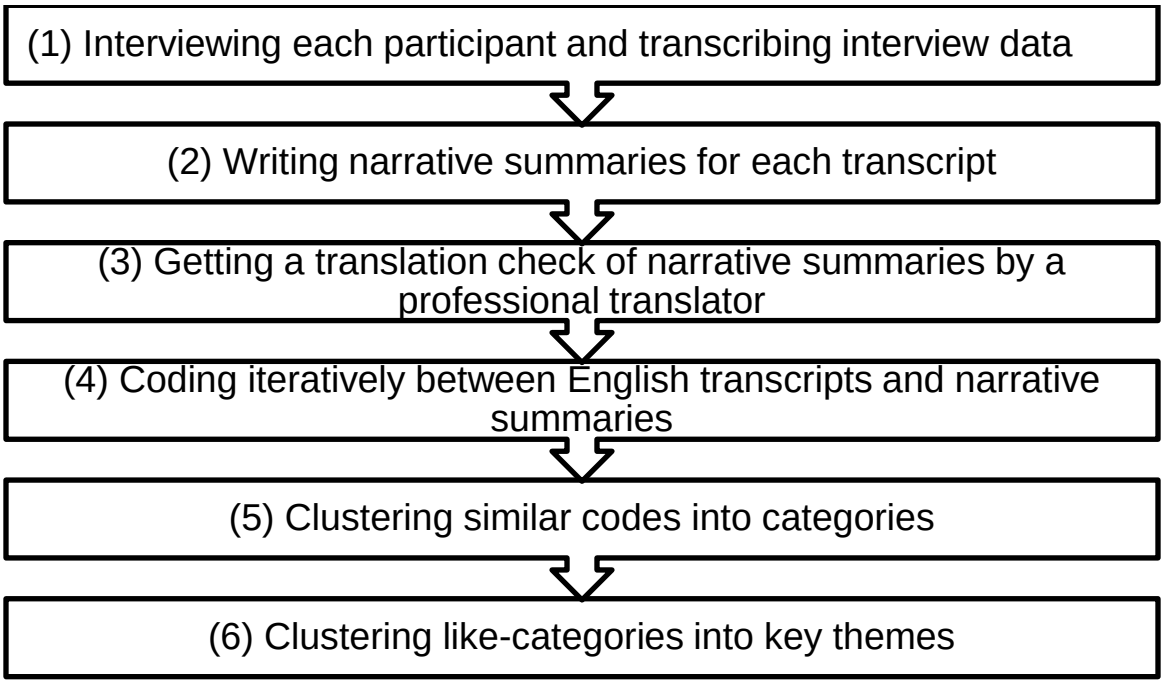

Figure 1: Schematic illustration of the data analysis process.

Step 1: Interviewing each participant and transcribing interview data. After conducting participants' interviews to collect data, a protocol for data handling was written to guide both the transcription and translation processes of all interviews (derived from McLellan, MacQueen, & Neidig, 2003; also see Nikander, 2008). After the transcription of the interviews in French from the audio recordings, I performed the translation of transcripts to English which was the language of instruction for the MN (Master of Nursing) program at the University of Alberta Faculty of Nursing, and thus of my supervisory committee. Features of the French transcripts, such as contracted forms of words, false starts or speech repetitions, and non-verbal noises, which did not contribute to the clarity or the fluency of the text were not translated in English. However, other features of the French transcripts that informed the reading and the understanding of the written text were kept, including pauses, interruptions, background noises, and emotional expressions such as laughing, smiling, and coughing.

During data translation, decisions were made to focus more on translating into English the key ideas embedded in the interviews, not speech mechanics and grammar per se. This way, the meaning of healthy aging could be captured using the exact words of older Francophone participants. According to Oliver, Serovich, and Mason (2005), decision-making during transcription and translation must be considerate of participants' voices as well the research question and design. As well strategies that inform the question under study must be emphasized by reaching an agreement on how much emphasis had to be put on the content of the interview instead of on the specifics of communication and vice-versa (Oliver et al., 2005). In this study, seven out of eight interviews were mostly conducted in French and thus translated from French to English using my personal knowledge, and paper and online bilingual dictionaries (Correard, 1996; Kellogg, 2012; Larousse, 2008; Pratt, 1998; Softissimo, 2008).

Step 2: Writing narrative summaries for each transcript. After the transcription and the translation of each interview, I wrote corresponding narrative summaries to establish a data translation check point. According to Dixon-Woods, Agarwal, Jones, Young, & Sutton (2005), a narrative summary "typically involves the selection, chronicling, and ordering of evidence to produce an account of the evidence. Its form may vary from the simple recounting and description of findings through to more interpretive and explicitly reflexive accounts that include commentary and higher levels of abstraction" (p. 47). Therefore, narrative summaries represented a synthesis of all key ideas of healthy aging embedded in each transcript. These key ideas were highlighted by reading repetitively transcripts in both languages and using color coding. Keeping with ID, narrative summaries were used to describe only what participants said about healthy aging. And I had summaries in French and English to check for the equivalence of

meaning between the two languages as prescribed by other researchers (see Chen & and Boore, 2009; Squires, 2008).

Step 3: Getting a translation check of narrative summaries by a professional translator. A paid professional translator was then asked to check narrative summaries in French and English for correspondence of meaning and accuracy. This step is necessary to ensure an accurate translation of key ideas and to minimize any possible loss of meaning between languages (see Chen & and Boore, 2009; also see Squires, 2008). This professional translator helped me improve the fluency of the English narrative summaries by providing me a feedback on grammatically correct terms in English. She was a bilingual Francophone who held a Bachelor of Arts in French Literature and a Master's degree in Library Sciences from a bilingual University. She also had several years of experience as a librarian in a Francophone setting in Edmonton, and as a consultant for translation and interpretation services in the Francophone academic and community contexts in Edmonton.

Step 4: Coding iteratively between English transcripts and summaries. Once the translation check of narrative summaries for correspondence of meaning and accuracy was completed, I began to code in English using a constant comparative method, which is central to ID (Thorne, 2008). I returned to the original transcripts in an iterative process wherein I coded between the English transcripts and the narrative summaries. The comparison within individual interviews and between interviews involved uncovering similarities and differences between portions of data and their interpretation (Boeije, 2002; Thomas, 2003). Initial codes were generated by reading carefully and comparing fragments of text within and between individual summaries and transcripts. These codes were made of words close to the data and were used to label data. And a different font was attributed to keep track of codes between participants.

Step 5: Clustering similar codes into categories. Codes that fitted together were grouped together to form categories. Categorizing codes meant to group them according to the conceptual relationships identified within the codes (Boeije, 2002; Grubs & Piantanida, 2010). Subsequently, similar smaller categories were aggregated to articulate data in a more structured and concise manner. At this point, nine higher level categories were retained which were adopting healthy practices; living with faith and staying positive; being connected to others; living on an adequate income; living and aging in supportive living places, remaining in control of personal affairs, keep learning, living in line with personal values, and aging in French.

Step 6: Clustering like-categories into key themes. According to Thorne (2008), using an ID methodology leads to render study findings into a thematic description. From the point of view of two nurse researchers, the function of the term 'theme' in nursing qualitative research is "to make explicit the implicit meaning of dialogue, behavior, and events. Themes are defining points and indicators of important issues. Themes are representations of important aspects of, and issues in, the lives of peoples. These aspects and issues should give rise to and prioritize health care interventions" (DeSantis & Ugarriza, 2000, p.367). From another perspective, themes are also interpretive in nature and purposely used to provide an understanding of recurrent patterns embedded in portions of data in order to answer the research question (Sandelowski & Barroso, 2003; Seers, 2012). One way of formulating themes is by combining categories (DeSantis & Ugarriza, 2000). Thus, two or more identified categories found to be related to each other were further clustered and interpreted into a few key themes representing what was understood about participants' perspectives of healthy aging, and these themes led me to further conceptualize healthy aging from a French-Canadian perspective.

Field note analysis. Field notes were used to record initial observations and ideas after interviews, and were helpful during data analysis. These notes were not used to provide additional data, but rather to provide contextual details for a more informed data interpretation process. Field notes were also used to check for coherence between early analytical hunches and study findings. I asked two questions when reviewing the field notes: (1) Were my initial observations and analytical hunches about healthy aging supported by study findings? (2) Did my initial observations and analytical hunches add complementary information to study findings?

My field notes helped to confirm study findings. For example, I better appreciated the meanings of living with faith when I recalled religious ornaments on participants' walls or clothing. My field notes also drew my attention to 'odd' occurrences during interviews such as different understandings of the same question by participants. To further illustrate, I kept notes on my words which were understood differently by participants such as 'resources' which was interpreted as either 'financial means' or 'information'. Or my field notes underlined words overly emphasized through the interviews such as 'to keep going', 'to keep active' or 'to keep alert'. These examples stimulated some critical reflection about the inferences I made regarding what participants said.

Strategies to Achieve Rigor

Criteria to ensure rigor in this qualitative study included credibility, auditability, and fittingness (Guba & Lincoln, as cited in LoBiondo-Wood & Haber, 2002). Credibility means findings were judged as coherent (LoBiondo-Wood & Haber, 2002). To meet this criterion, participant checks at different periods of the interview were performed by re-stating what

participants shared about healthy aging and by listening to their corrections or clarifications (as per Thomas, 2003). In addition, two members of the supervisory committee (GL/ BC) conducted an independent review of three transcripts and provided feedback against corresponding narrative English summaries to ensure that participants' perspectives of healthy aging were adequately portrayed. The (as above) supervisory committee also executed an independent coding of two narrative English summaries and these were compared against my own preliminary coding to reach consensus on coding and categorization processes. Moreover, being reflexive through the research process, as prescribed by Thorne and colleagues (Thorne, Kirkham, & O'Flynn-Magee, 2004), was helpful to ensure that my interpretation of the data was grounded in participants' perspectives, not in my personal assumptions about healthy aging. As part of being reflexive, I paid attention to several issues that could tarnish the credibility of this study. I avoided "going native" (Thorne et al., 2004, p.8) by questioning the influence of my Francophone background on study findings. I reflected upon the impact of my personal and professional knowledge in shaping early findings in the analytical process and explored alternative interpretations to avoid "premature closing" (Thorne et al., 2004, p.8). I suggested implications from study findings to nursing practice to avoid "bloodless findings" (Thorne et al., 2004, p.8) that fail to build more practice knowledge in promoting healthy aging.

As well, strategies to ensure the accuracy of translated data, with a focus on translating for meaning in context, included the support of two language assistants which reviewed study materials and summaries of key healthy aging perspectives of participants. According to some authors (Birbili, 2000; Squires, 2008, 2009), it was imperative to be accurate in translating qualitative data as well as to be explicit about translation strategies in order to preserve the integrity and the credibility of the proposed research.

Auditability refers to accountability in relation to demonstrating and documenting each decision in the analysis process (LoBiondo-Wood & Haber, 2002). I met this condition by writing memos to provide an audit trail about my decision making related to the collection of data, my analytical reasoning, and any critical reflections about the study in general and providing quotes to support descriptive and interpretive accounts of the data.

Fittingness reflects the ability to provide enough information to inform the practice or research projects of nursing colleagues and other professionals (LoBiondo-Wood & Haber, 2002). This criterion was met by my reporting on healthy aging from the perspectives of older Francophones and these views will be subsequently with program deliverers whose aim is to promote healthy aging among older Francophones living in Edmonton.

In sum, this chapter detailed the research methods used to explore and describe interview data collected from eight older Francophones of French Canadian descent living in Edmonton, Alberta. This data pertains specifically to what healthy aging means to this target group. In Chapter 4, these perspectives are presented in detail.

Chapter 4: Research Findings

The purpose behind this study was to explore and describe the healthy aging perceptions of community dwelling older Francophones using Interpretive Description as a research design. In this chapter, I present the findings articulating the specific healthy aging perceptions of eight older Francophones of French Canadian descent aged 73 to 93 years old living in Edmonton. These older Francophones were interviewed at their places of residence between December 2011 and February 2012. Audio recordings of interviews were then analyzed to identify key perspectives of healthy aging and interpreted in the light of memos and field notes. All interview quotes displayed in this chapter were assigned a code number between F1 and F8 which represent each study participant. And brackets were used to add clarifications to selected quotes.

Older Francophones in this study perceived healthy aging as a multifaceted concept. Their perspectives on healthy aging revolved around three central themes which are protecting health, maintaining dignity, and preserving identity as ways to promote, support and facilitate healthy aging. These three themes were interrelated and co-existed all together through participants' perspectives of healthy aging (see Figure 2). I have organized the chapter according to these three themes.

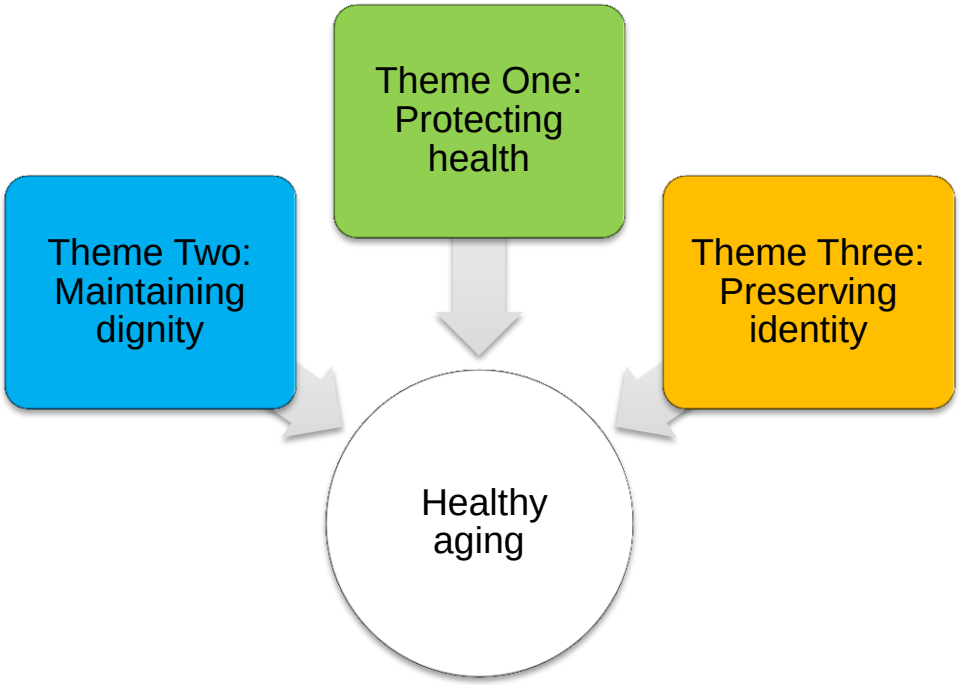

Figure 2: Themes of healthy aging.

Theme One: Protecting Health

Older Francophones in this study strongly emphasized that protecting health in older age was an important theme of healthy aging. Protecting health meant for participants to take actions to keep in good health "to enjoy their old days" (F8) despite experiencing a number of challenges. Five categories of the theme 'protecting health' were identified from participants' narratives. These categories represented factors that contribute to protect participants' health for healthy aging: Adopting healthy practices, living with faith and staying positive, being connected to others, living on an adequate income, and living and aging in supportive living places (see Figure 3).

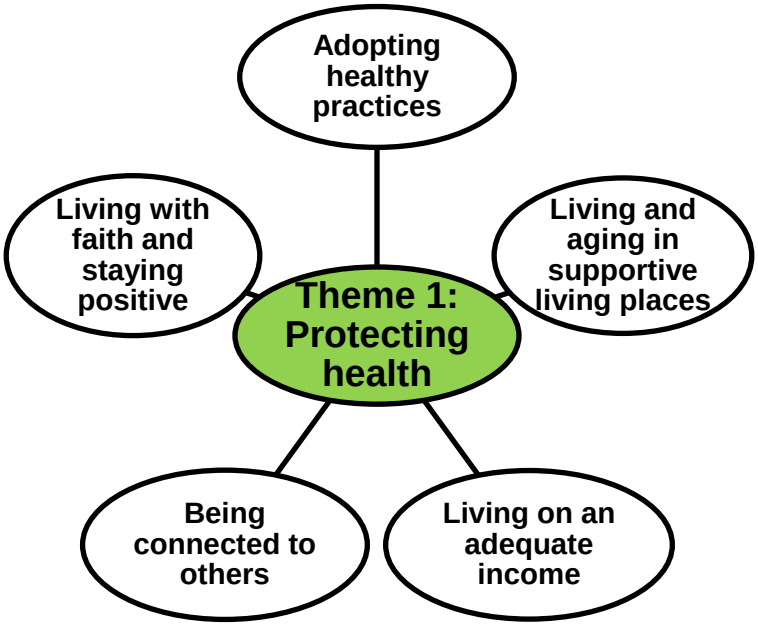

Figure 3: **Theme 'protecting health' and categories.**

Adopting healthy practices. All study participants highlighted adopting a variety of healthy practices to protect their health for healthy aging. The adoption of healthy practices was aimed primarily at protecting the physical aspect of participants' health. Keeping healthy physically in older age was perceived as a key aspect of healthy aging. One participant specified which body parts, for example, were important in aging in good health. She commented by saying "to have a good body health [healthy body]", and "to control your weight…to monitor the health of our eyes…to have a good dental hygiene" (F6). These data pointed toward the importance of staying in good health physically as part of aging in a healthy manner. Another participant defined healthy aging as not experiencing any illnesses and being physically fit. He said, "Growing old in good health [Healthy aging], it means…to enjoy good health…it means…what we can say [what can we say]? …good health that is not to be sick, that is to be in

good form, that is to be healthy" (F2). In another comment, the same participant highlighted not experiencing chronic diseases, but having only minor health problems as healthy aging. He said, "That means…not to be sick for example, chronic diseases, to be free of …not to have these diseases…not to have big diseases…to have little things from time to time" (F2). In these definitions, participants focused on health status as a barometer to measure healthy aging.

Experiencing challenges to their health further explained participants' desire to adopt healthy practices for better health. These challenges were the physical changes affecting health functions and functional abilities. They were perceived to be inherent to the aging process and were an inevitable part of growing older. One participant expressed it in these terms: "More you grow old, the more you face some problems…that you cannot always control…So, we cannot always grow older in very good health" (F3). Living to older age was equivalent to living with uncertainty, not knowing how long a person will remain healthy:

> **We realize that after 80 years…You live a day at the time, it is going well. Today, you do this, it is going well, but tomorrow, you do not know! So, you realize that, the years are passing by and then, you are more at risk now that your existence is declining. (F6)**

One participant described noticing changes in her memory and physical performance in older age compared to younger age.

> **Healthy aging, I think it has a lot to do with accepting what happens when you age. It could be about your memory. I experience that! Like, names become …Or, you put down something, not even two minutes later, you do not remember! You ask yourself, what did I do with it, it is like you never did that action…You know, it is**

> **gone! So you have to learn how to live with that! You should also learn how to live…I cannot push my body to do things that I could do before like running! I accept that I cannot run like before. Things, all that is concerned with such things. I think I have to accept that. (F7)**

For the older adults in this study, it seemed challenging to experience healthy aging as a person goes through the normal aging process as they seemed to perceive these changes affecting physical health as inevitable.

Adopting healthy practices was then considered essential to minimize the impact of physical health and activity challenges that participants experienced in aging. Participants thus appeared proactive in seeking and using a variety of strategies to deal with specific health concerns and promote good health. Coping strategies were tools or resources used to overcome physical and cognitive changes that participants experienced as they grew older. These tools allowed participants to keep pursuing various activities efficiently in their daily lives. One participant shared that physical aids helped her to remain mobile and to continue to see. She said, "there are some means…to walk…I have my walker. And then, for my eyesight, I take my lens" (F8). To deal with her episodes of memory loss, another participant developed an attitude of consciously doing routine tasks such as planning for activities, driving or remembering people' names:

> **How will I take measures to remember things? For example, I will make myself some dates to remember. Things like that. So, for example, I forget when I have this or that meeting. I go back to my sheet. So there is not tension here. There is no shock, no stress. Things like that. And also, I think I have not yet completely**

> **mastered that, but…For example, to say ok. I put this particular thing at this particular place. Consciously. You know, I put this document at this place. Well, to give myself a chance that it sinks in. So, I think, it is to become conscious…you have to become conscious of your actions. It is because it was easier before to do things. You know, well, there is this and that. It is working, it is going well. Whereas now, I have to be conscious, today, what day of the week it is, and then what do I do? What task do I have to do today? Or what outing or? You know, it is to be more conscious. Where I notice it a lot, it is when I get in my car to go somewhere, let us say to St Albert. Which way do I go? I have to go this way, you know, consciously. It is at all the levels, like in my relationships too. When I see someone, I have to say, what is his [or her] name? [laugh] You know, I become more conscious. (F7)**

In addition to coping strategies, common self-care strategies that participants used to protect their health for healthy aging were eating healthy food, exercising, and consulting medical professionals for advice and treatment. Participants privileged eating healthy food to promote healthy aging. Healthy food was recognized to be a healthy diet made of "less meat…more vegetables and fruits" (F4) and "food that you can digest" (F1). As one participant acknowledged that health concerns cannot be avoided in older age, she described prioritizing eating healthier to prevent diseases. When a participant was asked what healthy aging meant, she replied:

> **To do what we can to keep ourselves healthy, but…while aging…[pause] More you grow old, the more you face some problems…that you cannot always control…So, we cannot always grow older in very good health…But, it is up to each person…we can do better in our own condition…In my case, I am 90 years old…So, I followed a**

> **course on diabetes…And that course helps me a lot to eat better…Even though I do not have diabetes…But to eat better. (F3)**

Exercising alone or with others was another strategy for healthy aging. When one participant was asked about healthy aging, he said that "you have to move you have to exercise or take a good walk" (F4). He further described his exercising routine while watching television in these terms:

> **When I listen to the news, I developed a system, I have some rubbers. When you are listening to the news, you can do that… Yes standing… [Participant is getting up to go to the front closet to show some elastic bands used for exercising to the interviewer]. (F4)**

Another participant talked about following a fitness program with her neighbors:

> **We follow some exercises especially for older people…The active life of Kino-Quebec [resources for active living sponsored by the Quebec government]. We have it twice per week. It is a disk, a cd, you know…And then we meet every, we are about, this morning we were seven...Sometimes, we are up to 10…And then, we do all the exercises together. (F8)**

Consultation with medical professionals was another strategy for participants' health regimen in support of healthy aging. Mainstream medical doctors were often visited for routine care:

> **You notice, if there are small changes, you go to see the specialist. But every year, we go to visit the ophthalmologist, the optician…And then, he tells us if there is**

> **something that is not going well, and…we see our doctor from time to time, to renew our medications. (F6)**

In addition to conventional medical care, the use of "alternative medicine" (F2) to complement or to replace conventional medical treatments was also said to be crucial for healthy aging. Because she viewed sickness as having natural causes, one participant explained further why taking medications instead of natural health products was not perceived as a solution to cure sickness:

> **When your body feels sick, it is not because it lacks drug, it is because it lacks something natural from the food something natural which provides you the essential vitamins and then the essential supplements…it is not because you lack drug…but doctors do not learn anything else. (F1)**

Likewise, another participant talked about seeking advice from other professionals specialized in alternative medicine which offered broader options than medication and surgery. He said, "The doctors are good for drugs and for surgery other than that…you have to go elsewhere…there are homeopaths naturalists chiropractors acupuncturists" and "There is a variety of things you can try" (F2). This showed that these participants were open-minded in using even less conventional medical care options to protect their health. In sum, all these strategies revolving around diet, physical activity, resources for coping and medical care indicated that participants were actively adopting healthy practices to take care of their health.

Living with faith and staying positive. Although participants emphasized adopting healthy practices, they also valued living with faith and staying positive as contributing factors to protect their health for healthy aging. Living with faith and staying positive were two attitudes in

support of spiritual and mental health. One participant explained that living longer can be associated with being more spiritual and keeping a positive attitude. He said, "I learnt that trappist monks used to live very old…so, spirituality has a lot to do with good attitude, live in peace, that [all that] has effects on health" (F2). From participants' perspectives, living with faith and staying positive involved holding a set of beliefs, spiritual practices, positive mindsets and feelings that appeared to enhance healthy aging.

When a participant was asked about the role that her Catholic faith played in healthy aging, she discussed how her faith was connected to her physical being:

> **It is like my breathing. If I stop breathing, I will die. Then my faith is like my spiritual respiration. It keeps me alive. It is part of my whole being. It cannot be separated. Well, that is my faith…it is all one. (F7)**

For this participant, faith was perceived to be part of the physical body and to be a factor contributing to health and wellbeing. Having faith was demonstrated through holding a set of beliefs focusing on God as a provider of blessings noteworthy for healthy aging. In this study, these beliefs referred to acknowledging a spiritual connection to a higher being and to his love, "the love of the good Lord the love of God that helps us all the time" (F8). One participant commented on how she viewed the positive impact of her beliefs on her health:

> **You know, who nurtures the way I age? The more I am in relation with the supreme source, the more I am healthy. Not only spirituality, but physically too…Because I have joy of living, it does not come from the wars and all that is bad in this world. My joy of living comes from all the good things from the Supreme Being. ...So, that**

> **affects how I will grow old, with joy, with hope, in joy, I say that is about it. When you are happy, there is not much that does not go well. (F7)**

This implied that holding spiritual beliefs in a beneficent God were associated with experiencing better health in older age.

Living with faith was also expressed by practising some rituals. These rituals were ways for participants to keep cultivating their beliefs. One participant shared how she "attends church on Sundays" (F3), and another one talked about praying, watching the mass on television, and reading her Bible:

> **Every evening when I pray, I thank God all the time to have given me a good day... Yes. And then, that is another thing, I listen to the mass almost every day on television...And then, that is really helpful…Well, when you read the scriptures, it gives you some ideas…not ideas, but it gives you some advice on how to live well. (F8)**

Living in accordance with biblical teachings was another illustration of living with faith. The Bible was considered to represent a code of behavior as well as a source of advice for healthy living. The same participant goes on to say that "when you read the scriptures it gives you some ideas…not ideas but it gives you some advice to live well" (F8). Likewise, another participant reinforced that it is about applying spiritual principles that keep people healthy:

> **A spiritual, religious attitude…That has a lot to do [pause]... Not to bear a grudge. All he said in the gospel. That makes sense. Because it keeps people healthy. That is why you can be happy and healthy. The gospel is not just affairs in the wind [meaningless]. It is true, it is practical. (F2)**

Therefore, it appeared that the application of biblical moral principles was considered to be paramount for healthy aging as they promoted healthy minds and healthy interactions with others. In contrast, one participant considered living with faith as being about more than just practicing religious tasks. She rather viewed gardening and being with nature as a spiritual experience:

> **Well, I'm not very spiritual, but I believe in…that there is something…I'm not that spiritual that I'm gonna go in the corner and, and pray for hours, that's not my thing! My thing, I like [it] better doing gardening, and I think that's nature…I like better being in, in the nature thing. (F5)**

It seemed that this participant viewed living with faith in a broader sense than strictly performing religious tasks.

In addition to living with faith, staying positive was the other attitude that promoted healthy mental states and protected participants' health. One participant talked about how a positive attitude promoted good health:

> **A positive attitude, it is a foundation of good health…If you are sick, it may be because you have a negative attitude…That has an effect on the whole body and the whole person…So you have to be joyful, happy, in good attitude…You know, *yeah*. Because it is not interesting to be sad. You want to come back to what makes you happy. That is how I see it. (F2)**

This topic further encompasses adopting positive mindsets for healthy aging. More precisely, one participant discussed being optimistic as not complaining. She said, "To live…with an optimist spirit, because what happens is that when someone starts to complain, then it seems like our lives

become more painful…so to live optimistically is the complete opposite" (F8). The same participant further identified enjoying her life as a way to promote healthy aging. She said, "It means to live well in joy, with pleasure, with a good health. Then to enjoy life…To enjoy life, my old days" (F8). She continued saying that "learning how to have fun" is helpful to "staying healthy" (F8). All participants in this study emphasized that experiencing positive emotions were supportive of healthy aging. One participant repeatedly emphasized "not to worry", because "stress kills many people" (F4). Another participant further commented on how negative feelings such as feeling upset could impact on health negatively:

> **If you live [if you are always] too [excessively], all nervous or tense or you live angry, it has an impact on your health…Because there are some hormones which answer to that [which are secreted in response] and which cause problems. (F2)**

All these negative feelings were seen as emotional stressors that were detrimental to a person's health.

***Being connected to others*.** In addition to adopting healthy practices and spiritual and positive attitudes, participants emphasized the contribution of social aspects to protect their health for healthy aging. This additional factor to keep healthy was to be social by being connected to others. Older Francophones in this study were connected to others as they kept good relationships with their social circles, made up of family members, friends, peers and the community at large, and avoided being alienated from them in order to support healthy aging.

Families were the key part of participants' social circles. Cherishing and maintaining family ties were important aspects of being connected to others to enhance participants' healthy aging experiences. Attachment to family was demonstrated through participants stressing the

importance of having family in their lives. To illustrate, one participant expressed how it was important over the years to keep in touch with her family:

> **I have 3 sisters…I have 2 here, but one lives in =Foreign country= …You see now, I call her about once a month…Before, we wrote some letters, but now, to call is not expensive, you know. So, there is that contact. And, yes also family becomes more important when you age because you have more time to think about them. …relationships are strong in families…you have grandchildren as you age…Who keep you, you have nephews, nieces, grandnieces, grandnephews, and your family even expand. It is not just your brothers and sisters, there are their children. (F7)**

Another participant also valued for healthy aging being close to her family and the time that she spends with them:

> **To keep ties with my family, to keep good company with my children…As long as we are on earth…To keep good relationships… It is the affection we have for our children, it is important to us. So, we want it to continue. (F6)**

Because participants cherished family ties, they talked a great deal about how to maintain these ties. For example, participants sought out occasions to spend time and stay close to their families by doing various activities together. One participant mentioned how often he communicates with some of his children on a daily basis:

> **Yes it is important to keep ties with family, but, these things [computer] are helpful, I can talk to my daughter at =Alberta town= every day, it does not cost her anything, usually, when she is at =Alberta town =, she contacts me one time during**

> **the day…And then, her brother is at his own computer, he is working…He joined us so we are all three of us. (F4)**

Additionally, being a source of support for each other was another way to further strengthen family ties. For example, one participant shared how she gave a hand to her children by babysitting their children:

> **We volunteer with our children…Volunteering, time to time, and then, they come often in the evenings…To keep the little ones…To keep the little ones, or to go and pick them at the bus if my daughter in law…is suffering [sick], or if she is going somewhere, we go to get them then we kept them at home. (F6)**

By doing various activities together, family members helped each other to meet some of their everyday needs**.** Married participants further described how their spouses played a role in doing tasks in their daily lives. For example, one participant mentioned how her spouse helped her to remain mobile:

> **There are people who cannot walk, so, if they are alone…Myself, I have my husband, so, I can always hold on to his arm…And then, I…it is not necessary that I always have my walker…So I can do without [the walker] when he is there…But, if I have to go too long [on long distances]…by myself, I have to have my walker. (F3)**

For this participant, receiving help from her spouse was important to overcome a physical limitation. For another participant, she would rely first on her close family members such as her children for support. She said, "When you [parents] need some help, your children are the ones who can provide it to you, not strangers, you should not always count on strangers" (F6). From this perspective, family was seen to be a more appropriate resource than others to provide

assistance in challenging or vulnerable situations. Across all participants' narratives, remaining connected to other family members, helping them and receiving help from them were protective for participants' health. Indeed, maintaining roles within families as well as relying on families as trusted resources were perceived to protect participants' health.

After family relationships, relationships with peers were also part of being connected to others. As they grew older, participants identified some key features of quality relationships with peers that they enjoyed and that kept them healthy as well. Quality relationships with peers seemed to emphasize a sense of friendship in interacting with peers as a way to keep healthy. One participant described how she experienced friendly and enjoyable moments with peers:

> **I think that it is bonifying. It is a bonification, to be in contact with people of your language, with whom you can share anything, oh well. More or less…But, some common things that happen to you, some events, even to share jokes, you need to relax as well, and that is helpful for old age, to be able to relax and have some opportunities to have fun. (F6)**

Feeling a sense of friendship with peers could be interpreted as an experience that uplifts personal wellbeing, which in turn enhances healthy aging from participants' perspectives. Participants also spoke of this sense of friendship in a way that meant it grew stronger and more meaningful with time. One participant explained that being retired gives you more time to build deeper and meaningful contacts with peers of the same age:

> **You see, in the past, you met a lot of people from work. And then, you know them…But only a small number of them become close friends…But these contacts are mainly built around work. When you leave your job, you leave all these**

> **contacts. Except, maybe some close friends, but it depends on where you worked…Sometimes, if you move away, you lose your contacts…So, when you belong in the Francophone community, for example, like here, you have other contacts…With people of your age, where you can have something in common. Because it is not at the level of work. It is at the level of relationships…Of affection, intimacy, interest. Things like that. And then, that is why at that time, it becomes deeper. (F7)**

This further suggested that keeping meaningful relationships with peers of the same age for this participant was a contributing factor that enriched her social experience in later life in support of healthy aging.

Another way that being connected to others enhanced personal wellbeing is by decreasing loneliness in older age which was seen to affect negatively a person's health. One participant shared how meeting with others distracted her from focusing only her health concerns:

> **I think that it helpful not to feel isolated as an older person. Because I think, it is important. There are some people that feel very isolated, for different reasons, there are people that have a hard time to live alone. And then, there are some people who find it difficult to go out, they are not comfortable [in the company of others]! Or I do not know. They were not formed to [used to], their social life was a bit limited maybe. But everybody needs someone. Now that families are so small, and so scattered. Sometimes, older people are alone…I think that … it keep us current, we are not isolated from the world. You know, you do not isolate yourself in your**

> **house…it prevents you from withdrawing yourself…You know, you are not there, thinking about your little problems, I am in pain here, I am in pain there. When you are with someone, another group, when we go to church from 11am to 1pm…I am not there, thinking about myself. I think of others around me. And after that, that is not over. When I come back home, I still experience it. (F7)**

From this participant, social isolation experienced by older people who lived alone or who did not have a close family made them ruminate more about personal issues such as health issues. However, being in the company of others seemed to protect this participant's health because it created opportunities for distraction or from dwelling on health issues. Despite their willingness not to be isolated from others, timing of social events and weather conditions were two factors that could potentially lead participants to experience more isolated lifestyles by preventing them from attending social outings. Most participants expressed not feeling comfortable going out in dark hours and during bad weather:

> **You know in the evening, we do not want to go out…When, it works for us, in the past, it was not the same. Of course, but…Now, we are afraid to go out, we do not see very well, and then, to park the car, it is a problem, so it is…No, it is rather stressful. When you think you also have to go out at night, it is…So, you avoid it! That is what is happening while growing old. We feel a bit, limited. Luckily, the weather is nice at the moment, but sometimes it is cold, so, we are not well, to go out. (F6)**

Besides being connected to family and friends, a contrasting view highlighted reaching out beyond these two primary social circles as an opportunity to enhance social connectedness

for healthy aging. Only one participant talked about how she kept involved in her community through her participation in different volunteer projects:

> **I still, I have a lots of projects, I have a gardening project which I'm the treasurer of it…And now, we want to hire a person, so I have to look for a person for 2 months, and then I applied for a summer student…So there is many things you can do, I have a group every Thursday, I have a group of …we give bread to low cost housing, and I have a group of teaching people how to sew, not that I'm a good sewer, but I have principles of sewing…And these are new people who have come to our country, and you know, you look at the news every day, you read at the paper, you keep, you keep…going, and if there is some petition to do, like we are doing in the front street, I think even if you are older, this is part of our community…I did a survey of 320 people to help the whole community to have a place to park, you saw how awful it is to park here…So we are involved in that, so you keep involved in your community even though you are whether an old lady or whatever. Right? So these are the kind of things. I love gardening, I do lots of gardening. In the summer, this is full of flowers…I have a community plot over there, at the college there, and that's my expertise, I think it's gardening, I know lots of gardening, that's why I keep [segment inaudible]…This project we have, is called generations growing and gardening together, and we've gardening together with new, new arrival people, new people from this [community] that who does not [who do not] know how to garden in low cost housing, and we have up to…last year we had 600 and some gardeners. (F5)**

Thus, being connected to others from this participant' perspective was also about remaining open-minded about social opportunities beyond a person's age group, ethnicity, or social class.

Living on an adequate income. Living on an adequate income was important to protect participants' health for healthy aging. It meant that participants had enough financial resources to afford products, activities, and lifestyles that keep them healthy. First of all, participants believed that living on an adequate income in older age appeared essential for healthy aging even though not all of them talked about financial hardship. One participant acknowledged that he was able to meet his expenses with his current income. She said, "We make a lot of charitable contributions, I have to make a new budget…because, the cost of living is increasing but our pension does not follow…but nevertheless, it is not bad" (F4). All study participants were retirees. With the exception of one participant who was fully financially supported by a religious congregation, the other seven participants solely relied upon fixed pensions and whatever savings they had accumulated during their working years (see appendix A). Relying on such meager incomes made participants potentially prone to financial struggles. One participant shared her thoughts about the hardship of relying only on government pensions:

> **I do not have financial worries as a member of a religious community. Which is, how would I say? Because we live together, we planned our future, and I worked most of my life. I really do not have a pension. Like my old age pension. Because I was working for the church. There was no pension there. And you know, we do not receive pensions for the work we did…No. So I worked, I had a small salary… Not a lot, but no pension. When I stopped working, I had nothing...Except my old age pension. But, you will not go far just with your old age pension…You know, your housing costs, and all that. But as a religious worker, I do not have these worries.**

> **But I can see that many older people have these worries. In relation to, unless you are rich. Finances are a source of major worries for lots of them…And then, now that Harper wants to cut the retirement age to 67, I can see that some people will be affected by that, I can see that they are worried. But today, it is not easy financially for many older people. It is not easy. (F7)**

This participant suggested that subsiding solely on government pensions was not only a source of stress, but it also limited her ability to afford the things that she needed to keep healthy during retirement years. Thus, living on a limited income was seen as a detriment to achieving healthy aging.

Because it was important to live on an adequate income, participants had to manage their financial resources through budgeting, saving, and monitoring their spending habits. Prior to retirement, financial resources were accumulated from working and saving. One participant recalled spending carefully while saving during her working years. This in turn allowed her to meet her own expenses and look out for her children's welfare:

> **We worked and did not make a lot at the farm, it was also hard…There were a lot of expenses! And our little savings, so you should not spend everything…So, I always saved, therefore, we always had money to give to our son. (F6)**

It is suggested that having enough financial resources through budgeting and saving in younger years allowed this participant to meet her financial needs later in life. After retirement, monitoring spending habits meant being cautious about how much things cost as well as not overspending in service fees. For example, one participant hesitated to get accompaniment and transportation services for outings because she found them costly:

> **I could have some [support]. There is a couple that came here...He will come with me, he will pick me up. Then if I go somewhere, he will come to pick me up. He will stay with me as long as I want to stay. Then when I want to go back home, he will take me back. But is it fair? It cost me 40 dollars per hour for him [his services]…So I did not call back yet because I do not have that money. (F1)**

Monitoring spending habits was helpful for staying within a budget in the midst of increasing costs. One participant commented:

> **I notice that, for the past 12 months, when I go to =grocery store=, I know, everything [cost of things] is up, it did not climb proportionally to my increase [increase of my income] for my living costs. So…So, it is going to be tough, it is going to take more monitoring [now] than previously. (F4)**

Making such money management skills a habit in older age seemed essential to support healthy aging needs and priorities when subsisting on a limited income and dealing with inflation of living expenses in older age.

In addition to managing financial resources to live on an adequate income, selecting needed products, activities, and lifestyles according to their affordability was another strategy for some participants to spend within their means in older age. Participants ensured that they meet their basic and priority needs by giving priority to the affordability factor. One participant talked about grocery shopping monthly on discount days. She said, “Once a month I go to =grocery store= the first Tuesday of the month we have 10 % off. But they charge me 10 or 11 dollars to deliver here, so what I save in the store pays the delivery charge” (F1). Another participant

discussed the trade-off that she perceived between having enough money to either buy food or pursue some types of social activities:

> **So when we [participant and spouse] get a chance to take part in some conferences…meetings, luncheons…Then, we have means to do it…So, it is also helpful when we have the means, sometimes, it bothers us, we cannot do as much…So to have enough resources for the…to be comfortable to do that…You know, you should not always think if I do this, I will not be able to eat…as well, or I will not be able to eat what is necessary [what I need]. (F3)**

Living and aging in supportive living places. Living and aging in supportive living places was one more factor that contributed to protecting participants' health. Supportive living places or environments were more than just places of residences. These types of living places offered comprehensive options to meet participants' specific needs and maintain lifestyles that keep them healthy. They served different purposes and offered many resources used by participants to protect their health. Study participants pinpointed several key aspects that they found important in order to age in a healthy manner in their living places. They identified staying in living places with specific housing features where they had access to supportive services.

Some participants identified examples of housing features that were supportive of their activities and lifestyles to keep healthy. For example, one resident mentioned how climbing stairs in her four-storey residence was helpful to improve the mobility of her arthritic knee:

> **And then, for the exercises, I decided in the month of February…So, I decided to climb stairs here, there are four levels…So to climb and to go down the stairs every**

> **day, and because I have arthritis in one knee…It was quite helpful, I walk a lot better now than two years ago. (F3)**

Another participant described how she renovated her house to accommodate any restriction in mobility in her home in case of her health declining:

> **I have a bathroom there, and over there, I have a bed in there…So if I get sick, I can go like that. I don't have to go upstairs, but you can always go upstairs, there are things you buy …=my relatives=…bought an elevator to go up the stairs …and they are all the studies say, it's the best way to age in place, and age at home is the best, the best thing. (F5)**

Indeed, living in places where "you should be able to settle in, to feel at home" (F1) was also a priority for healthy aging. Similarly, living in their own home was preferred over sharing a living space with another person, as this participant shared:

> **Because one of the thing that I believe in, in good aging, is to stay at home, home, as long as possible…Stay in your house as long as possible…That is the best way to age. Some people coming to help you…you are in your own home, you are not sharing a bed with somebody. (F5)**

Living and aging at home in a familiar environment where a person also had privacy supported healthy aging. On the other hand, the lack of some housing features could also represent a challenge against at-home lifestyles by negatively affecting participants' ability to partake in activities that they deemed necessary for healthy aging. Because there is "no balcony" in a retirement home in her neighbourhood, one participant mentioned that she would not relocate in a place where she cannot keep gardening:

> **I have a friend that won't move over there because she likes to garden, I do too. If I have to move there, I lose that! Quality of life is, is lost. I can do that maybe in [at] the end of my life, go water plant [participant say it in a monotonous, boring voice tone]. (F5)**

Housing design was also perceived to support experiences of happiness, joy as well as social connections. When one participant was asked about the meaning of healthy aging, he viewed his living place as a place to experience joyful activities together with his peers:

> **To have some activities at the =retirement home= ...Some movies, dance, anything, music, singing, that helps a lot. To put some joy, you have to put some joy. Someone what to be in his [or her] apartment like in one of the city apartment, nobody knows nobody. No. That is good for nothing. (F2)**

Although enjoying happy moments with peers pertained to 'staying positive' and 'being connected to others', happiness and socialization also appeared to be optimized by housing features.

Staying in living places with access to supportive services also helped participants to meet their daily needs and priorities both in their immediate residence and surrounding neighbourhood. For example, using home care services was also helpful to manage living at home. One participant talked about receiving assistance to keep her home clean. She said, "We have a cleaning lady, one day per week…she comes for an hour and half, two hours…it is helpful to keep the house clean" (F3). Another participant shared that she used the dining room service in her residential facility because of her poor eyesight:

> **I am able to cook all my food by myself in my kitchen here, you know. But, my eyesight is decreasing…And then, what happens is…I take my meals at the dining room here…I am going to take my lunch, then my supper at the dining room…Regular meals, that is also very helpful to me. (F8)**

For this participant, having access to dining room services in her living place catered to her need for eating regular meals and "some good food" (F8). Neighbourhood conveniences were also emphasized in terms of having close by community services and places. All participants resided around the Bonnie Doon area, which was the Francophone quarter of Edmonton. Many of them mentioned attending the local Francophone church on Sundays and having access to the Francophone quarter's library, university campus, and associations offering educational and social programs to older Francophones. One participant said, "We have the Cité, we have the Campus St Jean with its good library which is available to us" (F4). Another participant was particularly satisfied to live close to health services. She said, "Well, I am happy to be here because it is easier to go to see the doctor, or to go to the hospital. Whereas over there, you had to do at least 25 km to go to the hospital" (F6). One more talked about "participating in activities at the Parish, such as community lunches every month" (F7). When one participant was specifically asked about the impact of her living place on her healthy aging experience, she expressed feeling better and healthier where she lives and pointed out to services and gathering places that she enjoys in her neighbourhood:

> **I do not feel isolated. And what happens is that, to live in good health, you should feel well in your body…And it is here that I feel better…To keep myself in good health…[Interviewer: In which way, when you say, you have to feel well in your body?] Well I can go out when I want…Eat some good food. And then I am going to**

> **the mass every Sunday. It is not far, it is just here…Then the Francophone city is just at another bloc further down there. And then, you do not feel so isolated. (F8)**

For all study participants, having access to community services and places offered further opportunities to be active in their community and to use a variety of resources needed to keep healthy in support their healthy aging experiences.

In their quest to protect their health (Theme one) to achieve healthy aging, some of the participants also found it important to exercise independent decision-making in matters significant to them such as their health. This element will be discussed in detail in Theme two because independent decision-making was not solely confined to health matters.

Theme Two: Maintaining Dignity

The second prevailing theme in this study was that of maintaining dignity in terms of facilitating healthy aging and had to do with exercising independent decision-making. Here, participants asserted that remaining in control of their personal affairs and having opportunities to keep learning supported independent decision-making and thus healthy aging. These were the two categories that made up theme two (see Figure 4).

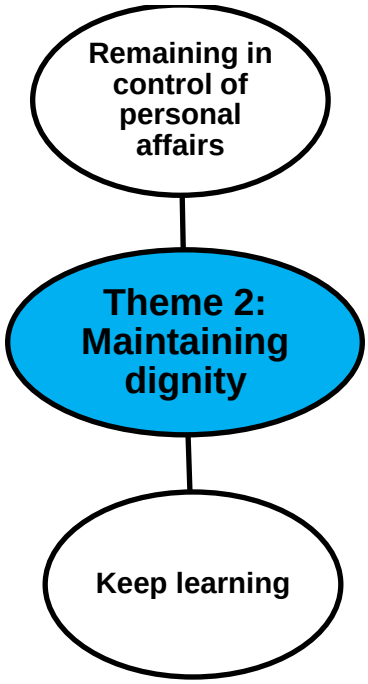

Figure 4: Theme 'maintaining dignity' and categories.

Remaining in control of personal affairs. The majority of participants emphasized the importance of remaining control over decision-making process for matters that concerned them as well as having their personal views respected. These participants insisted on expressing their choices, making their own decisions and doing their own things altogether as ways of remaining in control of their personal affairs.

Some participants discussed expressing their own choices concerning their health and lifestyles. For example, one participant viewed getting involved in affairs pertaining to health in older age as important for healthy aging:

> **Seniors have to speak out, that is why I speak out...They have to get involved in their health thing like I do…Like =spouse= and I do…otherwise, people decide for you, what you are going to be…for your healthy aging, they are going to decide. (F5)**

Another participant shared how important it was not to be kept on artificial life support in the case of serious illness. She found it crucial to exercise her right to decision making over her choices of end of life care treatments and took steps to voice these choices to her doctor and to her family.

> **It is not about dying, it is about living well…So I made a copy of this here, it was here on page 119 that [participant flipping through her book], and then I did that, I sent that to all my children during Christmastime with their Christmas card, saying that I do not want to be sustained by, let see…so that it is an example…So I took exactly what was here [participant is showing to interviewer a document template on decisions on end of life care and treatments from a book]…Then, I went to see my doctor…Then, my doctor signed it, which shows that, he too knows that I do not want to be kept alive with artificial [equipment]…So, I think that it is quite important that everybody do that, if they do not want, to be kept alive artificially...What is the point to be kept alive if you are not in good health? (F3)**

For this participant, remaining in control of her health aimed at maintaining her dignity by ensuring that her end of life choices were known and respected. Not only that, she also wanted to decide on living well with a certain "quality of life" for healthy aging. This perspective was echoed by another participant who preferred staying in living places that support a better "quality

of life" for herself (F5). This meant that participants led more satisfying and meaningful lifestyles when they felt in control of their living conditions or circumstances.

Interferences from others in relation to making decisions freely were perceived as challenges to participants' dignity and thus healthy aging. To illustrate such challenges, one participant indicated that she viewed "people in position of authority" (F1) as interfering with how she should behave in her rented apartment:

> **When there is some that are supposed to be in authority who come then who tell us what we should do such and such thing in a certain manner and then we have never lived like that and we don't feel able to live as they want [long pause]. But healthy aging for me it is not to live the way another person wants me to live. (F1)**

Another participant defined "ageism" (F2) as the lost ability to express oneself in older age and why she believed people of her age group should express themselves more to avoid being imposed others' views:

> **Because that is what the seniors are, that's why they don't participate, they don't give their opinion, because they are not asked, other people decide for them, that's what I found, that's not healthy aging…And there is a big discrimination on aging, we are not important anymore right... it's like being a teenager there, well, they are not…them too. They are not always asked their opinion although they are speaking more. But seniors should speak up more, may be the baby boomers will, may be, may be...Because baby boomers are more closed on themselves, I see, I read about that, but...Definitively, we need to speak out, and that's healthy aging. We need not**

> **to be discriminated…We are kind of ageism, you know the word ageism, that is what happens to the seniors. (F5)**

Another participant described his conflict with his doctor with respect to not following prescribed treatments and preferring alternative options. Experiencing such conflicts led this participant to believe that health professionals were paternalistic and imposed medical treatments upon patients without being open to discuss other options:

> **One time, he [doctor] got upset, he was talking loudly, I had to take this drug, pfff!...Then, he get angry, he tell me what he wants me to take then if I want to take it, I take it. If not, I do not take it, that ends [ends there?] Because…there is too much paternalism…It is them that know what is better for ourselves [Pause]. Not always. That is also the [their] attitude…There are some…because the one [doctor] I have is very old fashioned. I have seen others who were not as worse, who are a little bit more open-minded…That [Participant is explaining the term old fashioned] means drugs only…And the herbs and all that, no. Because, he says there has not been enough research done on them [herbs and all that]. (F2)**

Experiencing social prejudices such as "ageism" (F5) and "paternalism" (F2) was thus conceived of as a discriminatory experience that negatively affected participants' ability to remain in control of their own affairs by infringing decision-making.

Being able to do what they wanted to do in older age was another way that a few participants remained in control of their personal affairs. One participant insisted that she gained much satisfaction in being able to engage in activities in her own way:

> **As long as my ideas are good, as long as my eyes are good, as long as my ears are good, and that I am able to do a little bit of what I want, let me do it. It gives me satisfaction that meets my need [needs]. Do you understand what I mean? ...But it should not always be other people ideas because I was not brought up with other people ideas. (F1)**

From this participant' view, remaining in control over her activities appeared to boost her personal wellbeing associated with leading a satisfying lifestyle in older age. Referring to her involvement in community groups, another participant talked similarly about wanting to remain involved as she grew older, despite other people's undesirable views about her degree of involvement:

> **But I still want to keep, keep going with that…So I get a lot of things! People tell me, you gotta to slow down! I'm not! That's not, you got to maybe, you got to prioritize your things, you got to prioritize [banging the table in repetitive motion]. Lots of people say when you are getting 65 you got to quit everything. That's not my view…My view is to keep going. (F5)**

From these perspectives, participants F1 and F5 appeared to feel better fulfilled as older adults when they stayed engaged in meaningful activities in their own terms. Thus, remaining in control over choices of activities was respectful of these two participants' sense of dignity because they made their own choices and felt good about it.

Keep learning. Not only remaining in control over personal affairs illustrated participants' aim at maintaining independent decision-making, but seeking opportunities to keep learning also contributed to inform and support decision-making. Learning about available

options and accessing pertinent information allowed participants to make informed decisions on matters that are significant to them. One participant found it important to get reliable information and thus educate himself about how to independently manage his health:

> **They [natural remedies] also have some effects [side effects], you have to keep an eye on it… Myself, I keep an eye on my blood, and on my liver, that they do not harm both, or even the kidneys…There are also some herbs which can also harm kidneys…You have to keep an eye on, you have to know…that is why you have to study…If you want to do it yourself, you have to study, you have to know….I have been successful until now …They say, you have to take responsibility for your health, you have to follow, you have to take care of your health, then you have to know quite a lot…you know, if you take something not harmful, and then you have to go to reliable sources as much as possible…That takes some work. (F2)**

Most participants found it essential to seek ways to keep learning to make better decisions, especially when it came to matters of health. Therefore, continuous learning was perceived as essential to support healthy aging and accomplished through self-learning activities and learning from others, continuing education programs, and modern technology.

Self-learning activities included staying informed on general topics in an informal manner. One participant talks about learning as a day-to-day activity: "You learn everyday…you should not stop learning, you should not stop learning when you stop, it is over…you have to keep developing yourself, it helps [participant pointing to his head]" (F4). Comparing information from several sources was also a strategy for a few participants in gauging information to make educated choices. One participant commented about trying not to rely solely

on her doctor for health information. When she was asked about what healthy aging meant, she said:

> **You know, to be informed, not just to take the words of the doctor. You know, something I have a tendency to do, I am saying to myself, he knows everything. ...But I think, you have to take yourself in hand. Moreover, today, they say you have to take yourself in hand, then if you have some hesitations about the doctor for example, let us imagine that maybe you do not really agree with his diagnostic…You have to find out, to try to understand. I think that is part of living in good health. (F7)**

For this participant, questioning health information was helpful to understand better her health and to learn more about alternative explanations to a health diagnosis possibly leading to choosing treatment.

In addition to self-learning, all participants learnt more about aging in a healthy manner by observing and reflecting on others' experiences. One participant explained that she chose "to age the proper way" after witnessing others not keeping healthy:

> **I see many, many, many people, not aging the proper way, so I decide, well, in my mind I manage to age the proper way ...so I've so many times people saying, I'm too old to do this, you might be too old, but you do it in a different way. I told people, I suggested to people, this is how you do it. Do it in a different way. (F5)**

The same participant further talked about unhealthy attitudes displayed by others:

> **In that over there =retirement home=, they don't come out. They don't go do nothing. So, you stay, that's not healthy aging, that is not a proper thing. Even though you got arthritis, even though you got all kind of things…I see some examples, of arthritis, they got hip whatever, they need hip operations, they are still involved. It hurts, but they are involved. You know...I know some people are not healthy, but the worst you can do is to close yourself in with that, and you won't be healthy at all. (F5)**

Learning by reflecting on others' behaviours appeared to provide cues for participants about the healthy choices that they should make to remain healthy as they grow older.

Besides self-learning and learning from others, the majority of participants also sought formal opportunities to keep learning through continuing educational programs offered at their local Francophone university. One participant described one popular university program designed specifically for older Francophones:

> **We are going to *'Plaisir d'apprendre'* [*Learning with pleasure,* university program for older Francophones at the Campus St Jean in Bonnie Doon]. It is a one week program, during which it is like going to university for a week. (F3)**

It was understood that such an academic program kept participants well informed and updated on a variety of significant topics pertinent to them. Thus, participants were better equipped for informed decision-making.

In contrast to the other three ways of learning, learning and using modern technology was understood to be helpful in facilitating not only access to information in support of decision-making, but also the execution of daily tasks for healthy aging. For example, modern

communication tools facilitated participants' accessing, transferring, or learning of information in order to meet their needs in the comfort of their homes. In particular, modern communication tools were seen as a means of faster communication for learning new information and advice, managing personal affairs, entertainment, and "keeping in contact" (F7) with people that are far way. One participant spoke of technology devices that he used at home:

> **A computer, a printer…digital television…The television helps to relax…If you are tense, let say it is not going well at home [in the residence]…They are arguing, all you want…You go home [to your own apartment], you turn on your TV, then you watch a program that you like or a comedy or something you like…Hockey or…The computer…I work a little bit…I send my emails…I have my bank, I do all my banking on line, and…what else…I order my supplements. (F2)**

Despite finding modern technology useful, it was challenging at times. The need to keep upgrading user knowledge was identified as a limitation specifically for computer use. One participant found it challenging to improve her computer knowledge without any help:

> **Well, I am not an expert…with computer…My children showed me how to do that, something different...But what happens is that, I am going to the Server. Yes every day, almost every day, then I keep in contact with others…And I try to be a bit braver, then to try other ways, but I do not dare, because I do not have much help. (F8)**

It appears that continuous support is a necessary part of using newer communication tools to keep up with their apparent complexity and to use them in the most effective way.

As participants continuously prioritized protecting their health (Theme one) and maintaining their dignity (Theme two) to achieve healthy aging, they additionally chose to experience values, activities and lifestyles that were reflective of their identity which will be discussed in details in the subsequent section addressing theme three.

Theme Three: Preserving Identity

The third prevailing theme evident in participants' accounts of healthy aging was preserving identity in support of healthy aging. In the context of this study, the term 'identity' was inclusive of participants' personal values and cultural identity as French Canadians. Here, participants aspired to living in line with personal values about healthy aging and aging in French. These were the two categories that made up theme three (see Figure 5).

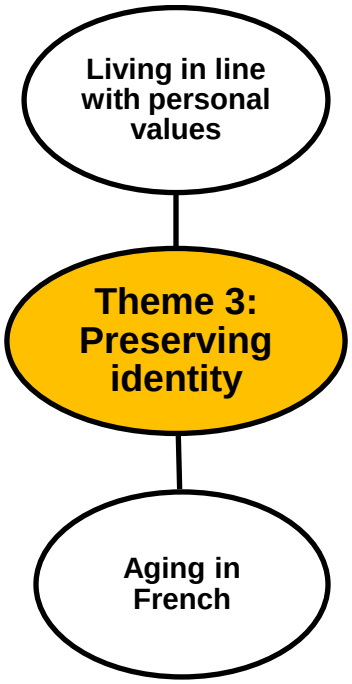

Figure 5: Theme 'preserving identity' and categories.

Living in line with personal values. Living in line with personal values was one way for all participants to live in a manner that preserved their identity in support of healthy aging. As participants grew older, they pursued living in accordance with their personal values as a healthy way to age. In this study, personal values represented what participants considered significant and kept from their past life experiences from childhood to older age. These values stemmed from participants' lifelong habits and life lessons and influenced their current healthy aging perspectives.

Lifelong habits contributed to shape participants' personal values for healthy aging today. Lifelong habits were personal habits that participants developed and were true to in the past, and such habits were acted out in their present day-to-day life for better health. These lifelong habits were influenced by past life experiences such as family traditions, personal interests, or prior-occupations. Some participants personally valued keeping family traditions. Some of their current healthy behaviors and lifestyles appeared to be tied to family traditions. Family traditions were integrated into their current lifestyles because they were perceived to be healthy ways to age. One participant explained that her preference for home remedies to cure her aches came from growing up in a familial environment free of medication:

> **When I have a headache…I do not run for an aspirin, I did not run for a Tylenol or none of these things. I take a cloth, I put it under the tap with cold water, I spread it out, then I lay down with that on my head, and then I cover my eyes, not the tip of my nose…Because I have to breathe. Put it like that…than the top a little bit here…nothing else calm down a headache [better than this] [long pause] I never saw my grandparents have an aspirin in their house neither any other pill. Than we**

> **were raised…all we had were aloes powder, tincture of iodine…and then…some absorbing junior…but that was when daddy's shoulders were too sore. (F1)**

This participant' recalling and putting to use health-related remedies that she had picked up from older generations of family members kept her healthy and thus facilitated healthy aging. Another participant described significant elements of healthy aging that she kept as she grew older from her grandmothers and mother:

> **I took examples from my grandparents, my grandmother…My 2, my grandmothers, they, they were [pause] and my mom too... I think that's a good example…from the grandmothers, from the mother, from the grandmother, my mom…she was cheerful, and she laughed…So was the grandmothers. And they always kept nice, nice clothes, dress nice and, that's another important thing too…It is the grooming, you see, you see, to me it is very important... The hair, you know, how you keep yourself as you age. (F5)**

These experiences showed that participants perceived older family members as models of ways to keep healthy now.

A few participants indicated that their personal interests were tied to keeping some specific habits in older age. One participant stated that she had never been too keen on mingling with others, even in older age: "I could go downstairs to chat [with other residents]…but as they say in Quebecoise I am not a yenta [someone who talks a lot]…Even at home I never use to go for coffee with others" (F1). On the other side, another participant explained that she considered keeping involved in various activities as her strong point:

> **I was always active, I couldn't … [it] seems to be at home, it was too boring. Washing the floors. I think that is part of life, but it's also part of growing older, healthy aging…To keep going, that's my strength…to always be involved. (F5)**

For these participants, how they engaged in activities over the course of their lives based on their personality and interests was habitual. That is, habits in one's younger years could determine one's habits in older age. In this respect, the experience of healthy aging was an individual experience that was enhanced by keeping personal values in older age emanating from one's preferences and interests. Keeping certain habits in older age was also linked to prior occupational background for a couple of participants. As an example, being accustomed to computers from previous work places facilitated computer use in the present. One participant used computer in her working years, and still finds it useful today:

> **There was a time when computers came out, I was still working at the parish…And then, I said, for the first time in my life, I was overwhelmed…And then, one day, the office secretary who was there told me, it is not complicated. I will show you half an hour a day. Well, I was sold out on it after the first half hour…Then, I learnt that, I use it, I did a lot of things…Then when I reach a point where I cannot anymore [nowadays], I am lucky that we have an employee in the basement during the day. He is very knowledgeable about computers. So I ask him, and I learnt so many things. (F7)**

In addition to lifelong habits, keeping life lessons also contributed to preserve participants' personal values about healthy aging. All participants were particularly insightful about their past experiences. They shared some of the life lessons gathered over the years from

significant life events and how these life lessons shaped their current attitudes toward and values about healthy aging. By recalling memories of the past, one participant, for example, emphasized which life lesson kept him living in good health and living longer until today. He evoked facing challenging times during the Second World War and coming back to Canada to raise his family on a farm. He put emphasis on keeping a worry-free attitude when facing life challenges which in turn permitted him to live longer years than others whom he knew before:

> **Above all….To avoid stress [pause] that is what causes many problems. When you can sleep…Everything gets better…and I think that it is a good recipe because I am almost 94 years old…To avoid stress and to sleep well…Yes, you should not worry… I cultivated for a while, I cultivated for 25 years…And during the fall, rain starts, and we get all our income for the year…from the field…And we worry…If there is enough time to harvest or not before winter time…And if we cannot sleep because of that…ah no, we are going to get sick, [that is] for sure. And I never lost sleep over it…All our salaries for the year are there. And we have to collect it… And many people cannot sleep because of it. I knew several of them…They are dead, they are dead now …Probably, it was helpful to me to spend [all] these 10 years in the army…You should not worry…You see some who drop dead around us…But if you start to worry about it, it is worse…That is when you are probably going to face the consequences. (F4)**

From this participant's perspective, preserving a positive outlook as a life lesson influenced his present day attitudes and behaviors in support of healthy aging. Another participant explained why she felt it important to move closer to her children later in life:

> **I said, we should absolutely come closer. At least, we could help you [parents living outside Canada], even if you live in the little country =little Francophone community=, it is not far. In even less than 10 minutes, we were there. So, I saw then the inconveniences and she [participant's parent] could have communicated with people here! But no! We could not make her change her mind...So, what do you do, when you take the wrong decisions and they suffer from it and then me too. But I could not do anything...I realize that it is what you have to do, you have to come closer to your children. (F6)**

This participant valued closeness to family in older age because she had a negative experience when she was separated from her own parents after migrating from Europe to Canada. Overall, many of the participants' personal values about healthy aging were rooted in their past life experiences. And continuously living by these values in their present lives preserved this aspect of their identity and seemed to facilitate healthy aging.

Aging in French. Besides personal values, an additional element of participants' identity was their cultural identity. Therefore, aging in French was in itself a way of living that preserved participants' cultural identity as French Canadians to facilitate healthy aging. Participants were aging in French in an Anglophone dominant society by seeking ways to express and retain their culture on a daily basis. Participants also felt that aging in French kept them healthy in older age.

Aging in French was part of participants' cultural background. As part of their culture, participants shared a common history and customs attached to being a French Canadian. Participants talked about being born, growing up, or moving to French Canadian communities during the settlement period of Western Canada by Francophone migrants. At that time, French

speaking families from other parts of Canada and Europe relocated to Western Canada searching to escape harsh living conditions. One participant explained that his French Canadian parents-in-law "came from the South of the province because it was dust over there" and "they could not harvest" (F4). Another participant talked about her family roots going back to the period when French Canadians were just getting established in Western Canada. She recalled "growing up in French" (F1):

> **I was born on the farm. Daddy was the first French in our region…In 1914…=In the North of Alberta, close to Peace River=…And then it is around the time when the government was opening new lands in that corner for development. (F1)**

Participants were all exposed to English as a language of education and to Catholicism while attending schools in their communities. One participant recalled growing up in a Francophone community in a province where education was only allowed in English:

> **Well, I did not speak English until I went to school…So, when I was 6 years old, in school, I had to take some English courses. We only just had one French class for 1 hour…Not because the population was not French Canadian, because of the government laws…Required it here in Alberta…Yes, we were in a Francophone community in the North of Alberta…Fallaire, McLennan, Girouxville, Guy, these are small villages very close, they are francophone…They were, they are less and less…Because our parents came from Quebec, and then our parents spoke only French. (F3)**

In particular, the majority of participants which were all of Catholic faith also talked about attending convent schools established by Catholic missionaries where they embraced that

religion. One participant recalled attending a convent school at a tender age away from her parents:

> **I was born in 1918… and then, my parents moved when I was 6 years old, but myself I was going to the =Albertan city= convent school…Then, when it was holiday season, I was going back home to visit my parents…Then I stayed at the convent school until 16 years old…17 years old. (F8)**

The same participant further explained how she embraced her Catholic faith in her youth: "What happens is that…since my youth I was shown…since my youth that I was advised to live with Jesus…Then it became like…inside of me" (F8). Some elements from participants' common history were being of French Canadian descent, having French as a mother tongue, being educated in English, and being Catholics.

Participants favored aging in French to preserve their identity by seeking and engaging in activities and lifestyles in which they spoke in French and displayed their culture: "If I will have the choice to go to a retirement home…a Francophone or an Anglophone center I will chose the Francophone center...because of the culture" (F7). In this case, aging in French for participants appeared to be a lifestyle of staying immersed in their French Canadian culture and practicing their customs daily such as "eating food…the way they were brought up" (F1), living in a residence with a "French atmosphere" (F4), "living in French" in a Francophone neighbourhood (F8), "to be in contact with people of your language" (F6), "brotherhood" (F2), or "singing…French Canadian songs" (F7). This suggests that aging in ways that meets participants' health-related and cultural needs and priorities was an optimal circumstance for healthy aging.

Even though participants' ideal was aging in French, this was a struggle to fully achieve because participants resided in a Canadian province where English is the dominant language. They identified a challenge of communicating poorly in English to request services without ambiguity. One participant underlined the lack of most of her needed services in French in her community. She said, "I have nothing the pedicure speaks English…the optician speaks French…Dr=optician=…but the rest…I have no services in French besides when I go to older adults' small meetings" (F6). Conversely, the lack of health services in French was an added challenge for aging in French. The same participant shared how she could not communicate her needs and concerns to her English-speaking doctor:

> **Something that is not going well...It is a bit difficult to make myself understand because the doctor would want to talk a little bit of French, but sometimes, he fall back on my husband, Dr=family doctor=…Because I say to him some words in English, and it is not said exactly how it should be, it is a bit lost. So, that is always the hitch. So, in our French language, we cannot use it as we want. What a shame. You say some words in English, but they do not always correspond to…what you want to say. (F6)**

One more participant wished for "a good health clinic for seniors in French" (F5) and another one deplored the lack of palliative care beds in her local health center:

> **If they had four rooms for palliative care in our Francophone (health) center…It would be helpful a lot for people who are dying and languishing, languishing, languishing, like that…Then, they would be in their environment…but there is no such place. (F3)**

Not receiving a variety of support services and medical care in their mother tongue were some challenges to aging in French in an Anglophone dominant society for a couple of participants. These challenges were also detrimental for healthy aging because all participants believed that aging within their own culture kept them healthier.

A few participants explained how they felt that aging in French enhanced their health. It was believed that people "go back to their mother tongue when they grow old" (F3) making them prone to feel more comfortable communicating in their native language. One participant justified the necessity to speak French when a person experienced physical pain. She said, "older people…of course they are sensitive about it [spoken language] because they want to be understood and when you are in pain you love to say immediately what you have but in French" (F6). For this participant, speaking French directly contributed to enhance healthy aging experiences by allowing her to communicate her needs effectively when she experienced pressing health issues. Furthermore, another participant offered a perspective about the positive impact of aging in French on health. She described how a person in her older age experiencing cognitive illness was more responsive when she sang songs in French learnt during her younger years:

> **I witness a lady, who came to entertain the group. Then she was singing songs that we learnt during our youth. Then you know, all kind of French Canadian songs, and then I saw, there were older people, then one of them with a little bit of Alzheimer, dementia...But, when we sang these songs, she sang too. You know, she sang the words. (F7)**

From this participant's perspective, aging in French for older French Canadians could be therapeutic in certain cases by reviving some memories of their cultural identity and thus enhances healthy aging experiences. Discussing why it is important to preserve someone's cultural identity for healthy aging, another participant further explained how not keeping someone's identity could lead to poor self-esteem, and confidence which in turn could impact on someone's health and happiness negatively:

> **We are happy when we are what [who] we are…So, if we lose, something that belong to us, it strips away how valuable [we feel]…And we feel less…how they would say…less confident, let us say less what [who] we are! ...So, all that, it is all interconnected. Health, happiness…self-esteem, all that, it is all interconnected. (F2)**

This participant considered positive feelings engendered from aging in French, in accordance to a person's cultural values, to be contributing factors to better health and wellbeing.

Despite self-identifying as "French" (F6), "Francophones" (F7) or "French Canadians" (F2) and having French as their "first language" (F7), there were some contrasting views about what made participants of French Canadian identity in terms of spoken language. Surprisingly, recognizing speaking both French and English, or being bilingual, was also identified as part of the French Canadian culture. One participant stated that to be a "French Canadian means bilingual" (F2). He perceived himself a Canadian with two languages. He said, "I see myself as a Canadian…I was born French, but I am rather Canadian…what I mean is that I speak both languages that is what my heritage is not just French" (F2). Another participant further explained that although older generations spoke only French, younger generations of French Canadians were more bilingual. She said, "Because our parents came from Quebec, and then our parents

spoke only French…but now, we are rather bilingual, and our children are more English bilingual" (F4). Although older generations spoke French only as new migrants to Western Canada, it was understood that participants themselves had a different cultural experience than their parents. They grew up, worked and lived in bilingual or English only communities and were themselves more bilingual than their parents:

> **Because I am in a Francophone medium, I speak French, I understand the mentality, in our country, even if English is a second language, we are still surrounded by Anglophones. So, I always lived in an Anglophone context. When I left my little village…Then I went for my training, it was in an Anglophone village. They were no Francophones there. And then, I lived, I taught in an Anglophone context, and then I came to Edmonton, then I was at a Francophone school, but all our meetings and all that were with Anglophones. So, you know, we are immersed in both cultures. (F7)**

Notwithstanding participants' cultural perceptions about what made them French Canadians, it was also considered as an asset to be cognizant of English. **S**peaking French and English was necessary because it facilitated participants' communication with others and access to a wider range of services. One participant talked about communicating with children and their families that did not speak French. She was glad to be bilingual to bridge this language barrier, even for watching television programs:

> **My children all have learnt to speak French. But, they are married, then now, they speak English more …So, my grandchildren also speak English, none of them speak French...For my family, it is better to keep contacts in English…What happens is**

> **that, I know with them I am more comfortable when I speak English…They know I speak French…the television…there are a lot of programs in English…I follow that…But I listen quite a lot to programs in French too. But I speak much English too. Like here, there are some women that speak only French…But myself, I can contact, stay in contact with people here that speak only English. (F7)**

Another participant felt lucky to have both languages to be able to communicate with her home care workers. She stated "what a chance that I have both [languages]" because "the girls who come to help us [at home] speak English" (F1).

What do the key themes tell us about healthy aging?

The relationship between the three key themes in this study led me to believe that healthy aging from a French Canadian perspective was a complex concept represented by four interrelated characteristics (see Figure 6). First, healthy aging was a multidimensional concept with health and non-health dimensions. Healthy aging was also a concept of self-preservation against challenges affecting the older adult's ability to lead healthy and satisfying lifestyles. Healthy aging was as well an action-oriented concept indicating self-responsibility for healthy aging. Finally, healthy aging appeared to be a culturally sensitive concept rooted in French Canadian culture.

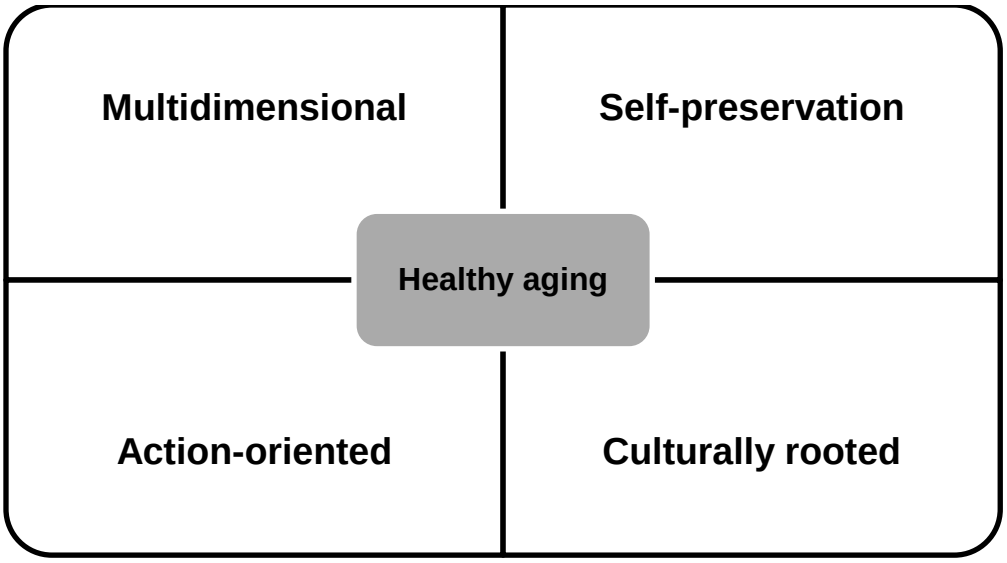

Figure 6: Interpretive description of healthy aging.

Older Francophones involved in this study perceived healthy aging as a multidimensional concept having to do with three dimensions which were protecting health, maintaining dignity, and preserving identity. No one dimension was distinctly emphasized as being more important than the others. Participants displayed a broad understanding of what they need to keep in good health to achieve healthy aging. First of all, protecting health as a key dimension of healthy aging was supported by various categories or factors contributing to keeping healthy in participants' daily lives. These factors were adopting healthy practices, living with faith and staying positive, being connected to others, living on an adequate income, and living and aging in supportive living places.

Conversely, maintaining dignity and preserving identity were the other two key dimensions of healthy aging in this study. Maintaining dignity was interpreted as participants' aim at maintaining independent decision-making in older age in matters important to them such as health treatments, preferred activities or lifestyles. Similarly, preserving identity revealed

participants' lifelong values, which included personal values about healthy aging and cultural values as French Canadians. It was understood that experiencing positive feelings about self in older age in situations that allowed participants to exercise independent decision-making as well to align their personal and cultural values with their current living experiences enhanced participants' perceived health and thus healthy aging.

Healthy aging was also perceived to be a concept of self-preservation against challenges affecting participants' ability to lead healthy and satisfying lifestyles. All three themes of healthy aging (protecting health, maintaining dignity, and preserving identity) were constructed to express participants' efforts in guarding what they considered significant for healthy aging against numerous challenges faced in older age. For example, study participants identified health and non-health related challenges in older age that had a negative impact on keeping good health such as changes in their physical health (i.e. changes in sensorial perceptions or physical abilities), negative feelings, timing of social events (i.e. poor weather, activities scheduled at night), limited income, and poor housing design.

Participants also dealt with social prejudices which challenged their dignity. Participants expressed that being able to maintain independent decision-making was important to them. Some participants vehemently protested about having a hard time to make their choices known and respected by others because of their age. Lastly, participants struggled to age strictly in French in a Anglophone-dominant society because many needed services such as health services were not available in French. Even though some participants were fluent in English as well, they keep seeking for opportunities to be and to live in French with other Francophones to preserve their cultural identity against the dominant culture. In sum, healthy aging from participants' experiences involved a continuous quest to preserve themselves against challenges that they

faced against their health, dignity and identity in their daily lives to achieve healthy aging. It was then important for participants to keep taking care of themselves.

Therefore, healthy aging was also understood to be an action-orientated process emphasizing self-responsibility in taking actions to achieve healthy aging. Across all three themes, participants continuously discussed healthy aging in terms of keeping behaviors, activities, and lifestyles that promoted their health and thus healthy aging. For example, participants protected their health (Theme one) to promote healthy aging by applying specific health-promoting behaviors in order to meet their needs and priorities in older age. Participants used various self-care and coping strategies to prevent and overcome health concerns. They practiced their faith by following biblical principles and going to church regularly. They remain engaged in social activities with families, peers, and their communities. They prioritized affordable products and services and used supportive services in their residences and neighbourhoods. In relation to maintaining their dignity (Theme two) to support healthy aging, participants sought to retain independent decision-making in matters important to them, such as choices of health treatments, and learning more about options available to them. Participants further sought to preserve their identity (Theme three) to facilitate healthy aging by keeping some habits and cultural ways from past experiences as healthy ways to age. For example, one participant who believed in "growing up as families" (F5) recalled having family dinners with her grandparents and kept having them today with her own children and grandchildren as a family tradition. That showed how closeness to family reflected a personal value about healthy aging rooted in this participant's own childhood. Like all the other participants, this same participant also valued aging in French as part of her cultural identity explained by growing up with French family members and in Francophone communities.

As all study participants demonstrated a strong attachment to aging in French as part of achieving healthy aging, healthy aging was then considered to be a culturally sensitive concept rooted in participants' culture as French Canadians living in Western Canada. Many ways that participants sought to protect their health, maintain their dignity and preserve their identity for healthy aging were intertwined with their culture. Healthy aging in French for them represented not only enjoying in French activities and lifestyles pertaining to healthy aging, but also having their cultural customs as part of their daily lives. Some examples that illustrated participants' strong preference to age within their culture included living in Francophone residences and neighbourhoods where they were in contact with other Francophones and had access to educational and social programs designed specifically for older Francophones.

In chapter 5, study findings representing participants' perceptions of healthy aging are examined and re-interpreted within a broader context of what is known in the grey and published literature to deepen my understanding of these perceptions, as prescribed by Thorne (2008). Study conclusions, limitations, and implications for practice, research, and policy will be presented as well.

Chapter 5:

Discussion, Study Conclusions, Limitations, and Implications

In the previous chapter, I introduced the healthy aging perceptions of eight older Francophones living in Edmonton. In this last chapter, I will first discuss the findings in two steps to aim at a better understanding of participants' perspectives. I will begin by re-interpreting my study findings against selected grey and published literature. Next, I will compare and contrast my findings with other similar studies of healthy aging to examine healthy aging as either a contextual or universal experience. Finally, I will conclude this chapter by presenting study conclusions and limitations, and implications for practice, research, and policy.

Discussion

Re-Interpreting Findings

Theme one: Protecting health. Older Francophones in this study indicated that protecting their health in older age was an important theme of healthy aging. Protecting health was further untangled into five interrelated categories or factors that contributed to keep participants healthier: adopting healthy practices, living with faith and staying positive, being connected with others, living with an adequate income, and staying in supportive environments.

Adopting healthy practices was executed to keep healthy physically, whether participants used coping strategies to manage physical and cognitive changes or common self-care strategies such as eating healthy and exercising. Adopting a variety of healthy practices, such as healthy eating and exercising, has been associated with good health in older Canadians with or without chronic diseases (Martel, Belanger, Berthelot, & Carriere, 2005; Ramage-Morin, Shields, &

Martel, 2010). Similar to this study, older people may utilize healthy practices to stay in good health, manage current symptoms and physical limitations, prevent any worsening of their health issues, and prioritize these practices based on their perceived benefits to the older person's specific health needs, interests, and goals in adopting these (Miller & Iris, 2002).

Living with faith and staying positive were two other contributing factors for better (spiritual and mental) health and were expressed through keeping a set of beliefs, spiritual practices, positive mindsets and feelings that appeared to enhance healthy aging from participants' perspectives. Similarly to my participants who were all Roman Catholics, following spiritual practices and feeling surrounded by God's presence were also ways to keep healthy from a Christian perspective in a study of ten older American Christian women aged 69 to 85 years old (Knestrick, & Lohri-Posey, 2005). While staying positive meant to have "the intention and the ability to perceive one's world with an open mind" and "reflect the ability and inner strength to focus on positive attributes in a world on diminishing prospects" from the perspectives of another group of older Americans (Van Maanen, 1988/2006, p.57). Besides being open-minded and hopeful, staying positive has also been associated with experiencing better health through living longer and practicing more preventive health behaviors (Levy & Myers, 2004; Levy, Slade, Kunkel, & Kasl, 2002). Therefore, living with faith and staying positive potentially contribute to participants' better perceived health despite reporting at least one health condition.

In addition to adopting healthy practices, and living with faith and positivity, participants found important being connected to others which were family, friends, peers, and the community at large to protect their health and thus promote healthy aging. Consistent with the present study, higher social networks and social support and being involved in more social activities were

associated to reporting better health status respectively in large samples of French Canadians aged 65 years old and above in New-Brunswick and in Quebec (Zunzunegui et al., 2004), and in a large sample of European people aged 50 years old and above (Sirven & Debrand, 2008). A national survey confirmed that older Canadians who received higher social support (support from children, family, or friends) and participated in frequent social activities reported a more positive perception of their own health, and as a consequence felt less lonely and dissatisfied with their lives (Gilmour, 2012).

Living with an adequate income was perceived to be a necessity for participants to be able to afford a healthy lifestyle for better health in older age. Two studies specifically reported on the costs associated with keeping a healthy lifestyle for older citizens in Canada and New Zealand (MacDonald, Andrews, & Brown, 2010; O'Sullivan & Ashton, 2012). As discussed by several participants in my study, these studies reported that older adults relying only on government pensions as sources of income did not have enough money to sustain a healthy lifestyle. Age was not a determining factor of how much participants in these studies could spend to sustain a healthy lifestyle, but rather other socio-economic factors such as health status, marital status, car ownership, and mortgage ownership/ rental status (MacDonald, et al., 2010; O'Sullivan & Ashton , 2012). Although all of my participants were retirees and found income important for healthy aging, the fact that many did not feel burdened by financial hardship could warrant more investigation to understand factors explaining their apparent financial security. Because all participants reported being in good health despite having at least one health condition, it is possible that they do not have high health related expenses. Additionally, many of my participants appeared to prioritize living within their means either through budgeting or

monitoring their spending which could also explain their ability to manage their post-retirement income.

Participants in my study emphasized the importance of living and aging in supportive living places with access to support services at home and to nearby community services to promote better health in their later years. Living and aging in supportive living places was also a priority in a larger sample of 536 older Francophones residing in Edmonton, Morinville, Beaumont, Legal and St. Albert in Alberta (Gobeil-Dwyer & Doucette, 2004). As discussed by my participants, aging at home, in retirement residences, and communities that support their sociocultural needs were also perceived to be essential to the wellbeing of Francophone people in another sample of Francophones aged 50 and above in a recent Federation of older Franco-Albertans survey (Freychet, 2012). Many participants in Freychet's study, who were living in different communities across Alberta, held a negative stigma associated with relocating to retirement homes because of perceived poor food, lack of sociocultural activities, and isolation from family and friends, language and culture (Freychet, 2012). Because all of my participants resided close by the French quarter of Edmonton (Bonnie Doon) where many services and programs are tailored to support older Francophones, this could potentially explain why they felt more satisfied with their current living places. Additionally, my participants focused more on the positive aspects of their living environments which suggested that their health and support needs are currently met in their living places. However, many of them were still very concerned about being able to relocate later in a Francophone retirement home when they will be in need of more health care, support services, or even palliative care. Currently, there are only three French-speaking retirement homes in Edmonton. One offers a mix of independent and assisted living options, while the other two only offer independent living options for those requiring little

assistance. Out of those three, only one is exclusively French-speaking. Therefore, more research is needed to explore how current home and supportive living options available in Edmonton meet or not the healthy aging needs and concerns of older Francophones.

My participants walked, took the bus, or drove their own car on a regular basis to access close by community services. Neighborhood design, such as the availability of walking environments and access to transportation services, has also been found to play a role in the level of participation of older adults in physical activity (Frank, Kerr, Rosenberg, & King, 2010) and family and social activities (Richard, Gauvin, Gosselin, & Laforest, 2008). Living in proximity of a church was found equally important in Gobeil-Dwyer and Doucette' study (2004) and possibly explained by the Catholic faith of my participants.

Theme two: Maintaining dignity. Participants' narratives in this study emphasized the importance of maintaining dignity through valuing independent decision-making. Older Francophones in this study wanted to remain in control of their personal affairs by making their own decisions regarding choices of lifestyles, living options, or health treatments. Similar findings were reported in studies of older adults residing in Europe (Witso, Vik, & Ytterhus, 2012), New Zealand (Breheny & Stephens, 2012) and the United States (Price, Bereknyei, Kuby, Levinson, & Braddock, 2012). In two of these studies, decision making was perceived as counting on oneself to manage own needs and not being dependent on others (Breheny & Stephens, 2012; Witso, Vik, & Ytterhus, 2012). Others found it was important to have a role in decision-making on medical issues, to be able to discuss these issues with doctors using a plain language, and to include significant ones in the decision-making process (Price, Bereknyei, Kuby, Levinson, & Braddock, 2012).

Additionally, my participants perceived situations that were disrespectful of their personal views and preferences as challenges to their sense of dignity. Receiving respect from others, behaving with respect toward self and others, and having self-value have been identified as attributes of dignity in a study of 23 older Americans aged 65 to 92 years old irrespective of race, gender, and marital status (Jacelon, Connelly, Brown, Proulx, & Vo, 2004; Jacelon, Dixon, & Knajl, 2009).

In contrast with the present study which linked dignity, independent decision making, control, choice, and respect together, differences in the personal meanings of these terms have been reported. In Martin and Roberto's (2006) study of 21 older Americans, independence and dignity were most strongly tied with decision-making about medical treatments, while choice, and control were among the least important ones (Martin and Roberto, 2006). Saltus and Folkes (2013) found that dignity was influenced by cultural beliefs and values among British citizens of African descent. It is possible that my interpretation of translated data may have influenced how I conceptualized dignity in relation to independent decision-making, independence, choice, control, and respect. Although participants strongly advocated for independent decision making, more research is needed to clarify the conceptual meaning and linkages of dignity with independence, choice, control, and respect in support of healthy aging among older Francophones.

Second of all, continuing learning appeared to further support independent decision-making. Participants in the present study were continuous learners using various formal and informal learning strategies to inform self-care, and compared information or available options. As explained in the literature, older adults wish to keep informed about their options on health and other available community support services to make their own decisions that meet their

needs (Harod, 2011; Palsdottir, 2012; Xie, 2009). Similar information-seeking behaviors to this study such as getting information about personal concerns using self-learning, others, and media/ internet were reported in other qualitative studies of older Europeans 60+ years of age residing in both Europe and North America (Hurst, Wilson, & Dickinson, 2013; Palsdottir, 2012; Xie, 2009). The internet has been used for accessing information and performing everyday tasks easily in another study by Boulton-Lewis, Buys, Lovie-Kitchin, Barnett, and David (2007). Hence computers are technologies that also help non-Francophone older people live independently at home.

Similar to suggestions in this study, taking non-degree university courses was also considered an opportunity to gain knowledge in a quantitative survey study of older Australians (Hebestreit, 2008). At the same time, however, these older Australians also spoke of gaining personal satisfaction, mixing with stimulating people, being curious, making new friends, and escaping routine in taking such courses (Hebestreit, 2008). Among older rural Croats, self-learning has been linked with leisure activities such as hobbies and volunteering (Roberson, 2005). Croat older people defined self-learning as a mechanism to adjust to having more time in retirement, new family roles as grandparents or great-grandparents and to compensate physical and social losses. Hence, learning in older age can fulfil more purposes than what was alluded to by the older Francophones in this study. Therefore, more investigation is needed to further explore and clarify the importance and meanings of continuing learning in healthy aging in another sample of older Francophones, especially in relation to self-learning, others, computer use, and non-degree university programs as indicated in my study.

Theme three: Preserving identity. Preserving identity in older age was a third prevailing theme of healthy aging and referred to participants' emphasis on living in line with

their personal values about healthy aging and aging in French. Living in line with personal values symbolizes "the connection to and continuity in time, place, and self" from the perspectives of older Norwegians (Witso, Vik, & Ytterhus, 2012). This suggests that some personal values are constant through a lifetime. In two longitudinal survey studies, older Americans kept similar priorities and values about treatments, and preferences about health care treatments and life sustaining treatments (Ditto et al., 2003; Martin & Roberto, 2006).

From my findings, personal values about healthy aging, thus, stemmed from participants' past experiences and affect their current habits and lifestyles in support of healthy aging. Consistent with my participants' narratives, other studies have shown the influence of life experiences, cultural backgrounds, and personal interests on habits kept in older age. For example, food and eating habits later in life were influenced by childhood and early adulthood experiences in a small sample of older Swedish people and in a larger cohorts of older Americans (Edfors & Westerngren, 2012; Maynard, Gunnell, Ness, Abraham, Bates & Blane, 2005). In another example, using natural, traditional, or home remedies as current self-care practices was influenced by inherited family and cultural customs kept over the years in a sample of 30 older Canadians of Cantonese, Mandarin and Portuguese ethnicities (Ballantyne, Mirza, Boon, & Fisher, 2011). And a person used to seek opportunities to socialize at a younger age continued to do so later in life (Ziegle, 2012). Although it is necessary to be cautious in drawing conclusive statements about my study of only eight participants as suggested by Thorne (2008), these aforementioned studies deepen my understanding about the influence of life experiences (from childhood to older adulthood) on my participants' lifelong values and habits, which in return shaped their today's needs and priorities for healthy aging.

My participants' life stories reflected a combination of their individual circumstances in families and communities and of their collective circumstances from an historical perspective which potentially explain their present priority for aging in French. Besides personal values, aging in French was a way of living that reflected my participants' cultural identity as French Canadians and was perceived to enhance their healthy aging experiences. Others have found that past historical events impact health later on in life. Elder and Liker's longitudinal study (1982), suggests that women who economically struggled through the Great Depression later reported better emotional health. Elder and Liker concluded that facing economic challenges gave rise to a stronger set of coping skills and resources that helped women to better prepare for aging (Elder & Liker, 1982). Consistent with the life course perspective, the significance of aging in French for healthy aging, despite living in an Anglophone dominant province and being bilingual in most cases, seemed to be better understood through the collective history of early French Canadian communities in Western Canada. Participants' accounts of their life histories were found to have more similarities than differences and situated their childhood between 1919 and 1940 during the Francophone settlement of Western Canada when white European settlers of French origin and Catholic missionaries established several early communities across Western Canada (Heritage Community Foundation, 2010). At that time, great political, religious, and socio-cultural tensions existed between the dominant group of English-speaking and Protestant Canadians and French-speaking Catholics inside and outside Quebec over language rights in building a unified western Canada which was still under economic and land development (Painchaud, 1978). Harsh living conditions in settling the land and not speaking English were among some of the struggles faced by early French Canadians in establishing themselves in Western Canada (Green, Mackinnon, & Minns, 2005).

Consistent with participants' narratives, struggles to preserve their culture and language rights have been ongoing since the earlier establishment of French Canadian communities in Western Canada. Although participants were younger, many recalled growing up in French, but attending Catholic school in English in their communities of origin in Northern Alberta. Therefore, participants' emphasis on aging in French for healthy aging despite being in an Anglophone dominant province appeared to be rooted in their personal histories. This appears to reflect participants' resistance against loss of cultural identity, preservation of cultural values and language, and pursuit of lifestyles reflective of their cultural ways, despite being minorities in Edmonton.

Other studies confirm participants' priorities in living and aging in places that support their linguistic needs, such as communicating in French with other Francophones, and accessing some support and community services in French. This finding was first reported by Gobeil and Doucette' community survey (2004) which highlighted the needs for accommodation and supportive services in French in a larger sample of Franco-Albertans living in Edmonton and neighbouring municipalities. Similarly, a survey of French-speaking adults outside Quebec indicated that these persons hold a strong sense of belonging and attachment to speaking French and to their francophone status (Corbeil, Grenier, & Lafreniere, 2006). Many French-speaking Canadians in Alberta identify themselves to both Anglophone and Francophone groups, despite wishing to receive government services in French, and to keep their linguistic rights in Alberta (Chavez, Bouchard-Coulombe, & Lepage, 2011). Furthermore, French-speaking adults outside Quebec residing in municipalities populated with more Francophones, compared to those who lived in places with fewer Francophones, reported French more often as a main language and found it more important to receive health care in French (Chavez et al., 2011). This could

potentially explain why my study participants who all resided in a Francophone neighbourhood felt strongly about being able to live and age within their culture in Edmonton for healthy aging. Even in the absence of an existing Francophone quarter in dominantly English-speaking cities such as Calgary, Stebbins (1993) found that Francophones of various age groups were still seeking leisure activities in French as a central way to live their culture in a minority context back in the 1990s. As discussed by my participants, other authors (Chavez et al., 2011; Freychet, 2012; Gobeil & Doucette 2004; Stebbins, 1993) also confirmed that Franco-Albertans strongly valued pursuing lifestyles in French despite living minority contexts.

Freychet's work (2012) confirmed that not speaking English and not having access to services in French were important challenges met by older Francophones across Alberta, including unilingual Francophones, newer immigrants, and Francophones in both urban and rural communities. As explained by one of my participant who was not fluent in English, not having access to French-speaking health professionals in particular was perceived to have a negative impact on older Francophones' self-perceptions and personal wellbeing (Freychet, 2012). Freychet (2012) also reports negative consequences with dealing with non-bilingual health professionals such as lack of autonomy and poor self-confidence. However, reporting higher risks for wrong diagnostics, anxiety, and discouraging follow-ups with health care professionals as causes of concern (Freychet, 2012) were not mentioned by my study participants possibly because the majority of them were bilingual.

Healthy Aging: A Contextual or Universal Experience?

By June 2013, seven other similar studies exploring healthy aging from a lay perspective were retrieved via the Social Sciences Citation Index and EBSCO discovery service databases.

Although I applied an interpretive description methodology in a small study of eight French-Canadians aged 73 to 93 years old, other authors used different methodologies but reported similar findings to my study. Boyle and Counts (1988) used a grounded theory methodology to investigate the views of 105 American adults (18-65+ years of age) from an Appalachian community (United States) and Bryant, Corbett, and Kutner (2001) used a quantitative-qualitative mixed methodology in another study involving only 22 older Americans aged 65 years old and above. Naaldenberg, Vaandrager, Koelen, and Leeuwis (2012) applied an appreciative inquiry approach to explore qualitatively a set of healthy aging themes derived quantitatively in a sample of 79 Netherlanders (Europe) aged 55 years and above. Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, and Steckler (2009) used an ethnographic methodology to study healthy aging in a sample of seven Thai people (South Asia) aged 60 and above; Thiamwong, McManus, and Suwanno (2013) applied a grounded theory approach in another study of 39 Thai adults (40-85 years old); and Thanakwand, Soonthorndhadam, and Mongkolprasoet (2012) reported using a qualitative approach in a larger sample of 160 Thai people aged 60 and above. Lastly but not least, Tohit, Browning, and Radermacher (2012) reported using a focus group methodology to elicit the healthy aging views of 38 Malays (South Asia) also aged 60 years old and above. Consistent with my findings, all participants in these aforementioned studies mostly reported healthy aging embedded in the older person's daily life and enacted it through attitudes, behaviors, activities, lifestyles, and/ or traditions that are believed to keep older people in good health.

There were several similarities between my French-Canadian study and the above-mentioned other similar studies on lay perspectives on healthy aging. American and European older adults defined healthy aging in terms of taking care of oneself, performing activities, being

resourceful and having the ability to use available resources such as community services and social support (e.g. loved ones, acquaintances), and keeping a positive attitude despite challenges in personal circumstances (Boyle & Counts, 1988; Bryant, Corbett, & Kutner, 2001; Naaldenberg, Vaandrager, Koelen, & Leeuwis, 2012). Supportive resources that facilitated communicating with others and keeping informed through the media (including internet), socializing, mobility and access to services were perceived to promote independence and control in activities and self-care (Boyle & Counts, 1988; Naaldenberg, Vaandrager, Koelen, & Leeuwis, 2012). Although these older adults did not discuss the importance of culture in healthy aging, I believe that situating a study in a particular geographical context is already a way of acknowledging the embedded culture. South Asian older people tended to describe healthy aging in terms of aging in a healthy manner physically, psychologically, and emotionally; having good family and social relationships; being financially independent; and keeping cultural and spiritual practices (Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, and Steckler, 2009; Thanakwand, Soonthorndhadam, & Mongkolprasoet, 2012; Thiamwong, McManus, & Suwanno, 2013; Tohit, Browning, & Radermacher, 2012). Being independent in terms of self-care and being respected by younger generations were also valued (Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, & Steckler, 2009; Thanakwand, Soonthorndhadam, & Mongkolprasoet, 2012; Tohit, Browning, & Radermacher, 2012). Culture and spirituality were the core aspects of healthy aging respectively in Danyuthasilpe and colleagues' study (2009), and in Tohit and colleagues' study (2012), and overlapped with all other dimensions.

Although there are some variations in priorities, apparent commonalities across lay dimensions of healthy aging indicated that healthy aging is more a universal than a contextual concept. Francophones' views of healthy aging in this study speak to dimensions and categories

of healthy aging evident in others' studies. Although the concept of self-preservation has not been used in others' studies of healthy aging, I found some evidences in support of this term with respect to adapting to age-related changes and challenges through putting resources to use to prevent, mitigate, or overcome any negative impact on their wellbeing. Participants' views of healthy aging hinted at an action-oriented process driven by a sense of personal responsibility to remain healthy. Previous studies took place in different geographical contexts from North America to Europe and to South Asia but seldom were culture itself explored. Despite similarities in the healthy aging perspectives between my French-Canadian participants and other people in different countries, it seemed that what is unique (or more central) to my participants' healthy aging perspectives was their quest to preserve their cultural identity in a specific English dominant sociocultural context. The fact that culture per se was not central for other people in similar studies, except in one ethnographic study (see Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, & Steckler, 2009), could possibly be explained by the lack of focus on culture in the research designs of these studies, and/ or the lack of ethnic and linguistic variations in their study samples. Additionally, other researchers worked with translated data and/ or considered the impact of languages and culture on their data, but scarcely discussed their translation strategies in reporting their findings. This could provide more information about working with older adults whose first language differ from researchers and its repercussions on formulating study findings.

Study Conclusions and Limitations

Despite the multiplicity of healthy aging practice, research, and policy definitions, there are significant gaps in understandings about what healthy aging means from the perspectives of older adults themselves and thus the healthy aging priorities of older Franco-Canadians. Hence, the present qualitative study exploring healthy aging among eight older Francophones of French

Canadian descent living in Alberta was undertaken. Interpretive description was used to analyze participants' perspectives of healthy aging. Three key themes of healthy aging were identified: (1) protecting health, (2) maintaining dignity and (3) preserving identity while aging. Protecting health had to do with adopting healthy habits, living with faith and staying positive, being connected to others, having adequate financial resources, and living and aging in supportive living places. Maintaining dignity meant remaining in control of one's own affairs and having an opportunity to keep learning. Lastly, preserving their identity reflected participants' aspirations to living in accordance with their personal values and aging in French. Thus Healthy aging, from a French Canadian perspective, was further characterized as a concept of self-preservation which was also multidimensional, culturally sensitive, and action-oriented, and comparable to other cultures (Bryant, Corbett, & Kutner, 2001; Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, & Steckler, 2009; Naaldenberg, Vaandrager, Koelen, & Leeuwis, 2012; Thanakwand, Soonthorndhadam, & Mongkolprasoet, 2012; Tohit, Browning, & Radermacher, 2012). Study findings confirmed the well documented factors which contribute to leading healthier and more fulfilled lives in older age which are physical, spiritual, mental, social, economic, environmental (i.e. housing design and neighbourhood), behavioral (i.e. decision making, learning, living in line with values), historical, and cultural influences. Although many of these findings have been reported previously in different bodies of literature, my study participants uniquely presented more comprehensive views about the concept of healthy aging, what contributes to enhance their healthy aging experiences, and their priority to age in French. Hence, study findings represent an additional source of empirical data about the healthy aging from the perspectives of older adults themselves and will potentially be informative for health

promotion practitioners, researchers, and policy makers specifically working with older Francophones.

Despite the contribution of this study to the healthy aging literature, several limitations should be considered in understanding the depth and breadth of this concept. First of all, working with translated data from French to English involved a certain degree of loss of meaning (Squires, 2009). In doing forward-backward translation, there is always a risk of something being lost such as translating words that do not have literal equivalent in English, lack of equivalent expressions between English and French and achieving a balance between word-to-word translation and translation of intended meaning in the English Canadian culture and context. The use of language assistants, bilingual dictionaries and the feedback of several English-speaking committee members on my descriptions and interpretations were beneficial to help mitigate these challenges. However, I had a lack of familiarity with equivalent expressions between English and some participants' French Canadian expressions.

Although the study aimed at exploring healthy aging from the perspectives of older Francophones, another limitation to this study was that I was only able to interview those people who agreed to participate to this study. Therefore, all participants that volunteered belong to a specific sub-group of Franco-Canadians, who are Francophones of French Canadian descent and were all Caucasian, Roman Catholics, relatively healthy, and active older adults. This study sample was relatively small (eight participants), and composed of more female than male participants.

Implications

Implications for Practice

Although community and public health nurses work to deliver programs and interventions developed according to healthy aging policies, the health promotion agenda in practice designed for older citizens is still focused on improving health and health behaviors to promote healthy aging (Anderson et al., 2008; Davies, 2011; Hanusaik, O'Loughlin, Kishchuk, Paradis, & Cameron, 2010; Richard et al., 2005). Therefore, several recommendations are suggested in the light of this present study for healthy aging programs and nursing interventions more centered on the older adult as supported by Potempa, Butterworth, Flaherty-Rob, and Gaynor (2010).

When working with older Francophones in Edmonton, nurses may assess spoken languages and offer available resources in preferred languages when possible. Nurses may also adopt a multidimensional approach and include clients' perceptions on priorities and needs for healthy aging in their assessment and interventions to address healthy aging in a holistic manner. Additionally, nurses may support participation and encourage feedback when delivering health education programs and activities, and discuss options and resources available in support of older Francophones' health and lifestyle preferences. Moreover, nurses may work with local and provincial organizations such as the Federation of older Franco-Albertans, the Albertan Network for health, and the Alberta government Francophone secretariat to identify community, professional, and government resources and social and educational programs available for French-speaking people in Edmonton. Lastly, nurses may seek continuing educational

opportunities to build their cultural competence skills to be better prepared to work with older Francophone and non-Francophone communities in and outside Edmonton.

Implications for Research

Current research still indicates that the focus of healthy aging research definitions and frameworks is on the maintenance of good health, and the preservation of physical, mental, and social functional status (Buckley, Denton, Robb & Spencer, 2004; Engberg, Oksuzyan, Jeune, Vaupel, & Christensen, 2009; Guralnik, & Kaplan, 1989; Hansen-Kyle, 2005; Haveman-Nies, De Groot, & Van Staveren, 2003; Hung, Kempen, & De Vries, 2010; Kerber, O'Brien, & Cawthon, 2009; Martel, Belanger, Berthelot & Carriere, 2005; Michael, Colditz, Coakley, & Kawashi, 1999; Oswald et al., 2007; Peel, Bartlett, & McClure, 2004; Ramage-Morin, Shields, & Martel, 2010; Reed, 1998; Shields & Martel, 2006; Tyas, Snowdon, Desrosiers, Riley, & Markesbery, 2007).

The present study contributes to the current body of knowledge by extending the possible dimensions and categories of healthy aging to non-health related dimensions from the unique perspective of older French-Canadians. Because my study is a first exploratory study of healthy aging among older French-Canadians outside Quebec, more research is needed to explore my findings in other samples of older French-Canadians and of Francophones of different ethnicities, using either quantitative surveys or other qualitative methodologies. Further research could benefit from using an ethnographic methodology to investigate the contribution of older Francophones' cultural ways to healthy aging, as done by Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, and Steckler (2009) with a sample of older Thai adults. This will possibly allow a better understanding of the Franco-Canadian culture and its influence on the

healthy aging experiences of older Francophones of different ethnicities. Another suggestion is to replicate this study using a grounded theory to develop a healthy aging framework to guide programs and services implemented by nurses working with older Francophones, in a minority context, similarly to the work of Boyle and Counts (1988) and Thiamwong, McManus, and Suwanno (2013). Such research is needed to identify commonalities and variations of healthy aging perceptions and priorities across Francophone communities in and outside Alberta, and inform policy-making and public health initiatives to allocate appropriate resources in support of healthy aging in these communities. Particular attention should be given to the spoken languages and to the location of residences of potential participants in subsequent research studies.

Implications for Policy

Although current healthy aging policy definitions and frameworks are informative on health behaviors and social determinants of health that influence the older adult's capacity for healthy aging, policy interventions still focus on a biomedical orientation to healthy aging. Most of these policies relied greatly on experts and evidence-based research on healthy aging and focus in priority on influencing health behaviors, disease prevention and management, and physical, mental, and social functioning (Edwards & Mawani, 2006; Farggren, & Wilson, 2009; KPMG consulting, 2002; The Swedish National Institute of Public Health, 2006).

A more immediate action I will take in the near future is to raise more awareness about the healthy aging views of older Francophones locally. In order to do so, I will disseminate my research findings to the members of the Francophone community in Bonnie Doon, in Edmonton, and to the Francophone organizations offering services to older Francophones (such as FAFA and the Saint-Thomas Manor). Given the fact that Bonnie Doon is also an electoral district, these

findings will also be shared with locally elected policy makers for possible consideration when planning healthy aging policies and programs affecting older Francophones in that district.

Based on the scarcity of evidence in Francophone communities and non-francophone communities in and outside Alberta, the first call for action to policy makers is to support and fund more research investigating healthy aging from the views of older people themselves to build more evidence-based knowledge. The second call for action to policy makers is to develop culturally sensitive policy indicators to evaluate the effectiveness and social relevance of current healthy aging policies and policy interventions and programs in Francophone communities and non-Francophone communities in and outside Alberta. The third call for action to policy makers is to survey older Francophones and non-Francophones' priorities in healthy aging across Alberta and Canada, to explore the potential impact of healthy aging policies more centered on older citizens' needs and priorities, and to evaluate the potential contribution of non-health dimensions of healthy aging (such as decision-making, learning, lifelong values, culture) to existing policy definitions and frameworks to promote healthy aging for all older citizens.

References

Anderson, D., Raine, K., Plotnikoff, R.C., Cook, K., Barrett, L., & Smith, C. (2008). Baseline assessment of organizational capacity for health promotion within regional health authorities in Alberta, Canada. *Promotion & Education, 15(2),* 6-14. doi: 10.1177/1025382308090339

Baer, D.E., & Curtis, J.E. (1984). French Canadian-English Canadian differences in values: national survey findings. *Canadian Journal of Sociology, 9(4),* 405-427. Retrieved from http://www.jstor.org/pss/3340527

Bailey, J. (2008). First steps in qualitative data analysis: transcribing. *Family Practice, 25 (2),* 127-131. doi: 10.1093/fampra/cmn003

Ballantyne, P.J., Mirza, R.M., Austin, Z., Boon, H.S., & Fisher, J.E. (2011). Becoming old as a 'pharmaceutical person': Negotiation of health and medicines among ethnoculturally diverse older adults. *Canadian Journal on Aging, 30(2),* 169-184. doi: 10.1017/S071498081100011

Bassett, R., Bourbonnais, V., & McDowell, I. (2007). Living long and keeping well: elderly Canadians account for success in aging. *Canadian Journal on Aging, 26 (2),* 113 -126. Retrieved from http://journals.cambridge.org/action/displayJournal?jid=CJG

Birbili, M. (2000). *Translating from one language to another*. Retrieved from http://sru.soc.surrey.ac.uk/SRU31.html

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and process. *Journal of Research in Nursing, 13 (1),* 68-75. doi: 1744987107081254

Blazer, D.G. (2008). How do you feel about…? Health outcomes in late life and self-perceptions of health and wellbeing. *The Gerontologist, 48(4),* 415-422. doi: 10.1093/geront/48.4.415

Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality & Quantity, 36 (4),* 391-409. doi: 10.1023/A:1020909529486

Boulton-Lewis, G., M., Buys, L., Lovie-Kitchin, J., Barnett, K., & David, L. N. (2007). Ageing, learning, and computer technology in Australia. *Educational Gerontology, 33(3),* 253-270. doi: 10.1080/03601270601161249

Bourque, P., Pushkar, D., Bonneville, L., & Beland, F. (2005). Contextual effects on life satisfaction of older men and women. *Canadian Journal on Aging, 24(1),* 31-44. doi: 10.1353/cja.2005.0001

Bowling, A. (2006). Lay perceptions of successful ageing: findings from a national survey of middle aged and older adults in Britain. *European Journal of Ageing, 3(3),* 123-136. Retrieved from http://www.springerlink.com/content/111371/

Bowling, A. (2009). Perceptions of active ageing in Britain: divergences between minority ethnic and whole population samples. *Age and Ageing, 38(6),* 703-710. doi: 10.1093/ageing/afp175

Boyle, J.S., & Counts, M.M. (1988). Toward healthy aging: a theory for community health nursing. *Public Health Nursing, 5(1),* 45-51. doi: 10.1111/j.1525-1446.1988.tb00559.x

Breheny, M., & Stephens, C. (2012). Negotiating a moral identity in the context of later life care. *Journal of Aging Studies, 26(4),* 438-447. doi: 10.1016/j.jaging.2012.06.003

Brislin, R. (1970). Back-translation for cross-cultural research. *Journal of Cross-Cultural Psychology, 1(3),* 185–216. doi: 10.1177/135910457000100301

British Columbia Ministry of Health. (2005). *Healthy aging through healthy living: towards a comprehensive policy and planning framework for seniors in B.C.: a discussion paper.* Retrieved from http://www.health.gov.bc.ca/library/publications/year/2005/healthy_aging.pdf

Bryant, L.L., Corbett, K.K., & Kutner, J.S. (2001). *Social Science & Medicine, 53(7),* 927-941. doi: 10.1016/S0277-9536(00)00392-0

Buckley, N.J., Denton, F.T., Robb, L.A., & Spencer, G.B. (2004). Healthy aging at older ages: Are income and education important? *Canadian Journal on Aging, 23(1),* S155-S169. Retrieved from http://journals.cambridge.org/action/displayJournal?jid=CJG

Burke, G.L., Arnold, A.M., Bild, D.E., Fried, L.P, Newman. A., Nunn, C., & Robbins, J. (2001). Factors associated with healthy aging: the cardiovascular health study. *Journal of American Geriatrics Society, 49 (3),* 254-262. doi: 10.1046/j.1532-5415.2001.4930254.x

Canadian Longitudinal Study on Aging (CLSA). (2009). *Executive summary: The Canadian longitudinal study on aging*. Retrieved from http://www.clsa-elcv.ca/en/executive_summary/index.html

Carlander, I., Ternestedt, B.M., Sahlberg-Blom, E., Hellström, I., & Sandberg, J. (2011). Being me and being us in a family living close to death at home. *Qualitative Health Research, 21(5),* 683-695. doi: 10.1177/1049732310396102

Center for Disease Control and Prevention. (2009). *Healthy aging. Improving and extending quality of life among older Americans.* Retrieved from http://www.cdc.gov/nccdphp/publications/aag/pdf/healthy_aging.pdf

Chavez, B., Bouchard-Coulombe, C., & Lepage, J.-F. (2011). *Portrait of Official-Language Minorities in Canada: Francophones in Alberta.* (Statistic Canada catalogue number 89-642-XWE2011007). Retrieved from http://www.statcan.gc.ca/pub/89-642-x/89-642-x2011007-eng.pdf

Chen, H.-Y., & Boore, J.R.P. (2009).Translation and back-translation in qualitative nursing research: methodological review. *Journal of Clinical Nursing, 19 (1-2),* 234–239. doi: 10.1111/j.1365-2702.2009.02896.x

Collings, P. (2001). "If you got everything, it's good enough": perspectives on successful aging in a Canadian Inuit community. *Journal of Cross-Cultural Gerontology, 16(2),* 127-55. doi:10.1023/A:1010698200870). Retrieved from http://www.springerlink.com/content/102929/

Corbeil, J.P., Grenier, C., & Lafreniere, S. (2006). *Minorities speak up: Results of the survey on the vitality of the official-language minorities*. Retrieved from http://www.statcan.gc.ca/pub/91-548-x/91-548-x2007001-eng.pdf

Correard, M.-H. (Ed). (1996). *The Pocket Oxford Hachette French Dictionary: French-English, English-French.* New York: Oxford University Press.

Danyuthasilpe, C., Amnatsatsue, K. Tanasugarn, C., Kerdmongkol, P., & Steckler, A.B. (2009). Ways of healthy aging: a case study of elderly people in a northern Thai village. *Health Promotion International, 24(4),* 394-403. doi: 10.1093/heapro/dap038

Davies, N. (2011). Promoting healthy ageing: the importance of lifestyle. *Nursing Standard, 25(19),* 43-49. Retrieved from http://nursingstandard.rcnpublishing.co.uk/

DeSantis, L., & Ugarriza, D. N. (2000). The concept of theme as used in qualitative nursing Research. *Western Journal of Nursing Research, 22(3),* 351-372. doi: 10.1177/019394590002200308

Dillaway, H.E., & Byrnes, M. (2009). Reconsidering successful aging: A call for renewed and expanded academic critiques and conceptualizations. *Journal of Applied Gerontology, 28 (6),* 702-722. doi: 10.1177/0733464809333882

Ditto, P.H., Smucker, W.D., Danks, J.H., Jacobson, J.A., Houts, R., M., Coppola, C.M.…Gready, R.M. (2003). Stability of older adults' preferences for life sustaining medical treatment. *Health Psychology, 22(6),* 605-615. doi: 10.1037/0278-6133.22.6.605

Division of Aging and Seniors Health Canada. (1998). *Principles of the national framework of aging.* Retrieved from http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/pro/healthy-sante/nfa-cnv/aging_e.pdf

Dixon-Woods, M., Agarwal, S., Jones, D.R., Young, B., & Sutton, .A.J. (2005). Synthesising qualitative and quantitative evidence: a review of methods. *Journal of*

Health Services Research and Policy, 10(1), 45-53. doi: 10.1177/1468794107078517

Dwyer, S.C., & Buckle, J.L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8(1),* 54-63. Retrieved from http://ejournals.library.ualberta.ca/index.php/IJQM/index

Edfors, E., & Westergren, A. (2012). Home-living elderly people' views on food and meals. *Journal of Aging Research,* 1-9. doi: 10.1155/2012/761291

Edwards, P., & Mawani, P. (2006). *Healthy aging in Canada: a new vision, a vital investment.* Retrieved from http://www.health.gov.nl.ca/health/publications/vision_rpt_e.pdf

Elder Jr., G.H., & Liker, J.K. (1982). Hard times in women's lives: historical influences across forty years. *American Journal of Sociology, 88(2),* 241-269. doi: http://www.jstor.org/stable/2779548

Engberg, H., Oksuzyan, A., Jeune, B., Vaupel, J.M., & Christensen, K. (2009). Centenarians-a useful model for healthy aging? A 29-year follow-up of hospitalizations among 40 000 Danes born in 1905. *Aging Cell, 8(3),* 270-276. doi: 10.1111/j.1474-9726.2009.00474.x

Esso, C., & Black, M. (2011, March). *Bilingual nursing students learning experience with their first community health promotion presentation.* Poster presentation at the Dr. Olive Young Teaching/ Learning Scholarship Day, Edmonton, Alberta, Canada.

Farggren, R.T., & Wilson, G. (2009). *Healthy Ageing in Europe. Lessons Learnt and Ways Forward.* Retrieved from http://www.fhi.se/en/Publications/All-publications-in-english/Healthy-Ageing-in-Europe---lessons-learnt-and-ways-forward/

Fédération des aînés et des aînées franco-canadiens (FAAFC). (2007, March). *Mémoire présenté à la fédération des communautés francophones et acadiennes dans le cadre du sommet des communautés francophones et acadiennes [Document presented to the Federation of Francophones and Acadian communities during the summit of Francophone and Acadian communities]*. Retrieved from http://www.faafc.ca/sites/default/files/M%C3%A9moire%20pr%C3%A9sent%C3%A9%20%C3%A0%20la%20FCFA.pdf [in French]

Fédération des Communautés Francophones et Acadiennes du Canada (FCFA). (2009). *Francophone community profile of Alberta.* Retrieved from http://www.acfa.ab.ca/Documents/alberta_en.pdf

Frank, L., Kerr, J., Rosenberg, D., & King, A. (2010). Healthy aging and where you live: Community design relationships with physical activity and body weight in older Americans. *Journal of Physical Activity & Health*, 7(Supp 1), S82-S90. Retrieved from http://journals.humankinetics.com/jpah

Freychet, Y. (2012) *Portrait des 50+ franco Albertains. Analyse qualitative des besoins des adultes francophones de l'Alberta, âgés de 50 ans ou plus [Portrayal of Franco-Albertans 50+. A qualitative analysis of Francophone adults in Alberta, aged 50 years old and more]*. Retrieved from http://www.fafalta.ca/publications/index.php [In French]

Friedemann, M.-L., Mayorga, C., & Jimenez, J.D. (2011). Data collectors' field journals as tools for research. *Journal of Research in Nursing, 16(5),* 453-465. doi: 10.1177/174498110387319

Fryer, C., Mackintosh, S., Stanley, M., & Crichton, J. (2012). Qualitative studies using in-depth interviews with older people from multiple language groups: methodological systematic

review. *Journal of Advanced Nursing, 68(1),* 22-35. doi: 10.1111/j.1365-2648.2011.05719.x.

Gilmour, H. (2012). Social participant and the health and well-being of Canadian seniors. *Health reports, 23(4),* 3-12. (Statistic Canada catalogue number 82-003-XPE). Retrieved from http://www.statcan.gc.ca/pub/82-003-x/2012004/article/11720-eng.htm

Gobeil-Dwyer, F., & Doucette, S. (2004). Les besoins des aînés francophones d'Edmonton et des régions en matière de logement et de services de soutien [Needs of French elders of Edmonton about housing and support services]. *Vie et Vieillissement, 3(3-4),* 27-32. Retrieved from http://www.aqg-quebec.org/7/revue_vie_et_vieillissement.gerontologie [In French]

Government of Alberta. (2008). *Proportion of population by mother tongue, Alberta economic regions, 2006. Alberta official statistics-fact sheet. Languages. Mother tongue*. Retrieved from https://osi.alberta.ca/osi-content/Pages/Factsheets/ProportionofPopulationbyMotherTongue,AlbertaEconomicRegions.aspx

Government of Alberta. (2009). *A portrait of Alberta seniors.* Retrieved from http://www.seniors.alberta.ca/policy_planning/factsheet_seniors/factsheet-seniors.pdf

Government of Alberta. (2010a, September). *A profile of Albertan seniors*. Retrieved from http://www.seniors.alberta.ca/policy_planning/factsheet_seniors/factsheet-seniors.pdf

Government of Alberta. (2010b, November). *Aging Population Policy Framework.* Retrieved from http://www.seniors.alberta.ca/Seniors/AgingPopulation/docs/AgingPopulationFramework.pdf

Green, A., Mackinnon, M., & Minns, C. (2005). Conspicuous by their absence: French Canadians and the settlement of the Canadian West. *The Journal of Economic History, 65(3),* 822-849. doi: 10.1017/S0022050705000306

Grubs, R.E., & Piantanida, M. (2010). Grounded theory in genetic counselling research: An interpretive perspective. *Journal of Genetic Counseling. 19(2),* 99-111. doi 10.1007/s10897-009-9270-8

Guralnik J.M., & Kaplan, G.A. (1989). Predictors of healthy aging: prospective evidence from the Alameda County study. *American Journal of Public Health, 79(6),* 703– 708. Retrieved from http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.79.6.703

Halaschek-Wiener, J., Amirabbasi-Beik, M., Monfared, N., Pieczyk, M., Sailer, C., Kollar, A…Brooks-Wilson, A.R. (2009). Genetic variation in healthy oldest-old. *PLoS ONE, 4(8), e6641.* doi:10.1371/journal.pone.0006641

Hansen-Kyle, L. (2005). A concept analysis of healthy aging. *Nursing Forum, 40(2),* 45-57. doi: 10.1111/j.1744-6198.2005.00009.x

Hanusaik, N., O'Loughlin, J.L., Kishchuk, N., Paradis, G., & Cameron, R. (2010). *European Journal of Public Health, 20(2),* 195-201. doi: 10.1093/eurpub/ckp140

Haveman-Nies, A., De Groot, L., & Van Staveren, W.A. (2003). Dietary quality, lifestyle factors and healthy ageing in Europe: the SENECA study. *Age and Ageing, 32(4),* 427–434. doi: 10.1093/ageing/32.4.427

Hebestreit, L. (2008). The role of the University of the Third Age in meeting needs of adult learners in Victoria, Australia. *Australian Journal of Adult Learning, 48(3),* 547-565. Retrieved from http://www.eric.ed.gov/

Heritage Community Foundation. (2004). *Edmonton's French Quarters.* Retrieved from http://www.abheritage.ca/francophone/en/people/people_french_quarters.html

Heritage Community Foundation. (2010). *French Canadian settlers.* Retrieved from http://wayback.archive-it.org/2217/20101208164233/http://www.albertasource.ca/alphabet/article.php?article_id=158&alphabet_id=adult

Holstein, M. B., & Minkler, M. (2003). Self, society, and the "new gerontology". *The Gerontologist, 43 (6),* 787−796. doi:10.1093/geront/43.6.787

Human Resources and Skills Development Canada. (2011). *Canadians in Context — Aging Population.* Retrieved from http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=33

Hung, L.-W., Kempen, G.I.J.M., & De Vries, N.K. (2010). Cross-cultural comparison between academic and lay views of healthy ageing: a literature review. *Ageing and Society, 30(8),* 1373–1391. doi:10.1017/S0144686X10000589

Hurst, G., Wilson, P., & Dickinson, A. (2013). Older people: how do they find out about their health? a pilot study. *British Journal of Community Nursing, 18(1),* 34-39. Retrieved from http://www.internurse.com/cgi-bin/go.pl/library/issues.html?journal_uid=10

Jacelon, C.S., Connelly, T., W., Brown, R., Proulx, K., & Vo, T. (2004). A concept analysis of dignity for older adults. *Journal of Advanced Nursing, 48(1),* 76-83. doi: 10.1111/j.1365-2648.2004.03170.x

Jacelon, C.J., Dixon, J., & Knajl, K.A. (2009). Development of the attributed dignity scale. *Research in Gerontological Nursing, 2(3),* 202-213. doi: 10.3928/19404921 -2009042 Í -03

Keating, N. (2005). Perspectives on healthy aging. *Canadian Journal on Aging, 24(1),* 3-8. doi: 10.1353/cja.2005.0006

Kellog, M. (Ed). (2012). *English-French Dictionary.* Retrieved from http://www.wordreference.com/enfr/

Kerber, R.A., O'Brien, E., & Cawthon, R.M. (2009). Gene expression profiles associated with aging and mortality in humans. *Aging Cell, 8(3),* 239–250. doi:10.1111/j.1474-9726.2009.00467.x

Knestrick, J., & Lohri-Posey, B. (2005). Spirituality and health: perceptions of older women in a rural senior high rise. *Journal of Gerontological Nursing, 31(10),* 44-50. Retrieved from http://www.healio.com/geriatric-medicine/journals/JGN

KPMG Consulting. (2002). *Alberta's healthy aging and seniors wellness strategic framework, 2002-2012.* Retrieved from http://www.assembly.ab.ca/lao/library/egovdocs/alhw/2002/135336.pdf

Larousse. (2008). *Larousse Dictionaries.* Retrieved from http://www.larousse.com/en/dictionaries/english-french

Leininger, M. (1988). Leininger's Theory of Nursing: Cultural Care Diversity and Universality. *Nursing Science Quarterly, 1(4),* 152-160. doi: 10.1177/089431848800100408

Leininger, M. (1996). Culture care theory, research, and practice. *Nursing Science Quarterly, 9 (2),* 71-78. doi: 10.1177/089431849600900208

Leininger, M. (2001). *Culture care and diversity and universality. A theory of nursing*. Sudbury: Jones and Bartlett.

Levy, B.R., & Myers, L.M. (2004). Preventive health behaviors influenced by self-perceptions of aging. *Preventive Medecine, 39(3),* 625-629. doi: 10.1016/j.ypmed.2004.02.029

Levy, B.R., Slade, M.D., Kunkel, S.R., & Kasl, S.V. (2002). Longevity increased by self-perceptions of aging. *Journal of Personality and Social Psychology, 83(2),* 261-270. doi: 10.1037//0022-3514.83.2.261

Litwin, H. (2005). Correlates of successful aging: Are they universal? *International Journal of Aging and Human Development, 6(4),* 313-333. Retrieved from http://www.metapress.com/content/300312/

LoBiondo-Wood, G., & Haber, J. (2002). *Nursing research: Methods, critical appraisal, and utilization.* St Louis: Mosby

Luhtanen, E. (2009, February). *Including immigrant and refugee seniors in public policy. A discussion paper for the Calgary immigrant seniors "speak out" forum.* Retrieved from http://www.isccalgary.ca/publications/031510%20Seniors%20including_immigrant_refugee_seniors_public_policy.pdf

MacDonald, B.-J., Andrews, D., & Brown, R.L. (2010). The Canadian Elder Standard- Pricing the Cost of Basic Needs for the Canadian Elderly. *Canadian Journal on Aging, 29(1),* 39-56. doi: 10.1017/S0714980809990432

Magilvy, J. K., & Thomas, E. (2009). A first qualitative project: qualitative descriptive design for novice researchers. *Journal for Specialists in Pediatric Nursing, 14(4),* 298-300. doi: 10.1111/j.1744-6155.2009.00212.x

Manitoba Seniors and Healthy Aging secretariat. (n.d.). *Age Friendly Manitoba. Creating communities committed to healthy, active aging.* Retrieved from http://www.gov.mb.ca/shas/publications/agefriendly.pdf

Martel, L., Belanger, A., Berthelot, J.-M., & Carriere, Y. (2005). *Healthy today, healthy tomorrow? Findings from the national population health survey. Healthy aging.*

(Statistics Canada catalogue number 82-618-MWE2005004). Retrieved from http://www.statcan.gc.ca/pub/82-618-m/2005004/pdf/4224883-eng.pdf

Martin, C.V., & Roberto, K.A. (2006). Assessing the stability of values and health care preferences of older adults: A long-term comparison. *Journal of Gerontological Nursing, 32 (11),* 23-33. Retrieved from http://www.healio.com/geriatric-medicine/journals/JGN

Maynard, M., Gunnell, D., Ness, A.R., Abraham, L., Bates, C., J., & Blane, D. (2005). What influences diet in early old age? Prospective and cross-sectional analyses of Boyd Orr cohort. *European Journal of Public Health, 16(3),* 315-323. doi: 10.1093/eurpub/cki167

McConnell-Henry, T., Chapma, Y., & Francis, K. (2011). Member checking and Heideggerian phenomenology: a redundant component. *Nurse Researcher, 18(2),* 28-37. Retrieved from http://www.nursing-standard.co.uk.login.ezproxy.library.ualberta.ca/

McLaughlin, S.J., Jette, A.M., & Connell, C.M. (2012). An examination of healthy aging across a conceptual continuum: Prevalence estimates, demographic patterns, and validity. *Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 67(7),* 783-789. doi: 10.1093/gerona/glr234

McLellan, E., Macqueen, K.M., & Neidig, J.L. (2003). Beyond the qualitative interview: data preparation and transcription. *Field Methods, 15(1),* 63-84. doi: 10.1177/1525822X02239573

Michael, Y.L., Colditz, G.A., Coakley, E., & Kawashi, I. (1999). Health behaviors, social networks, and healthy aging: Cross-sectional evidence from the nurses' health study. *Quality of Life Research, 8(8),* 711-722. doi: 10.1023/A:1008949428041

Miller, A. M., & Iris, M. (2002). Health promotion attitudes and strategies in older adults. *Health Education & Behavior, 29(2),* 249-267. doi: 10.1177/109019810202900209

Montgomery, P., & Bailey, P.H. (2007). Field notes and theoretical memos in grounded theory. *Western Journal of Nursing Research, 29(1),* 65-79. doi: 10.1177/0193945906292557

Morse, J.M. (2000). Determining sample size. *Qualitative Health research, 10(1),* 3-5. doi: 10.1177/104973200129118183

Naaldenberg, J., Vaandrager, L., Koelen, M., & Leeuwis, C. (2012). Aging Populations' Everyday Life Perspectives on Healthy Aging: New Insights for Policy and Strategies at the Local Level. *Journal of Applied Gerontology, 31(6),* 711-33. doi: 10.1177/0733464810397703

Newfoundland and Labrador Aging and Seniors division. (n.d.). *Provincial healthy aging implementation plan year 1: 2007 – 2008. Building a foundation*. Retrieved from http://www.health.gov.nl.ca/health/publications/healthy_aging_implementation_plan.pdf

Nikander, P. (2008). Working with transcripts and translated data. *Qualitative Research in Psychology, 5(3),* 225-231. doi: 10.1080/14780880802314346

Office of the Commissioner of Official Languages. (2010a). *History of Official Languages.* Retrieved from http://www.ocol-clo.gc.ca/html/history_histoire_e.php

Office of the Commissioner of Official Languages. (2010b). *Official languages at the heart of our identity. An overview of the Official Languages Act.* Retrieved from http://www.ocol-clo.gc.ca/docs/e/ola_llo_e.pdf

Oliver, D.G., Serovich, J.M., & Mason, T.L. (2005). Constraints and opportunities with interview transcription: towards reflection in qualitative research. *Social Forces, 84 (2),* 1273-1289. doi:10.1353/sof.2006.0023

O'Sullivan, J., & Ashton, T. (2012). A minimum income for healthy living (MIHL)- older New Zealanders. *Ageing & Society, 32(5),* 747-768. doi: 10.1017/S0144686X11000559

Oswald, F., Wahl, H.W., Schilling, O., Nygren, C., Fange, A., Sixsmith, A…Iwarsson, S. (2007). Relationships between housing and healthy aging in very old age. *The Gerontologist, 47(1),* 96-107. Retrieved from http://gerontologist.oxfordjournals.org/

Palsdottir, A. (2012). Elderly peoples' information behavior: accepting support from relatives. *Libri: International Journal of Librairies & Information Services, 62(2),* 135-144. doi: 10.1515/libri-2012-0010

Painchaud, R. (1978). French-Canadian historiography and Franco-Catholic settlement in Western Canada, 1870-1915. *The Canadian Historical Review, 59(4),* 447-466. Retrieved from http://www.utpjournals.com/Canadian-Historical-Review.html

Peel, N.M., Bartlett, H.P., & McClure, R.J. (2007). Healthy aging as an intervention to minimize injury from falls among older people. *Annals of the New York Academy of Sciences, 1114,* 162-169. doi:10.1196/annals.1396.026

Potempa, K.M., Butterworth, S.W., Flaterty-Robb, & Gaynor, W.L. (2010). The healthy ageing model: health behavior change for older adults. *Collegian, 17(2),* 51-55. doi:10.1016/j.colegn.2010.04.008

Pratt, T. K. (ed). (1998). *The Gage Canadian Thesaurus.* Vancouver: Gage educational Publishing Company.

Price, E.L., Bereknyei, S., Kuby, A., Levinson, W., & Braddock, C.H., III. (2012). New elements for informed decision making: A qualitative study of older adults' views. *Patient Education & Counseling, 86(3),* 335-41. doi:10.1016/j.pec.2011.06.006

Prince Edward Island Department of Health. (2009, February). *Prince Edward Island's healthy aging strategy.* Retrieved from http://www.gov.pe.ca/photos/original/doh_agingstrat.pdf

Public Health of Canada. (2004). *What determines health?* Retrieved from http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#culture

Raina, P.S., Wolfson, C, Kirkland, S.A., Griffith, L.E., Oremus, M., Patterson, C…Brazil, K. (2009).The Canadian Longitudinal Study on Aging (CLSA). (2009). *Canadian Journal on Aging / La Revue canadienne du vieillissement, 28(3),* 221– 229. doi:10.1017/S0714980809990055

Ramage-Morin, P.L., Shields, M., & Martel, L. (2010). Health-promoting factors and good health among Canadians in mid to late life. *Health Reports, 21(3),* 1-9. (Statistics Canada catalogue number 82-003-XPE). Retrieved from http://www.statcan.gc.ca/pub/82-003-x/2010003/article/11289-eng.pdf

Reed, D.M., Foley, D.J., White, L.R., Heimovitz, H., Burchfiel, C.M., & Masaki, K. (1998). Predictors of healthy aging in men with high life expectancies. *American Journal of Public Health, 88(10),* 1463– 1468. doi: 10.2105/AJPH.88.10.1463

Richard, L., Gauvin, L., Ducharme, F., Gosselin, C., Sapinski, J.-P., & Trudel, M. (2005). Health promotion and disease prevention for older adults. *Canadian Journal of Public Health, 96(6),* 467-470. Retrieved from http://journal.cpha.ca/index.php/cjph/article/viewArticle/650

Richard, L., Gauvin, L., Gosselin, C., & Laforest, S. (2008)**.** Staying connected: Neighborhood correlates of social participation among older adults living in an urban environment. *Health Promotion International, 2009, 24(1),* 46-57. doi:10.1093/heapro/dan039

Roberson Jr., D.N. (2005). Leisure and learning: Investigation of older adults and self-directed learning. *Leisure/Loisir: Journal of the Canadian Association for Leisure Studies, 29(2),* 203-237. doi: 10.1080/14927713.2005.9651330

Rowe, J.W., & Kahn, R.L. (1997). Successful aging. *The Gerontologist, 37(4),* 433-440. doi: 10.1093/geront/37.4.433

Ryan, F., Coughlan, M., & Cronin, P. (2009). Interviewing in qualitative research: one-to-one interview. *International Journal of Therapy and Rehabilitation, 16(6),* 309-314. Retrieved from http://www.ijtr.co.uk/

Ryff, C.D. (1982). Successful aging: a developmental approach. *The Gerontologist, 22(2),* 209-214. doi:10.1093/geront/22.2.209

Saltus, R., & Folkes, E. (2013). Understanding dignity and care: an exploratory qualitative study on the views of older people of African and African-Caribbean descent. *Quality in Ageing & Older Adults, 14(1),* 36-46. doi: 10.1108/14717791311311094

Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Research, 13(7*), 905-923. doi: 10.1177/1049732303253488

Seers, K. (2012). Qualitative data analysis. *Evidence-Based Nursing, 15 (1),* 2. doi: 10.1136/ebnurs.2011.100352

Shields, M., & Martel, L. (2006). Healthy living among seniors. *Health Reports Supplement, 8,* 7-20. (Statistics Canada, Catalogue 82-003). Retrieved from http://www.statcan.gc.ca

Sirven, N., & Debrand, T. (2008). Social participation and healthy aging: An international comparison using SHARE data. *Social Science & Medicine, 67,* 2017-2026. doi: 10.1016/j.socscimed.2008.09.056

Softissimo (Ed). (2008). *Collins English French Electronic Dictionary.* Retrieved from http://dictionary.reverso.net/french-english/

Speziale, H.J.S., & Carpenter, D.R. (2007). *Qualitative research in nursing, advancing the humanistic perspective.* Philadelphia: Lippincott Williams & Wilkins.

Squires, A. (2008). Language barriers and qualitative nursing research. *International Nursing Review, 55(3),* 265-273. doi: 10.1111/j.1466-7657.2008.00652.x.

Squires, A. (2009). Methodological challenges in cross-language qualitative research: A research review. *International Journal of Nursing Studies, 46(2),* 277-287. doi: 10.1016/j.ijnurstu.2008.08.006

Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.-A. (2008). *Community health nursing in Canada.* Toronto: Elsevier Canada.

Statistics Canada. (2003). *Ethnic diversity Survey: A portrait of multicultural society.* (Statistics Canada Catalogue number Catalogue no. 89-593-XIE). Retrieved from http://publications.gc.ca/Collection/Statcan/89-593-X/89-593-XIE2003001.pdf

Stebbins, R.A. (1993) Le style de vie francophone en milieu minoritaire [The Francophone lifestyle in a minority context]. *Cahiers Franco-Canadiens de l'Ouest, 5(2),* 177-193. Retrieved from http://www2.ustboniface.ca/cusb/presses/cefco.html [in French]

Thanakwang, K., Soonthorndhada, K., & Mongkolprasoet, J. (2012). Perspectives on healthy aging among Thai elderly: A qualitative study. *Nursing and Health Sciences, 14(4),* 472-9. doi: 10.1111/j.1442-2018.2012.00718.x

The Swedish National Institute of Public Health. (2006). *Healthy aging a challenge for Europe*. Retrieved from http://www.eurohealthnet.eu/images/Policy/SIG/HA/final%20report%20healthy%20ageing.pdf

Thiamwong, L., McManus, M.S., & Suwanno, J. (2013). Development of the Thai healthy aging model: A grounded theory study. *Nursing and Health Sciences, 15(2),* 256–261. doi: 10.1111/nhs.12028

Thomas, D.R. (2003, August). *A general inductive approach for qualitative data analysis.* Retrieved from http://www.fmhs.auckland.ac.nz/soph/centres/hrmas/resources/default.aspx

Thorne, S. (2008). *Interpretive description.* Walnut Creek: Left Coast Press.

Thorne, S., Kirkham, S.R., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health, 20(2),* 169–177. doi: 10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO;2-I

Thorne, S., Kirkham, S.R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3(1),* 1-11. Retrieved at http://ejournals.library.ualberta.ca/index.php/IJQM/article/view/4481

Tohit, N., Browning, C.J., & Radermacher, H. (2012). 'We want a peaceful life here and hereafter': healthy ageing perspectives of older Malays in Malaysia. *Ageing & Society, 32 (3),* 405-424. doi: 10.1017/S0144686X11000316

Tornstam, L. (1992). The quo vadis of gerontology: On the scientific paradigm of gerontology. *The Gerontologist, 32(3),* 318−326. doi:10.1093/geront/32.3.318

Turcotte, M., & Schellenberg, G. (2007). *A portrait of seniors in Canada.* (Statistics Canada Catalogue number 89-519-XIE). Retrieved from http://www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf

Tyas, S.L., Snowdon, D.A., Desrosiers, M.F., Riley, K.P., & Markesbery, W.R. (2007). Healthy ageing in the nun study: Definition and neuropathologic correlates. *Age and Ageing, 36(6),* 650-655. doi:10.1093/ageing/afm120

Twinn, S. (1997). An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. *Journal of Advanced Nursing, 26(2),* 418–423. doi: 10.1046/j.1365-2648.1997.1997026418.x

Van Maanen, H.M. (2006). Being old does not always mean being sick: perspectives on conditions of health as perceived by Bristish and American elderly. *Journal of Advanced Nursing, 53(1),* 54-61. doi: 10.1111/j.1365-2648.2006.03670.x (Original work published 1988)

Witso, A.E., Vik, K., & Ytterhus, B. (2012). Participation in older home care recipients: a value-based process. *Activities, Adaptations, & Aging, 36(4),* 297-316. doi: 10.1080/01924788.2012.729187

Wood, M. J., & Ross-Kerr, J. C. (2006). *Basic steps in planning nursing research: From question to proposal (6th edition).* Sudbury, MA: Jones and Bartlett Publishing.

Ziegle, F. (2012). ‘‘You have to engage with life, or life will go away’’: An intersectional life course analysis of older women’s social participation in a disadvantaged urban area. *Geoforum 43(6),* 1296–1305. doi: 10.1016/j.geoforum.2012.03.013

Zunzunegui, M.V., Koné, A., Johri, M., Béland, F., Wolfson, C., & Bergman, H. (2004). Social networks and self-rated health in two French-speaking Canadian community dwelling populations over 65. *Social Science & Medicine, 58(10),* 2069-2081. doi:10.1016/j.socscimed.2003.08.005

Xie, B. (2009). Older adults' health information wants in the internet age. *Journal of Health Communication, 14(6),* 510-524. doi: 10.1080/10810730903089614

Appendix A Characteristics of study participants

Table A1:

Characteristics of study participants

Characteristics	Number of participants (n=8)
Gender	
Male	2
Female	6
Age (years)	
70-79	3
80-89	2
90-99	3
Place of birth	
Alberta	6
Saskatchewan	1
Europe	1
Length of stay in Edmonton	
Less than 10 years	4
10 to 20 years	1
21 to 30 years	1
31 to 40 years	0
More than 40 years	2
Spoken language at home	
French only	3
French and English	6
Marital status	
Single	2
Married	4
Widow	2
Level of education	
High school	3
University	5
Income (estimate)	
Less than $10,000	2
$10,000- $19,000	1
$20,000- $29,000	1
$30,000- $39,000	4
More than $40,000	0
Living arrangements	
Alone	3
Roommate	1
Spouse	4
Recruitment place (length of involvement)	
Retirement home	

0-5 years	0
6-10 years	2
Community group	
0-5years	6
6-10 years	0
General health status	
Good	1
Very good	7
Chronic conditions	
Hypothyroidism	1
Allergies	1
Heart condition	1
Asthma, bronchial irritation	2
High cholesterol	2
Dry eyes, macular degeneration	2
Upper body weakness, loss of balance	2
Heartburn, gastric reflux, hiatus hernia	3
Organ transplant, hip replacement	
Hypertension	3
Osteoarthritis, arthritis, rheumatism,	4
joint pain, hip bursitis	6

Appendix B Recruitment poster/ Affiche de recrutement

Healthy aging among older Francophones in Edmonton

Sharing your views on healthy aging will contribute to understand better older Francophones' needs and inform the delivery of community and public health services.

Are you 65 years of age or older? Do you live in Edmonton?
Are you a francophone?
Are you involved in health and social activities?
Are you interested in sharing your views on healthy aging?

To volunteer for this study, please call 780-405-8621. Thank you for your help.

For more information, please contact
Christelle Esso, RN, MN student
Faculty of Nursing
University of Alberta
Phone: 780-405-8621
Email: esso@ualberta.ca

Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621	Christelle Esso, RN, MN student#780-405-8621

« Vieillir en bonne santé » selon les aînés francophones d'Edmonton

Partager votre point de vue va nous aider à mieux comprendre les priorités des ainé (e)s francophones d'Edmonton et à sensibiliser l'offre des services en santé communautaire et publique à ces priorités.

Avez- vous 65 ans et plus? Vivez-vous à Edmonton?
Êtes-vous Francophone?
Participez-vous à des activités sociales ou de santé?
Êtes-vous intéressé(e)s à partager votre opinion sur le concept "vieillir en bonne santé" ?

Pour être bénévole pour cette étude, prière d'appeler au 780-405-8621. Merci de votre aide.

Pour plus d'information, prière de contacter
Christelle Esso, IA, étudiante à la maîtrise
Faculté de Sciences Infirmières
Université d'Alberta
Téléphone : 780-405-8621
Courriel : esso@ualberta.ca

Christelle Esso, RN, étudiante à la maîtrise #780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621	Christelle Esso, RN, étudiante à la maîtrise # 780-405-8621

Appendix C Information letter/ Lettre d'information

Title of project: Perceptions of healthy aging among older Francophones living in Edmonton.

Principal investigator: Christelle Esso, R.N., MN student, University of Alberta.

Supervisors: Dr. Gail Low**,** Faculty of Nursing, University of Alberta.
Dr. Belinda Parke, Faculty of Nursing, University of Alberta.

Purpose: You have invited to participate in this study. You will be asked to share your views on healthy aging because you are an older Francophone living in Edmonton.

Procedure: If you agree to participate in this study, Christelle Esso will interview you twice at the time and place of your choice. During the first interview, Christelle will ask you to share your views on healthy aging. During the second interview, Christelle will discuss in more details your views on healthy aging. Both interviews will last about one (1) to two (2) hours. Interviews will be recorded.

Risk: There are no known risks to you if you take part in this study.

Benefits: Your contribution to this study may help nurses and program planners learn more about what you think is important for healthy aging. You will receive a summary of study findings. You will also be invited to a presentation of the study findings.

Confidentiality: Your information will remain confidential. Your name will not appear in this study. Christelle will use numbers to identify you on interview notes. Only Christelle and her supervisors will have access to your recordings. Your interview records and consent forms will be stored in a locked cabinet for at least five (5) years in separate locked locations. Your recordings will be stored in a locked computer.

Voluntary participation: You are free to withdraw from the study anytime with no consequences.

Further information: If you have concerns about this study, you may contact the Research Ethics Office, at 780 492 2615. This office has no direct involvement with this project.

If you have more questions regarding this study, please contact

Principal investigator: Christelle Esso, RN, MN student *Phone number: 780 405 8621*
Supervisors: Dr. Gail Low *Phone number: 780 492 2947*
Dr. Belinda Parke *Phone number: 780 492 8685*

Titre du projet : Perspectives des aînés francophones d'Edmonton au sujet du concept "vieillir en bonne santé".

Responsable principal du projet : Christelle Esso, Infirmière Autorisée (I.A.), étudiante à la maîtrise, Faculté de Sciences Infirmières, Université d'Alberta.
Superviseures : Dr. Gail Low et Dr. Belinda Parke, Faculté de Sciences Infirmières, Université d'Alberta.

But général de ce projet de recherche : Si vous êtes un(e) aîné(e) francophone résidant à Edmonton, vous êtes invité à participer à ce projet de recherche. Cette étude s'intéresse à vos perspectives au sujet du concept « vieillir en bonne santé ».

Procédure : Si vous acceptez de participer à cette étude, vous allez passer une (1) à deux(2) entrevues personnelles. Ces entrevues auront lieu à un lieu et à une heure qui vous conviennent. La première entrevue consistera à répondre à des questions au sujet du concept « vieillir en bonne santé. La deuxième entrevue permettra de discuter en plus de détails. Les entrevues dureront une (1) à deux (2) heures maximum. Les entrevues seront enregistrées.

Risques : Il n'y a aucun risque connu lié à votre participation à cette étude.

Avantages : Votre participation pourrait aider les infirmières et les planificateurs de projet à mieux comprendre vos priorités en matière de vieillissement en bonne santé. Vous recevrez un résumé de cette étude ainsi qu'une invitation à une session de diffusion des résultats.

Confidentialité : Toute information recueillie restera confidentielle. Votre nom ne sera pas mentionné dans cette étude. Christelle utilisera un numéro pour vous identifier. Seulement Christelle et ses superviseures auront accès à vos enregistrements audio. Vos entrevues et formulaires de consentement seront conservés séparément sous clé pour une durée d'au moins cinq (5) ans. Tout enregistrement numérique sera conservé dans un ordinateur dont l'accès est protégé par un mot de passe.

Participation volontaire : Vous être libre de mettre fin à votre participation à cette étude sans aucune conséquence en tout temps.

Contacts : Si vous avez des inquiétudes au sujet de ce projet ou vos droits comme participant, vous pouvez contacter le comité responsable de l'éthique en recherche de l'Université d'Alberta au 780 492 6832.

Si vous avez des questions par rapport à ce projet, prière de contacter :
Responsable du projet : Christelle Esso, I.A., Étudiante à la maîtrise Téléphone : 780 405 8621
Superviseures : Dr. Gail Low Téléphone : 780 492 2947
Dr. Belinda Parke Téléphone : 780 492 8685

Appendix D Consent form/ Formulaire de consentement

Part 1

Title of Project: Perceptions of healthy aging among Francophone older adults living in Edmonton, Alberta.

Principal Investigator: Christelle Esso, RN, MN student Phone Number: 780-405-8621

Co-Investigators: Dr. Gail Low Phone Number: 780-492-2947
Dr. Belinda Parke Phone Number: 780-492-8685

Part 2 (to be completed by the research subject):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your records?	☐	☐

Who explained this study to you? _____

I agree to take part in this study. I agree to be interviewed for the purpose described in the information letter. I understand that my name will not be associated with my interview recordings.

_____ _____ _____
Signature of research participant Date Printed name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____ _____
Signature of the investigator Date Printed name

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Partie 1

Titre du projet : Perspectives des aînés francophones d'Edmonton au sujet du concept " vieillir en bonne santé"

Responsable du projet : Christelle Esso, I.A., Étudiante à la maîtrise Téléphone: 780-405-8621
Superviseures : Dr. Gail Low Téléphone: 780-492-2947
Dr. Belinda Parke Téléphone: 780-492-8685

Partie 2 (à être complété par le participant au projet de recherche):

	Oui	Non
Avez-vous compris que vous êtes invité à participer dans un projet de recherche ?	☐	☐
Avez-vous lu et reçu une copie de la lettre d'information ci-jointe ?	☐	☐
Avez-vous compris les bénéfices et risques associés à la participation à ce projet de recherche ?	☐	☐
Avez-vous eu la chance de poser des questions et de discuter de ce projet de recherche ?	☐	☐
Avez- vous compris que vous êtes libre de mettre fin à votre participation en tout temps, sans avoir a justifier votre choix ?	☐	☐
Avez-vous reçu des explications au sujet de la clause de confidentialité ?	☐	☐
Avez-vous compris quelles sont les personnes qui auront accès à vos renseignements?	☐	☐

Cette étude vous a été expliquée par_____

J'accepte de participer à ce projet de recherche. J'accepte d'être interviewé selon le but de l'étude tel que décrit dans la lettre d'information. Je comprends que mon nom ne sera pas associé aux enregistrements de chaque entrevue.

_____ _____ _____
Signature du participant Date Nom en caractères imprimés

Je crois que la personne qui a signé ce formulaire comprend en quoi consiste ce projet et accepte volontairement d'y participer.

_____ _____ _____
Signature de la responsable du projet Date Nom en caractères imprimés
projet

LA LETTRE D'INFORMATION DOIT ÊTRE ATTACHÉE A CE FORMULAIRE DE CONSENTEMENT ET UNE COPIE DOIT ÊTRE REMISE AU PARTICIPANT AU PROJET DE RECHERCHE

Appendix E Interview scripts

Interview script (English)

Introductory statement: Thank you for agreeing to talk with me about healthy aging. As I mention in the information letter, I will record this interview. Is it ok with you?

I will start by asking a very broad question. In this study, several older Francophones have shared with me their thoughts on healthy aging and I have learnt a lot from them.

- What does healthy aging mean to you?

(Relevant prompt questions will emerge from the conversation with participants. For example, I could ask participants to give an example to explain further what they describe. I could also ask participants to provide more details about an experience they describe)

Conclusion statement: In closing, I would like to ask you more questions about yourself to know you better. You can choose to answer me or not (Here, I will proceed to collect participant information).

Interview script (French)

Introduction: *Merci d'accepter de discuter avec moi du concept « vieillir en bonne santé ». Comme je l'ai mentionné dans ma lettre d'information, notre entrevue sera enregistrée. Êtes-vous d'accord?*

Au cours de cette étude, plusieurs aîné(e)s francophones ont partagé avec moi ce qu'ils pensent du concept vieillir en bonne santé et j'ai beaucoup appris de chacun d'eux.

- *Selon vous, que signifie vieillir en bonne santé ?*

Conclusion: *Pour conclure, je souhaiterai vous poser quelques questions personnelles pour mieux vous connaitre. Vous êtes libre de répondre ou non (Ici je fais la collecte des informations personnelles du participant).*

Appendix F Participant information

Participant number/ numéro de participant_____
Date_____
In this section, your personal information will be used to describe your general profile.
Dans cette section, votre information personnelle servira à décrire votre profil de façon générale.

1. Are you male or female? *Est-ce que vous êtes de sexe masculin ou féminin?*
   _____
2. How old are you? *Quel est votre âge?*
   _____
   _
3. Where were you born? *Quelle est votre lieu de naissance?*
   _____
4. How long have you been in Edmonton? *Depuis combien de temps habitez-vous à Edmonton?*
   _____
5. Which languages do you speak at home? *Quelles sont les langues que vous parlez à la maison?*
6. Are you married? *Etes-vous marié?*
   _____
7. What level of education have you reached? *Quel niveau d'études avez-vous atteint ?*
   _____
8. What is your income? *Quel est votre revenue?*
   _____
9. Who do you live with? *Avec qui habitez-vous?*
   _____
   _____
   _____
   _____
10. How long have you been involved in this local center or organization (_____)? *Depuis combien de temps êtes-vous impliqué dans ce centre ou dans cette organisation (_____) ?*

_____

11. In general, how is your health*? De façon générale, comment est votre état de santé ?*_____
12. Do you have any chronic conditions? If yes, which one? *Êtes-vous atteint de maladies chroniques? Si oui, lesquelles ?*
    _____
    _____