

## SENIOR WOMEN AND RURAL LIVING

Elsa Arbuthnot, RN, BN, MN<sup>1</sup>

Jane Dawson, PhD<sup>2</sup>

Patti Hansen-Ketchum, RN, BN, MN<sup>3</sup>

<sup>1</sup> Assistant Professor, [School of Nursing](#), St. Francis Xavier University, [earbuthn@stfx.ca](mailto:earbuthn@stfx.ca)

<sup>2</sup> Associate Professor, [Department of Adult Education](#), St. Francis Xavier University, [jdawson@stfx.ca](mailto:jdawson@stfx.ca)

<sup>3</sup> Assistant Professor, [School of Nursing](#), St. Francis Xavier University, [phketchu@stfx.ca](mailto:phketchu@stfx.ca)

**KEYWORDS:** Senior Women, Well Being, Rural Life, Formal and Informal Support, Health and Social Policy

### ABSTRACT

This study examined perceptions of what is important to maintaining health and well-being for senior women, 65 years or older, living independently in a rural community. One-on-one interviews were conducted with 22 senior women and 10 informal and formal support providers identified by the women participants. Participants discussed physical and psychosocial health care needs, available resources, and accessibility to health-related services. The senior women also expressed their desire to remain in their own home and community despite the challenges of household maintenance, distant family members, loneliness, chronic transportation difficulties, and limited access to social resources. Burdens placed on the voluntary efforts of informal care providers were also identified. Study findings suggest that women's needs exceeded the resources available, and that accessible health and social support services must be organized, funded and factored into future health services and community development planning to meet the needs of senior women in an aging society.

### INTRODUCTION

This article reports on findings from a study of the health, well-being and sources of support for senior women living in rural Nova Scotia, Canada. The study provided insight into the broad determinants of health, and the social as well as health care supports available for senior women living independently in the region. Issues related to community-based development and community sustainability, in terms of the circumstances and challenges faced by rural senior women, were also explored. The aim of the study was to learn more about what senior women living independently in a rural community identify as necessary to maintain their health and well being.

For the purposes of this discussion, "senior" is defined as age 65 or older. "Independently" is defined as living in one's own home, either alone or with others. "Formal support" refers to publicly funded health care and community services, including the church. "Informal support" is associated with family, neighbors, and other community groups and networks. Our definition of "rural" follows the Canadian census definition of a rural area, pertaining to "individuals living outside places of 1000 people or more, or outside places with densities of 400 or more people per square kilometer" (Health Canada, 2002).

## BACKGROUND

By the middle of the 21st century the proportion of seniors in North America is expected to more than double (Statistics Canada, 2001; Cox, 2004). Seniors today are generally healthier, and economically better off than seniors in previous generations. Due to their increased life expectancy, women over 65 years of age outnumber their male counterparts. However, the more rural their location, the more likely they are to live alone, experience a number of health-related concerns and have less access to social resources and health care than their urban counterparts. Additionally, recent Canadian federal and provincial restructuring policies, particularly in the areas of health care and social services, have been particularly problematic for senior rural women living in their own homes (Romanow, 2002) as levels of support have been severely cut. Hospital closures and reduced funding for home care and community services have disproportionately affected the rural elderly because of their greater health needs and distance from necessary hospital and health care services (Armstrong et al., 2001; Division of Aging and Seniors, 1998). Therefore, it is important to know more about the rural conditions in which senior women live and the supports available to contribute to their health and well-being.

For many older rural dwellers, with strong ties to community and the land, the ability to live independently in their homes is an important marker of quality of life. In a study of rural culture in upstate New York, Pierce (2001) found that seniors associate their level of health and well-being with their level of independence and ability to remain in their homes and would not consider living anywhere else despite the challenges of rural living. However, living at home is not always an easy or entirely positive experience, especially when independence is accompanied by isolation, poverty, ill health, and inadequate social and health services. It is a mistake to assume that elderly people in either rural or urban communities have strong support networks of family and friends (Coward & Krout, 1998). In rural Atlantic Canada, as elsewhere, there is growing fragmentation of families both socially and geographically. Great distances often separate aging parents and their adult children who must relocate to find employment in urban centers (Statistics Canada, 2001).

Despite widespread knowledge that population aging is anticipated to be one of the most significant challenges of the next few decades, there are few participatory initiatives to engage seniors in discussions about their own concerns, perceptions and needs. More particularly, there are few locally-based empirical studies examining the living conditions and formal and informal support needs of senior women living independently in rural communities. A health-related scan carried out in rural Nova Scotia (Guysborough Antigonish Strait Regional Health Authority [GASHA], 2002) demonstrates that there were no health-related studies that examined the overall health of elderly women within this predominantly rural district.

## SOCIO-CULTURAL SETTING

While the health concerns of senior women are international in scope, the sample population for the study lived in a rural area in northeastern Nova Scotia, Canada. The region's approximately 45,000 inhabitants are distributed among several small towns, villages and rural routes, with an average population density of 8.0 per square kilometer. The largest town and service centre in the region has a population of approximately 5000 and is the site of the regional hospital. At 14.5%, the senior population is greater than the provincial and national average.

Approximately 56% of the seniors in the region are women, and approximately 29% live alone (GASHA, 2001; Statistics Canada, 2001).

The geographic area has a long history of economic challenges. The settlement population relied primarily on subsistence farming, fishing, and forestry. Recent decades have been characterized by limited availability of services, out-migration of youth, and a relatively high incidence of senior women living alone on low retirement incomes (Nova Scotia Provincial Health Council, 2000; Veugelers & Hornibrook, 2002). More recent social changes and service cutbacks have placed the burden of care on families and volunteer services to care for seniors, or for seniors to independently cope with limited resources and support.

## METHODS

A participatory evaluation guide prepared by the National Advisory Council on Aging (1998) was used as a framework for the study. A core principle of participatory evaluation is that it uses a “bottom up” rather than “top down” approach to exploring the phenomenon in question. Likewise, the themes addressed in the study were not locked-in in advance, but emerged during the qualitative research process. Data collection entailed observation and open-ended interviews carried out by a research assistant. All standard ethics review protocols were employed in designing and conducting the research.

### *Participants*

The sample population included 22 senior women, five informal, and five formal support providers identified by the senior women. Informal support providers were identified by the women participants, and were usually either neighbors or family members. Formal support providers included health and home care providers or members of the clergy.

Senior women participants were living independently in the community, as defined earlier. A few of the women lived in apartments designated as seniors’ residences but none required extended care or lived in long term care facilities. Senior women participants ranged from 65 to 80-plus years of age. Participants were recruited by word of mouth and a variety of community publications.

### *Interviews*

Most of the interviews were carried out in the women’s homes, the research assistant’s home, or in places of mutual convenience. In most cases, the senior women participated in the interview on their own, although sometimes family members were also present. The interviews lasted from 20 minutes to 1.5 hours. Data were coded and analyzed for common themes.

## FINDINGS

The interviews provided valuable detail about the health and well-being of many senior women living in this rural area, and a broad profile of the possibilities and limits of the various forms of support available to them. Some of the women came from backgrounds where they had started factory work in their early teens, had given birth to numerous children (in one instance,

19) or had been homemakers all their lives. A smaller number had retired from professional careers. Several themes emerged from the interviews about the conditions in which the women lived, and the individuals and organizations active in the region providing various forms of formal and informal care.

### ***The Context: Home Life and Rural Circumstances***

One of the most prevalent themes that emerged from the interviews concerned the concept of home and the importance of remaining there. Some lived with their husbands or with other family members, such as an adult child (sometimes quite senior themselves) or sibling, but many lived on their own. Many of the women were living in the same homes they had lived in all their married life, and in some cases in the same house that had been in their family for generations. Others had grown up in the area, gone away for work or marriage, and returned later in life. A minority were relative newcomers to the area, having retired to the region from the city or other parts of the country. Although the interview participants reflected a wide range of lifestyle and socioeconomic backgrounds, a common perception was a strong tie to home and place, and a strong wish to remain where they lived.

For virtually all of the senior women, home life provided a vital sense of purpose, independence, meaning and pride, as well as an opportunity for physical activity. The advantages of living at home identified by the women included enjoying the scenery, taking pride in home decoration indoors and out, gardening, and being able to keep active through carrying out routine housekeeping activities. As one participant stated:

I do a lot of various things. I do all the work outside...like mowing the grass in the summer and shoveling the snow in the winter, and whatever I can do myself, I do.....if it's not a big snowstorm or too cold...I like to keep active, I guess, rather than sit around.

Many of the women felt that to move away from home and go to a nursing home meant death, and would do almost anything to maintain their independence in their home. In the words of one of the formal support providers:

I get the sense from talking with the women that...they would like to stay in their own environments, their own homes. They don't want to go to nursing care facilities unless they really have to.....They have lived there all their life, many of the women are widowed and they've been living on their own and by themselves and it is a big change to move in to a facility where they many have to share a room with someone else....It is pretty traumatic for them to have to face that.

Despite the women's strong commitment to remaining at home, the choice to do so was not without difficulty and presented a variety of challenges, not only to the women but to the people who provided their support and care. Many of the women lived in areas which were in "not just [a] rural but an isolated setting." The communities in which the women lived were often scattered, with neighbors "not always immediately handy" according to one formal service

provider, although “typically at least in sight.” Access to amenities was also sometimes problematic. As one participant stated, “to get to a store is big, basically half a day.”

An additional source of difficulty was the severity of winter weather. As one service provider commented:

The weather conditions [are a factor]...it puts added stress on the caregivers to know if [the women] are going to [be okay]. There are instances where there is no power. You worry about people falling. You wonder if they are burning candles or using lamps that are unsafe. Are they able to get something to eat, are they warm? Are they scared? Those are many of the concerns I have.

However, a common attitude among the women was that they simply did what they had to do, and sometimes even enjoyed the seasonal challenges.

Another difficulty posed by weather conditions was that many of the women lived in older homes that were poorly insulated, and were heated either by a wood or oil furnace. The maintenance of wood heating systems can be labor intensive and potentially hazardous. With regard to oil, there was a concern about fuel-trucks being able to make deliveries during difficult winter driving conditions. Participants also commented on the risk of power outages causing problems with water supply from wells that were dependent on electricity for operating the pump.

Despite these difficulties, what emerged from these interviews was a portrait of women who were proud of their independence and accustomed to the challenges of rural life. They largely accepted that facing these hardships in their own home led to a better sense of well-being than moving away to someplace less beloved and familiar.

### ***Physical Health and Health Care***

A second theme concerned the day-to-day needs involved for the senior women in looking after their physical health and well-being. For some, these concerns involved minor aches and pains. “I think I’m in perfect health,” said one woman, “except for the old creaky joints, the stiffness and soreness that happen to us all as we go along.” Others had more serious concerns. Some recounted long histories of acute physical ailments, having had to contend with shattered bones, hip replacements, cancer and attendant treatments, loss of eyesight, and other major diseases. Others were facing challenging problems with significant health concerns requiring ongoing medical treatment, such as kidney dialysis, oxygen supply, chemotherapy and radiation, and colostomy care.

With these physical realities, access to appropriate and effective medical care was naturally an important consideration. One dimension of this involved being able to get to the pharmacy, the hospital, and the doctors’ offices (general physicians and specialists) in a timely and effective manner. Those who lived in more isolated areas sometimes had to travel long distances to get to the drug store or doctor’s office. The women had access to a regional hospital in a nearby town which provided a sufficient level of care to attend to their more routine health needs, but for specialist services, a number of women had to travel back and forth to the two major urban areas in the province, both entailing a trip of between 2 and 4 hours each way. One woman, taking treatment for cancer, needed to travel to the urban area on a regular basis,

which involved a 3 and a half hour drive, followed by a 4 or 5 hour treatment: “It’s a tiring trip, it’s a long trip [and] you’re never sure when you’re going to be going. And there’s the weather factor, so you watch the weather a bit. Last year there was a lot of storms.”

Although it was often necessary to travel to receive needed medical care, some medical services were also available in the home. “I have a nurse coming twice a week,” said one woman. Another mentioned “a nurse that comes in and checks my [oxygen] machine. She checks my pressure and, every so often, if she has time, she calls for an appointment.” One informal support provider said: the “nurse comes in once a week, usually Tuesday or Wednesday, and she checks her blood pressure, checks the toenails, makes sure that I have supplies, catheter supplies, blue liners and that type of thing.” Other participants spoke of the availability of other in-home services such as palliative care, traveling foot and diabetic clinics.

The portrait of physical health concerns for rural senior women revealed by the interviews was not, however, simply a catalogue of conditions and ailments, and the forms of health care treatments available. In response to questions of what kept them healthy, matters of self-care and overall well-being also came up frequently. Many of the women commented on the importance of healthy practices such as diet, exercise, sleep, and maintaining a positive attitude. As one woman commented:

Regular check-ups and the care doctors give me [is important, but also there is] good food...and trying not to worry too much....If you sit and worry about things you’re not going to get anywhere, you know. I try to be positive about everything. It makes it easier.

Many of the women also identified the beneficial effects of keeping up with various recreation and crafts activities, including crosswords and jigsaw puzzles, baking, sewing, rug-hooking, bird watching, reading, watching the news, and learning how to use a computer. The women consistently placed a positive emphasis on the importance of keeping active, upbeat, and connected with the world around them.

### ***“At Home” Connections***

A third theme concerned the importance of other dimensions of connectedness. In living at home, often alone and at a distance from others, it was vital for the women to overcome feelings of isolation and to have a sense of connection “to the outside.” This was not always easy. Often, the work of looking after themselves and keeping up the home was beyond their capability. In many cases, the women were assisted by various kinds of home care, in addition to the in-home medical care mentioned previously. Many women had access to different levels of housekeeping support. Sometimes this was provided by a home support service, with financial assistance available for these services. Sometimes the women independently paid for assistance with some of the heavier activities, such as chopping wood and other outdoor chores.

However, the availability and level of interest in home care was not without attendant challenges regarding, first of all, what various homecare service agencies could do. According to one formal support provider:

What they are allowed to do is fairly limited...these elderly women... need extra things done such as house cleaning...the refrigerators cleaned out, their ovens cleaned, they need the heavier type of work... And also groceries, things that need to be picked up at the drug store...it is a very strict criteria that allows the home support workers to do that for them.

Another problem, according to a different formal support worker, involved the women's' reluctance to use services available:

Most elderly women are unwilling to take in home care. They feel that if they have to have help come in the home for any length of time, that they have failed their duty as a wife or in their career as a homemaker, so they tend to resist having any in home support.... These women have been the queen of the castle for, many of them, fifty, sixty, seventy years and they don't want to be told what to do. Then there is the problem of they don't want to admit that they do have problems...that they need help with at home.

Another dimension of "at-home" connections important to the women concerned keeping in touch with family, and receiving support from family members. For all of the women, family connections were paramount, and all spoke of the vital meaning they attached to being able to see or speak with family members as often as they could. For some of them family was quite far flung, reflecting a characteristic of the region. As one formal support provider stated:

Of course, in many of the areas now their young people, the families, the nieces, the nephews, the grandchildren have all moved away because there is no employment in the area so that connection with them is gone, and they may get home, if they are lucky, maybe once every couple of months.

For others, family and close relatives were either living with the women or close by, and seeing to the women's' needs on a regular basis. In some cases, family members were the primary caregivers. As one woman stated, "I have to have my daughter-in-law come and ah flush the line every day. I have to have somebody come every day." As another said, "It's only my family that's any help."

Sometimes family members stepped in of necessity, due to the limitations in the availability of funded in-home formal support, filling the gap to maintain the senior women's health and independence in the home. Many of the women, as well as support providers, noted the pressure on families that can result from caring for their senior relatives on top of maintaining jobs and caring for their own families. In the words of one family support provider: "I can think of numerous occasions... where family members are carrying the load...there is a lot of pressure on the family members or immediate family. Where is the respite for these people? How do they get a break?"

In a similar vein, another formal support provider noted gaps in the provision of palliative care, where all of the attention is focused on the dying person, not the people providing care who are left alone once the dying person has gone:

Once this spouse passes on, there you are, you're left, after he's gone, after the whole process of the death and the funeral and all of that takes place and everybody goes back to their lives, here you are left sitting with a whole ton of issues and the services are pulled. Bang!

Another area of concern, according to this same formal support provider, was that sometimes family members were not the best people to be involved in dealing with difficult situations.

At times, family members are not always the ones that can deal most efficiently with these women. It takes, sometimes, somebody from the outside to come in because of the different perspectives and it's just the whole family issue and family get frustrated with their loved ones because they don't do what they are suggesting, etcetera because [the women] want to remain independent.

### *Socialization*

A fourth theme that emerged from our analysis revealed the importance of wider patterns of support and socialization beyond the home, family, and health care system. Senior women discussed the importance of getting out and socializing with other people, and being involved in activities outside the home and family circle. Some of the social connections beyond the family identified as important included opportunities to travel, and to take part in community activities. Events mentioned ranged from bingo to carpet bowling to volunteer work to church attendance. For some of the women, opportunities to get together with people of the same age were deemed important for their sense of identity as well as a source of comfort. As one participant stated, "I value [the] companionship...with people of our own age. You know, just being with a group you can have fun with. Because younger people don't...have the same idea. They're a little different than we are."

For some, friends and neighbors in the local community were also an important part of their social life. They not only contributed to a sense of well-being but sometimes helped out with various tasks, and kept an eye on them. "My neighbors do things," said one. "I find that neighbors are like that, little things like that are appreciated." As one formal support provider stated, sometimes neighbors are a life line, taking on a sense of responsibility for the seniors, especially those living alone and/or with mobility challenges, in their community. "They automatically assume the responsibility. Not necessarily legally, but still morally they say, I've got to care for this person." Another formal support provider said:

People help each other without batting an eyelash.... I know two little old elderly ladies who lived on a country road and they could see across to the front window of each house. One of them was frailer than the other and the most frail lady used to pull her blinds up in the morning to tell her neighbor that she was up and alive and awake. And the agreement was that if the blind wasn't up by ten o'clock the neighbor was supposed to walk down the road, across the street and go in and see what was wrong with her. So they looked after themselves and each other very well.

Another important lifeline was the telephone. It allowed communication with friends and loved ones at any time of day. One formal support provider stated, “there’s usually someone around who calls up and says how are you today?” However, the need to be in touch by telephone could also create a burden for friends and families to make time and be available when the call arrived.

Despite all of these points of contact and sources of socialization however, a sense emerged from the data that one of the most persistent concerns faced by the women had to do with a chronic sense of loneliness, and sometimes even isolation. The women expressed a sense of loneliness due to their physical separation from others, and they related that they and others like them were sicker when the necessary supports were not in place. One individual commented further that “a lot of the support I think the women need, it’s more of an emotional support. Not more, but there’s a lot of emotional support. A friendly visitor, or whatever you want to call it.”

Of course, the women who had no family members nearby faced many challenges regarding loneliness and isolation. For these women, emotional support from informal and formal support providers was not adequately addressed by anyone. There was a commonly expressed sense of loneliness and yearning for companionship and affirmation that they were valued and important to society. Said one formal support provider:

They need that reassurance that they are still valuable, that they can still contribute to the world and what is going on around them. These women that I talk to, they’re sharp and they know, they’ve got a lot of experience and they can teach a lot....A lot of them are much more open to change than we anticipate....There is still a lot of resources and knowledge and information that we can glean from these people if we give them a chance.

### ***Transportation***

A final theme centered on the challenges associated with the lack of transportation. Many formal support providers as well as senior women and family members consistently indicated that transportation was one of the most critical factors affecting the senior women’s health and well-being. “The greatest need I think is transportation,” said one of the formal support providers. Due to the rural setting of the study, public transportation services were limited. There was no local transit, an ever-shrinking inter-provincial bus system and taxi services largely restricted to the towns. Therefore, transportation primarily meant access to and use of a car. However, as one support provider commented, “in that generation of women we are speaking of now, very few of them drive. Very, very few.” Another commented:

Transportation is a contributing factor....For many, they no longer drive, [and] their partners, if they have them, are no longer driving, and it is an inconvenience for others to drive them and they don’t like that. Or in some cases people are charging them to drive them to the doctor’s appointments....Even those who have automobiles can’t drive necessarily after dark and in winter they don’t get to as many social functions as they would like.

Another dimension of this was not simply accessibility but the negative feelings associated with being dependent on others for their mobility. As one woman said, “You hate to be phoning people all the time...well, are you going here? Can I go with you? You know...and I just get tired of it and they don’t ask me...Well, sometimes I don’t ask to go either....”

## DISCUSSION AND RECOMMENDATIONS

The findings from this study outline the perspectives of a group of rural senior women, along with people involved with providing their care, about the everyday circumstances of their lives and the sources of support they identified as important to their health and well-being. The findings are not necessarily representative of all senior women in the region since, as a qualitative study, the aims of the project were not to determine generalizable patterns but to gain insight into the particularities of individual experience. However, the results provide a glimpse into the kinds of realities faced by a sector of Canadian society who are not often consulted about the nature of their life circumstances or their views on what matters to them as contributors to their health and well-being.

Similar to other studies, many women who participated in the research project described themselves as healthy and active, yet virtually all of them identified some manner of physical condition which they had to factor into their daily living. Although seniors generally report good health in their later years, they are more likely than younger people to suffer from chronic conditions, to have activity limitations, and to be dependent on others for assistance with activities of daily living (Division of Aging and Seniors, 1998; Statistics Canada, 1999).

Yet, one important result of the study was the consistent view that the various forms and levels of physical infirmity these rural women experience are only one aspect of their health and well-being. While physical health concerns were always a factor, there was a larger sense of urgency and poignancy associated with the broader picture of life in a rural community. Our data revealed that the ordinary life circumstances of the women were inextricable from their overall sense of happiness and well-being. It was difficult to separate their medical concerns from other physical concerns of daily life such as getting the groceries in, the house cleaned, the lawn mowed, the wood stacked, and the driveway plowed in winter. It is essential that such factors be included in the development and implementation of social programs and policy that meet the needs of rural senior women.

Another significant finding of the study was that the women and their care providers placed as much importance on social and emotional needs as they did on physical concerns. Our findings conform closely to the view that “social relations and support from family, friends and communities have been shown to contribute to health” (Genuine Progress Index Atlantic, 2002, p. 64). In accordance with other studies that show a strong correlation between negative well-being and feelings of loneliness and isolation (Hall & Havens, 1999; Patrick, Cotrell & Barnes, 2001), our study emphasized the importance of maintaining an active and socially engaged life style alongside adequate provision of health care and disease treatment.

An overarching recommendation is to have a nurse leading a multidisciplinary team to plan and evaluate holistic support, tailored to the on-going needs of the client. In accordance with Pullen, Walker and Fiandt (2001), health services for rural senior women need to be holistic and involve a focus on health promotion and prevention of disease and disability. This includes a composite array of services, attending to both physical and psychosocial aspects of health and

well-being, and attuned to the particular needs of women living in rural settings where services of any kind are difficult to access and fairly limited.

Regarding specific nursing care, recommendations that emerged from the study include the need for such programs as traveling clinics for foot care, diabetic services, health promotion counseling, and increased availability of nurse practitioners as a means of improving access to medical and nursing care. Concerning psychosocial needs, resources such as a telephone lifeline, and a network of neighbors keeping an 'eye out' for each other, are other central factors vital to the health continuum.

In addition to these dimensions, another result of the study touches on the all-important challenge of transportation in rural settings. For women participants in rural Nova Scotia, transportation was a key element in maintaining independence and quality of life at home. However, because these senior women were often unable to drive, they were dependent on others to meet their transportation needs and, in juxtaposition, the women were hesitant to ask for help related to transportation issues. As corroborated by Michalski (2002), lack of transportation, particularly in rural areas, is a major barrier to health and well being for those who require health and social supports outside the home.

Another important implication concerned societal views of senior women as a resource with something to offer, rather than simply as a burden needing care. As other studies have shown, for healthy rural communities to be sustained, seniors must be seen as central to community strength and identity (Jensen & Royeen, 2002). Thus, holistic care is not simply a matter of seeing health services more holistically, but also seeing the place of seniors in the community in a more holistic and integrated way.

## **FINAL WORDS**

Health and social policy not informed by individual and community interests are seldom successful or lasting (Meegan, 1993). This study serves as a foundation for additional community-based research projects aimed at increasing awareness of the support needs of senior women in the region, and developing policy and practice recommendations for improving the availability of support for these women. Data from this study indicates that, within one rural community, senior women are struggling to sustain their health and well-being and live independently in their own homes. These women and others like them will be unable to continue living independently with an adequate quality of life without an improved array of holistic, accessible and funded support.

## **ACKNOWLEDGMENTS**

The authors would like to thank the St. Francis Xavier University Research Council and the Centre for Regional Studies for funding this study. Sincere gratitude is also extended to our research assistant; Nancy Emerson. Last but not least, a special 'thank you' to participants who shared their life stories.

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