Health Needs of Northern Women 45 Years and Older

- Preliminary Findings –

A project undertaken in conjunction with
Northern Health Women's Health and Wellness Program,
with support from British Columbia Provincial Women's Health Network,
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Note: Further analysis of the data will be undertaken in the context of the author's Master of Social Work thesis as well as for publication in relevant journals. Copies of these future publications will be made available to, and will acknowledge, Northern Health and the BC Provincial Women's Health Network.

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Table of Contents

Executive Summary

This project was funded by the Ministry of Healthy Living and Sport [1] with support from the BC Provincial Women's Health Network and the Northern Health Women's Health and Wellness Program, to explore the self-identified determinants of health most salient to women 45 years and older in northern BC. Almost five hundred women from across the North have contributed their voices to this report through the completion of surveys and participation in focus groups.

Descriptive statistics and summative themes enhanced with participant quotations have all been used to present the most salient preliminary findings of this research. The strongest messages which emerged out of the data are related to access to health care; affordability / accessibility of health and wellness supports; socialization and community connectedness; information and education; and life transitions and adjustments.

This report offers a number of recommendations based on the research findings, directed at Northern Health specifically, as well as other levels of governmental decision makers and health policy writers. Study challenges and limitations are also outlined as are suggestions for future research related to women's health and wellness in northern BC.

[1] Specifically, funding was provided in 2007/08 by the Healthy Women and Children's Branch, Population Health and Wellness, Ministry of Health (which, as a result of a Cabinet realignment in June 2008, is now within the Ministry of Healthy Living and Sport).

Introduction

The study of health has undergone considerable transformation over the past several decades. The World Health Organization defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Ruzek, Clarke & Olesen, 1997, p. 12). This definition represents a shift in the conceptualization of health, from the former, traditional bio-medical model, and takes into account behavioral and social influences.

The women's health movement has evolved historically in parallel with the women's movement in general. A discussion of the multitude of historical details included in the women's movement would be too extensive for this report. However, one important and noteworthy shift in thinking about women's health, which emerged out of the second wave of feminism in the 1960s was the challenge to the medicalization of women's health (Morrow, Hankivsky & Varcoe, 2007). Feminists' conceptualizations of health "link the source of health to communities, where food, housing, education, and environmental hazards; the prerequisites to health, are located" (Ruzek, et al. 1997, p. 21).

Social models of women's health eventually began to evolve as it was increasingly recognized that sources of risk for women's health were to be found in the nature of women's lives and their social and economic environments (Kuh & Hardy, 2002). Feminists argued that health had to be "understood holistically, and that addressing the social determinants of health such as poverty, racism, experiences of violence and other forms of social inequality was critical" (Morrow, 2007, p. 44).

In the 1990s, the Centres of Excellence for Women's Health Program was established by Health Canada and was mandated to improve the health status of Canadian women by enhancing the health system's understanding of, and responsiveness

to, women's health issues (Morrow, 2007). In 2000, the federal government also established the Canadian Institutes of Health Research, one of which is the Institute of Gender and Health, which served to increase the capacity of researchers to investigate questions related to gender and health.

It is not the intention of this research to make generalizations about the health and wellness of women in other geographic locations. Although the purpose is to provide a descriptive presentation of the self identified health needs of women in northern BC, given the geographic diversity of northern BC, we would be remiss if we did not provide some commentary on the differences in health between rural and urban regions.

In BC the Provincial Health Officer's Annual Report (2000) outlines that health status varies across the province with better levels of health being found in the south, and northern regions having the poorest health, based on the measures available. The same report indicates that women living in the northern and rural communities of BC have the lowest levels of health status indicators, such as life expectancy, when compared to women of a similar age and circumstance living in other parts of the province.

Research has been done in other northern Canadian communities. Wakewich and Parker (2006) revealed gaps in health services for women in northern Ontario, highlighting how northern environments (social, cultural, economic, political and geographical) influence women's health beliefs, practices and access to care in unique ways. It was also discovered that there was very little published research which explored the social, cultural, political, economic and geographical aspects of northern women's experiences and understandings of health and health behaviors (Wakewich & Parker). It was suggested that "women's voices and perspectives on their health and the health of their communities

are muted in the existing studies and would be more centrally drawn out by complementing existing quantitative studies with more in depth qualitative research projects" (p. 6).

Numerous research projects have been conducted within northern BC related to health and health care services. In one unique study by Healy et al. (2001) entitled "North of 65 Years: Report of the Research into Health Services for Seniors in the Northern Interior Health Region of British Columbia" northern seniors were surveyed and asked about how they used the health system, what did and didn't work for them and how things could be made better. Interestingly the authors noted that "most seniors do not identify medical care as a factor in maintaining their health" (p.16). However the same report indicated a strong message that "having a health care system that was 'once again, reliable and available' was the major factor in service delivery" (p.14). Hemingway and MacLeod (2004) noted, as a result of the North of 65 Years project, "the profile of seniors and seniors' health needs has been elevated within the Region" (p. 144).

In an equally informative study produced by Madrid (2003) entitled "Speaking With Our Own Voices: Recommendations for Initiatives to Improve Women's Health in Northern British Columbia", it was noted that "what northern women required the most was support in their present endeavors to enhance the local women's health and wellness and to have the importance of northern women's health acknowledged" (p.5). In another study based in northern BC, by Hemingway and McLennan (2005), it was noted "women are coming to recognize that local concerns about the health and wellbeing of their communities and families have larger structural, systemic implications that need to be addressed collectively and beyond narrow geographic confines" (p. 161). Leipert and Reutter have also done a great deal of research into the area of women's health in northern BC, concentrating on

issues such as community health nursing (1998); the role of geography and gender (2005b); and how women develop resilience (2005a).

The women's health movement in Canada has shown a great deal of promise in the past decade in terms of pushing the women's health agenda forward. This study will contribute to the cause by providing a more focused view of the self-identified determinants of health and wellness most salient to women 45 years of age and older in northern BC.

Background

In 2007, in her role as the Northern Health Authority (NHA) representative for the British Columbia Provincial Women's Health Network (BC PWHN), Lynda Anderson (Program Coordinator for the NHA Women's Health and Wellness Program) initiated a region wide survey, asking women in northern BC to identify the most pressing needs related to women's health. Two major themes emerged: 1) violence, mental health and addictions and the need to address the links between abuse, trauma related to colonization and addictions, and 2) older women (self-identified as age 50 years and older) and their need for better access to services, increased emphasis on disease prevention and services that care for caregivers. To date, research on the health needs of women in their post-reproductive years appears to remain largely unaddressed, especially for older women in marginalized populations in northern, rural and remote communities.

As a result of the NHA survey completed by Lynda Anderson, the BC PWHN provided support to NHA to facilitate another research project, through funding made available from the Ministry of Healthy Living and Sport. The BC PWHN recommended that new research be undertaken to gather information from post-reproductive women (age 45 years and older as defined by this project) in northern BC on a number of holistic health

related factors, including nutrition, exercise, social supports, housing, preventative health screening, mental health and stressors. University of Northern BC Social Work Professor Dawn Hemingway was contracted by NHA to carry out this research project, along with graduate student Melinda Allison, who will further this research by utilizing the data collected from women 65 years and older as the basis for a graduate thesis for her Master of Social Work degree.

Purpose

The purpose of this project was to explore the self-identified determinants of health and health concerns that study participants believe to be most salient in the lives of post-reproductive women (age 45 years and older) in northern BC, the service gaps that they believe are present, and suggestions regarding which services, policies and programs participants believe may result in better health outcomes for northern women. The research findings will be presented by way of descriptive statistics and summative themes which emerged out of the data and will be highlighted by the personal words and lived experiences of northern women. It is hoped that this report will be used by health service delivery agents and policy makers to better meet the health needs of northern women.

Research Questions

The following research questions have been explored in this study:

1) What are the self-identified social determinants of health and health concerns that participants believe are most salient in the lives of women age 45 years and older in northern BC?

2) What are the percieved gaps in services that these same northern women believe currently exist?

3) What recommendations are made by study participants to achieve better health outcomes for northern women age 45 years and older?

Ethics Approval

This research has been approved by the Research Ethics Board of the University of Northern British Columbia as well as the Research Review Committee of Northern Health.

Methodology

Data Collection

Data collection took place during the months of March, April and May, 2008, and included focus groups as well as surveys. To be eligible, participants must have been living within the boundaries of Northern Health. The specific geographic boundaries included Quesnel to the south, Haida Gwaii to the west, and the provincial boundaries to the north and east of Prince George.

The surveys were made available to complete both on-line at www.zoomerang.com and in paper format. The link to the on-line survey was distributed by way of emails through numerous distribution lists, by the researchers and their extensive community connections across northern BC. Some of the distribution lists and networks included the Women North Network, BC Association of Social Workers (Northern Branch), Prince George Council of Seniors, and Northern Health Authority's Women's Health and Wellness Program. The email introducing the survey encouraged participation and also asked that each recipient assist with distribution by passing the email along to their friends and colleagues.

An interesting point to mention here is that on June 1, after the electronic survey had been closed for data analysis, it was discovered by happenstance that the survey was

still being promoted on the website for the Canadian Breast Cancer Network, (a network that was not one of the original distribution sites). With this in mind, it would be very difficult to precisely determine the extent to which the electronic survey was distributed. However, this example does confirm that it traveled beyond the bounds of the original distribution networks.

The paper surveys were distributed through various public venues, including but not limited to women's wellness centers, UNBC regional campuses, community colleges, seniors centers, community workshops, conferences, fundraising events and the Prince George International Women's Day Breakfast celebration. Efforts were also made to reach out to women who may be homebound through delivery by the Meals on Wheels program, the Council of Seniors outreach program and directly to two seniors' housing projects.

Nine focus groups took place in total and were conducted in the communities of Prince George, McBride, Quesnel, Terrace and Smithers.

Research Participants

Almost 500 women from across northern BC contributed their voices to this research project. Four hundred and six women completed surveys, (155 completed electronic versions, and 253 completed paper versions). Ninety women participated in the focus groups. It should be noted that some women chose to complete a survey in addition to participating in a focus group, and therefore the exact number of actual individual participants could not be precisely accounted for.

The demographic details solicited from the participants who took part in focus groups were limited to determining their age ranges. Thirty three of the participants were between 45 and 64 years of age; and 57 participants were 65 years or older. Over

sampling of focus group participants 65 years and older was done intentionally to better capture the voices of the older women who completed only 27% of the surveys.

More detailed demographic information was collected from survey respondents, including ethnicity, age range, employment status, education, annual household income, marital status, sexuality, and whether or not they had a disability. The majority of respondents were between 45 and 65 years of age; heterosexual; either married or common-law, separated or divorced; had education levels of college or higher; working full or part time; and with an annual household income of $40,000 or more. More detailed demographic information on the survey respondents is available in table form at the end of this report (see Appendix A).

Sixty-three survey participants (15%) indicated they had a disability. Of this group of women, 40% described having back / joint pain, rheumatoid or osteo-arthritis, or fibromyalgia; 16% described their disability as a psychiatric or mental illness; 11% had a visual or hearing impairment; 24% indicated various other health conditions, including diabetes, heart conditions, kidney disease, multiple sclerosis, hepatitis C and sleep disorders. Interestingly, 5 women described their disability as “old age”.

In response to the question about ethnic / cultural / national origins a variety of responses were provided. An overwhelming majority (89%) of respondents indicated some kind of Canadian, or European origin; while 7% indicated an indigenous origin, including First Nations, and Métis. The remaining 4% of respondents described a variety of other ethnic origins, including American, Chinese, Mexican, Filipino, East Indian, West Indian, and Australian.

To gain a sense of the geographic location within northern BC where survey participants were living, they were asked to include the first three digits of their postal

code. According to Canada Post if the second digit is a "0", this indicates a "rural" rather than an "urban" address; meaning residents must come to a centralized post office to pick up their mail. It is important to note that the "rural" regions as defined by Canada Post are quite large in geography and therefore cannot be used to determine precise locality. Based on Canada Post's categorization of rural versus urban, 22% of the surveys completed came from women who live in rural areas.

Data Analysis

Paper surveys were converted into electronic format, and all of the survey data was merged into one electronic database. Quantitative data were first analyzed directly on the Zoomerang on-line survey tool, and then exported to Excel for further analysis. Descriptive statistics have been used to highlight the findings from the quantitative data.

The focus group sessions were tape recorded and later transcribed into text, allowing for all of the qualitative data collected through both surveys and focus groups to be analyzed using a thematic analysis approach. Themes which emerged from the qualitative data will be outlined later in this report.

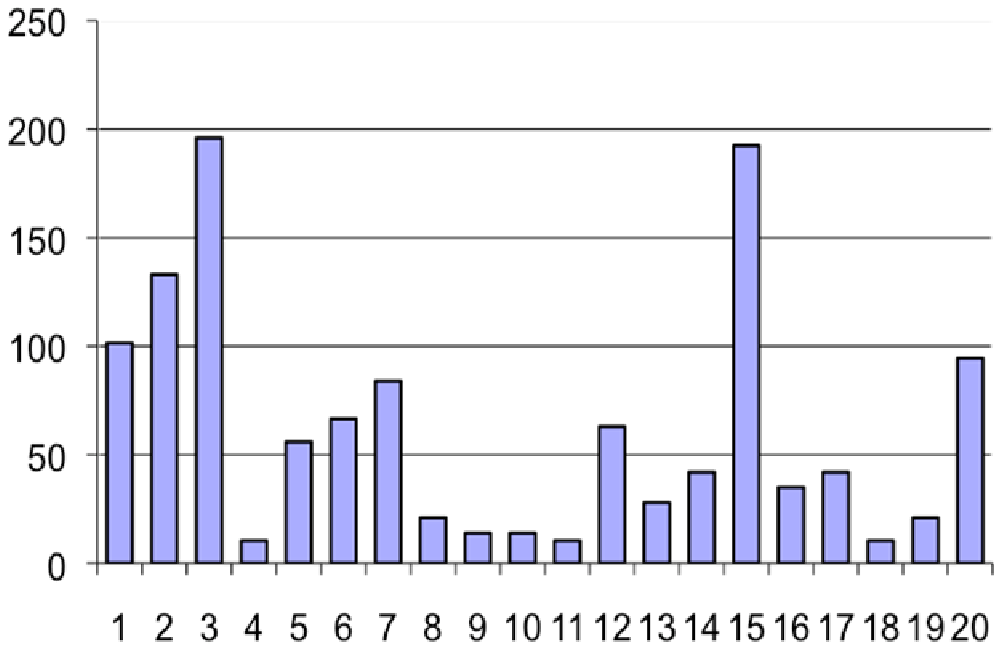
Research Findings: Quantitative descriptive statistics

The survey questions which provided quantitative data related to factors that impact health and wellness; preventative health screening measures; ways in which support could be provided; and the availability of those supports.

In terms of what is currently having the most impact on their health and wellness, the top eight factors reported by northern women were: stress (56%); not enough exercise (55%); anxiety (38%); depression (29%); financial problems (24%); limited social supports (18%); prescription (or non-prescription) drug use (18%); and issues of abuse (16%). With

respect to the women who had identified issues of abuse, the types of abuse reported were: emotional (88%); physical (44%); financial (42%); and sexual (38%). For a complete list of factors and responses, please see Figure 1.

Figure 1. Factors affecting health and wellness (n=350)



Legend

1 – Depression
2 – Anxiety
3 – Stress
4 – Other mental health
5 – Abuse
6 – Drug use
7 – Financial problems
8 – Housing problems
9 – Lack of childcare
10 – Alcohol use
11 – Gambling
12 – Limited social supports
13 – Limited community supports
14 – Poor nutrition
15 – Not enough exercise
16 – Transportation problems
17 – Problems with social relationships
18 – Effects of colonization
19 – Racism / discrimination
20 – Other issues

Interestingly, only 46% of respondents agreed that the factors referred to above have more influence on women's health as compared to men's health. In addition, 80% of respondents agreed that the issues influencing their health and wellness have changed as they have become older.

When asked about ways in which support could be provided, in relation to the factors influencing their health and wellness, the most common sources of support that women indicated would be helpful were: support from friends, family and support groups (86%); followed by reading materials / brochures (75%); women's wellness centres (72%); family doctors (69%); on-line information / education/ support (66%); social workers / counselors (57%); access to hospitals / health care centres (49%); and financial support (47%). It is important to note that respondents were able to identify multiple responses to this question.

Respondents were also asked whether or not these same sources of support were available to them. The following were the top five sources available to respondents: family doctor (97%); support from friends, family and support groups (94%); access to hospitals or health care centres (94%); reading materials / brochures (93%); and finally public health nurses (84%). It is interesting to note that although 97% of women indicated they had access to a family doctor, only 69% identified a family doctor as a source of support in terms of factors that they perceived as influencing their health and wellness.

Participants were asked to rate how important various preventative health care measures were to their overall health and wellness. Using a Likert Scale, measures were rated from 1 to 5, with 1 representing "not important", and 5 representing "extremely important". Mean scores for the top five preventative measures rated as most important to survey respondents were: vision testing (4.4); breast cancer screening (4.34); cardiovascular / heart health checks (4.23); dental care (4.13); and cervical cancer screening (4.09). For detailed information on all measures scored, see Appendix B.

In terms of access to preventative health care measures, women generally indicated that access was available through a physician or an outside referral. However, a

common theme among the responses was related to a need to be heard by physicians when requesting preventative health care. Respondents reported having to be "assertive" with their doctors when inquiring about some screening.

> "*These services are available if you have a doctor who listens to you (many of them don't), if not, a woman could go without screening for ever!"*

For a number of participants access to health care measures depended on their finances. In other words, not having the financial resources to pay for some preventative health care services (e.g., dental care, bone density testing) would preclude women from accessing them.

> *"… all are readily available, however some are chargeable services which takes them out of readily available based on finances."*

The issue of access to health care services will be explored in more detail in the next section of this report.

A number of survey questions were specifically related to the role of caregiving, and the following was revealed. One hundred and twenty-two (32%) of the respondents identified themselves as being in a caregiving role. Of those self-identifying as a caregiver, 56% indicated that they share their home with the person they provide care for. In terms of who was being cared for, 39% reported caring for children; 25% reported caring for a parent; while 23% reported caring for their spouse. In terms of satisfaction and stress related to the caregiving role, 37% of respondents indicated that they were "very satisfied" with their caregiving role, while 49% indicated that they were "somewhat stressed". Given the potential negative impact of stress on health and wellbeing, finding ways to provide support to these caregivers should be explored. Regarding respite or caregiver relief, 75% indicated that they get some type of relief from their caregiving responsibilities, leaving one

quarter of respondents receiving no respite at all. For further details regarding the data on caregiving, please see Figures 2-4.

Figure 2. Who are you a caregiver for? (n=122)

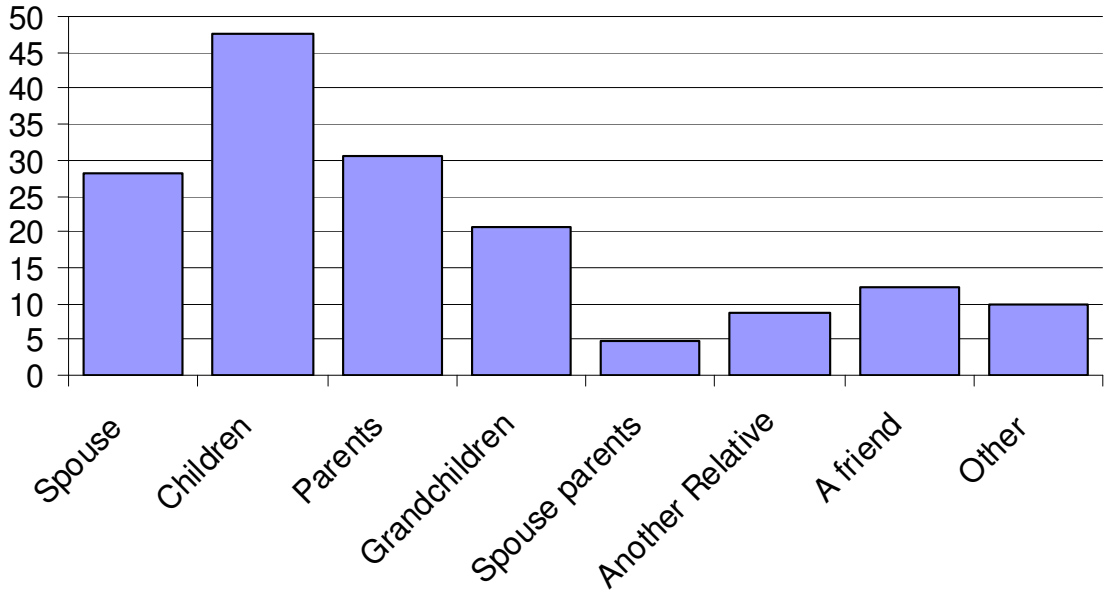
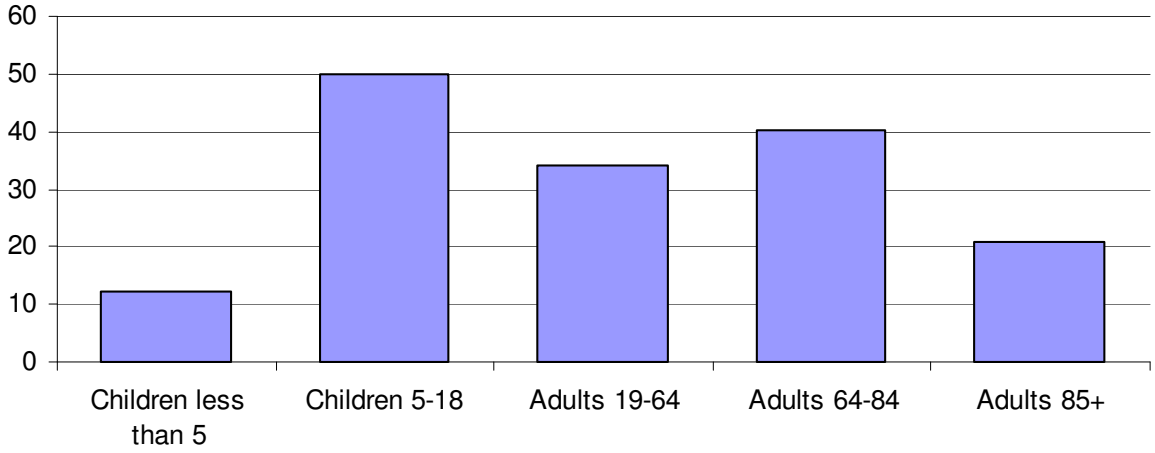
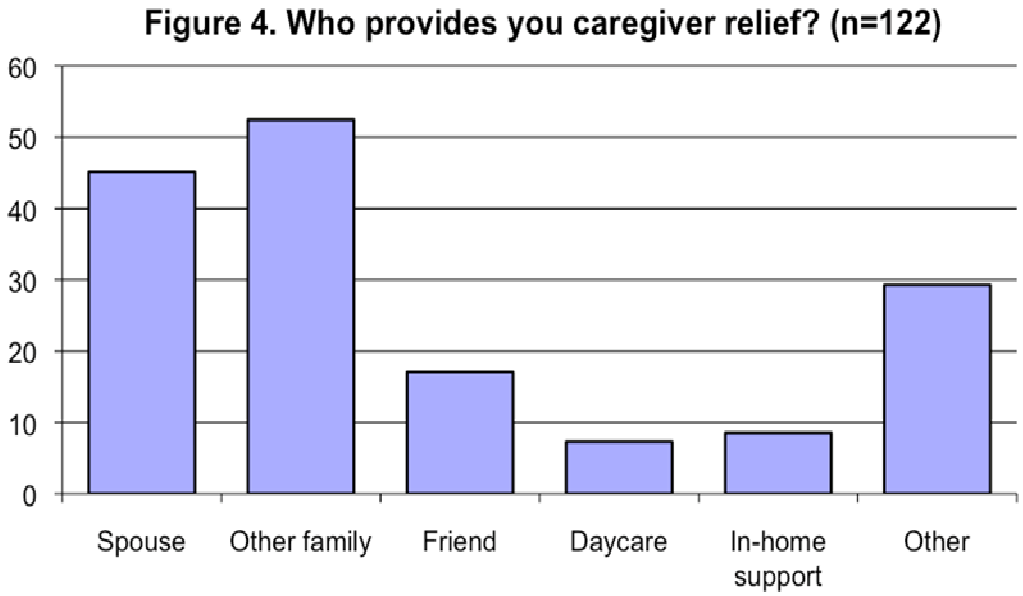


Figure 3. What are the ages of people you care for? (n=122)





Research Findings: Qualitative Themes

Qualitative data from the surveys and focus groups were examined using a thematic analysis approach. The following themes emerged from the data:

1) access to healthcare services (medical / specialist / extended / alternative);

2) affordable and accessible supports;

3) socialization and community connectedness;

4) information and education;

5) transitions and adjustments.

Some of the themes contain sub-themes which could be categorized within more than one of the larger themes, indicating a common tendency towards interconnectedness and enmeshment when exploring issues related to women's health and wellness. The themes are presented in the following section as descriptive summaries of the data and are given richness with the inclusion of quotations from the study participants. Relevant research is also included to provide context to the themes and findings.

1) Access to Healthcare Services (Medical/ Specialist/ Extended/ Alternative)

The issue of frequent and extensive waitlists for medical doctors and specialists was highlighted consistently throughout the data. This theme consisted of access to basic medical care from family physicians and general practitioners as well as numerous specialties, including but not limited to cardiology, oncology, orthopedics, internists and psychiatry.

Waiting for various types of screening and diagnostic testing was also frequently raised as a concern, including MRIs, CAT scans, colonoscopies, liver testing, bone density testing, hormonal testing, and diabetes screening to name a few. In response to one survey question which asked about the availability of various preventative health checks, some responses included:

"Most are available, some you are dependent on your doctor as he sees fit. My doctor told me 'all these tests are a burden on the health system' and would not do most of them."

"I think all are available to me because I have money – I've been told bone density tests are no longer covered but I would like one as osteo is in my genes. Dental, vision tests physiotherapy, chiropractor – not accessible to the poor."

"When I need a dentist it would be helpful if the town dentists had a better relationship with Health Canada. One dentist accepts native clients and the others say it is too bothersome to deal with the bureaucracy waiting for payment."

Several personal stories were shared about the stress and anxieties of having to endure extensive travel at high financial cost in order to access medical treatment and health care.

"But you know money wise, what happens when you don't have that money? I asked my doctor, and I said is there any way? He said well Air Canada will give you a bit of a discount if I write you a letter. The doctor charges $35 for 3 lines! You know… and there you go… that's more than the blessed discount you get on the airplane!"

Over and above the financial costs of traveling, women also reported experiencing a great deal of stress related to being away from home and the support of their friends and family when they needed it most. Sadly, some women gave examples of having to forego medical treatment for reasons such as being unable to afford to take time off work or find alternative child care, or caregiving supports in their absence.

In addition to basic medical and specialized services, participants also expressed concerns about the inability to access preventative health measures as well as so-called "extended" health care services. Some of these services, including dental and vision, are not covered through the BC Medical Services Plan, making access especially problematic for women with limited financial resources. The high cost of medications is additional strain on many women, and particularly so for older women.

> *"… there was a problem with the pharmaceutical here… I ran into some people who were having to pay… I forget… X number of dollars and they said well it was a toss up with buying all of his medicine or eating and so they bought one of his medicines and groceries."*
>
> *"Well you have to pay to live… I mean let's put it that way… I mean if you're paying rent in here but if you're only on a certain income, if you're only on old age and the guaranteed supplement you're not getting a lot of money and if you've got to pay for your medications, I mean there is people who have to make a choice – do I pay for my pills or do I eat?"*

Finally, the use of alternative or complimentary therapies was raised as a common preference for many women. It was suggested that in order to have a health care system that was truly holistic, traditional medical practitioners need to develop a collaborative working relationship with complementary health care providers that is inclusive and respectful, allowing women to have choice.

> *"I would like to see alternative health services covered by MSP – I rarely use allopathic medical services or prescription drugs – a fair amount of my disposable income is spent on maintaining my health – vitamin supplements, exercise class, massages, etc."*

"It's complimentary rather than alternative… and mutual respect, because I think the allopathic community hasn't given a lot of respect to natural or alternative health care, and I'm almost seeing the same in reverse whereas alternative health care doesn't respect allopathic… in reality it's holistic and it's complementary and one really can't exist 100% without the other."

There were some respondents who indicated satisfaction with access to medical and extended health care services, including positive relationships with doctors and other health care professionals as well as the availability of information, resources and good quality care.

"I'm a breast cancer survivor so medical covers checkups. I live in a nursing home with excellent care and support especially re: diabetes and mini-strokes/hypertension."

"… women's wellness clinics – excellent resource, safe, accessible. Screening mammography services. No yoga anymore – I really miss it!"

The theme of inadequate access to health care services is consistent with other research, including the findings of Madrid (2003) who reported that women in northern BC were angered and frustrated by the accessibility of health care services at the local community level as well as regionally. Leipert and Reutter (2005b) noted that health care is inadequate for northern women, in particular diagnostic, treatment, and heath promotion and illness prevention services.

In a study of seniors' health care in northern BC, Healy et al. (2001) noted "most seniors do not identify medical care as a factor in maintaining their health" (p.16). However the same authors also revealed a strong message that "having a health care system that was 'once again, reliable and available' was the major factor in service delivery" (p.14).

2) Affordable and Accessible Supports

There was a definite theme within the data with regard to the need for affordability and accessibility related to health and wellness supports. The term "supports" is used here to represent specific factors that support health and wellness, including healthy foods, exercise, transportation, housing, homecare, housekeeping and caregiver relief. Some of these supports fit into what the National Collaborating Centre for the Social Determinants of Health (2006) would describe as social determinants of health. In addition to social supports (which will be discussed in detail in the next section), the importance of being able to afford these supportive factors was heard loud and clear.

"But to some people $6 is a lot of money, like I said when you're on a limited income and it doesn't last you forever. I know lots of people who half way through the month when you've got your pay cheque they're already broke and they still have 2 and a half weeks to go and they have no money 'til next payday."

"*The Metis Society here in Ft. Nelson has received a grant from the ACTNOW-BC funds and is paying the drop in fees for us to use the swimming pool, Curves, and Esteem fitness gym. This has just started and I expect to use it on a regular basis. The mandatory monthly membership was a barrier before."*

One group of women was outraged by the passing of a recent law related to food safety, prohibiting them from having pot-luck socials. They saw this as a real loss for their community, having negative impacts on their health and wellness in terms of their ability to access affordable, locally produced healthy food, as well as the loss of the social networking benefits of such gatherings.

Although there were some differences between northern communities in terms of health and wellness priorities, there were also clear commonalities. The need for appropriate levels of accessible and affordable housing was expressed in every community as was the need for in-home support, including home care, and housekeeping

assistance. Numerous personal stories were shared about people who have been inappropriately "housed" in assisted living units, or "held" in acute care hospital beds because of a shortage of local long term care beds. Some people have even been forced to move to other communities, and leave friends and family behind in search of care facilities that would meet their needs.

> *"Some have to leave town here if they're in a position where they're not ready for long term care, they can't look after themselves in their own home so they'll have to be sent away if there is an opening and then they lose out on friends and family visits, and that's very important. We need that second step."*
>
> *"… the big thing that I find that is lacking in this community is like housekeeping types of services – there is none there for them… you know the vacuuming, cleaning the bathroom and just general housecleaning say once a week will keep a senior at home a lot longer."*

In terms of the value of homecare and home support services, the National Coordinating Group on Health Care Reform and Women (2002) reports that this assistance can mean the difference not only between staying at home and entering a facility, but also between life and death. The Canadian Research Institute for the Advancement of Women (CRIAW, 2007) has also published documents highlighting the numerous negative consequences associated with women living in poverty including substandard housing, inadequate access to transportation and healthy foods, subsisting in violent relationships due to lack of alternatives and increased physical and mental illnesses, to name a few.

In a national study by the Centres of Excellence for Women's Health on rural, remote and northern women's health, it was found that poverty and financial insecurity were key determinants of health for rural women and their families, (Sutherns et al. 2004). Leipert and Reutter (2005a) studied this same issue in northern BC and reported that

although northern women develop resilience, they remain vulnerable to health risks because of their limited ability to address systemic factors that are beyond their influence.

3) Socialization and Community Connectedness

On the surface, this theme could seem to have the least connection to women's health and wellness. However, the responses to one survey question asking "what 3 factors would you say currently have the most positive influence on your health and wellness?" reflect an overwhelming endorsement for the importance and value of support from friends and family, and having healthy relationships. Some of the responses to this question are included here

> *"The fact that I still have my husband (60 years wed), some family members nearby, and opportunity to socialize at seniors clubs, and a good family doctor who cares."*
>
> *"Family love, friendship, church friends and functions, ability to dance and participate in social functions at our Seniors Centre."*
>
> *"A loving/caring soul mate who accepts me for who I am… good friends who gave me the courage to get help… and my own resilience."*
>
> *"At least a hug a day!"*

One focus group participant commented on the importance of accessible transportation for her health and wellness, in particular for social outings which she felt were just as important as medical appointments.

> *"… it's just as important for me to get out of my house – cause I live alone and there is no one to talk to and it's just as important for me to go down to the seniors centre and talk my head off and I can go home happy – you know? So it is for my health too, not just for a doctor's appointment."*

A Fact Sheet by CRIAW (2001) indicates that social isolation and loneliness are as great a predictor of disease and premature death as smoking, obesity, lack of exercise and high blood pressure. A metasynthesis of literature on Australian rural women by Harvey

(2007) also lends support to this theme by highlighting the important contribution a sense of connectedness to others and community makes to health and wellbeing.

Research suggests social ties have the potential to provide both health promoting factors and health deterring demands sometimes at the same time. Social relationships that incur strains as well as gains may be more common among women than men, making women more vulnerable to the cost of caring and maintaining their commitments to social relationships (Marks & Ashleman, 2002). In a national Canadian study by Sutherns et al. (2004), it was found that many women praised the health benefits derived from the social capital in their communities, including services clubs, community spirit, proximity to family and supportive interpersonal relationships.

This theme is also consistent with the work of Leipert and Reutter (2005a) who reported that social support was seen as central to women's health in northern BC. These authors acknowledged the fact that in northern communities where women often have to move away from their families for employment, "friends often take the place of family" as central to their support networks. Thurston and Meadows (2003) have reported similar findings, and have noted that the social context, particularly relationships, were very important for women's health, as was the emotional and practical support gained from sharing similar experiences with other women. Fortunately, in a recent study of quality of life indicators in northern BC, Michalos et al. (2007) found that older adults reported very high levels of social support from within their local communities through church social groups, voluntary organizations, ethnic associations, social clubs and senior centres.

4) Information and Education

The need for accurate and accessible information about health and wellness was a clear message which emerged from the data. Participants acknowledged that women are

busier than ever before, with multiple roles, and little time to spend researching their particular health issues. Women appreciate information both for general interest, as well as to educate and inform them, especially for preparing to go to medical appointments.

> *"You know what the challenge is to health care? Is that nobody tells you what's available. You don't find out unless you talk to somebody else… the government doesn't tell you anything. You go to the government office… and say; well what's available for health care? And they say "I don't know, I don't know", everybody tells you no they don't know anything. You know how depressing that is for somebody who is looking for help and they can't get it?"*
>
> *"I think that women's assertiveness to understand what's going on with them, we're demanding answers now as opposed to just taking what we get… and to have more of an input into how you're going to address whatever the situation might be… we're not just pretty in an apron anymore!"*
>
> *"There needs to be a focus on helping, especially the First Nations community to understand the long term effects of poor diet and lack of exercise. We need a plan and people to provide leadership with passion and patience."*

Information was a very broad theme in this study and related to topics such as preventative health, signs and symptoms of health conditions, alternative and complementary therapies, as well as resources and services available in their communities. Some participants gave credit to the media for keeping the public informed about health, naming sources such as Oprah, Dr. Oz, the Knowledge Network on cable television, as well as some commercials.

The desire for access to information and education on health maintenance was also a theme noted by Tannenbaum, Nasmith and Mayo (2003) in their qualitative study of older women in Quebec. Madrid (2003) noted a similar recommendation in her research on women's health initiatives in northern BC.

It is worth mentioning here that the focus groups held for this research project were also seen by some of the participants as an opportunity for women to learn about resources in their community that they may not have otherwise known about.

> "*I really enjoyed the presentation on April 25 in Smithers by Melinda Allison – I think similar presentations and workshops would be well attended and beneficial."*
>
> *"I think that perhaps having group meetings regarding health and happiness may be important – therefore more information? Always good for women to get together and share. Very pleased with the comments after our session."*

It may be fair to say that the focus groups met two needs for many northern women; the need for information sharing and the need for socialization.

5) Transitions and Adjustments

The women who participated in this research referred to various transitions and adjustments that they had gone through in their lives, which had significant impact on their health and wellness. The following quote highlights some of the adjustments one participant was concerned about.

> *"I think the other thing all of us think about… one in the partnership is gonna go… and so I guess my looking down the road at all of the different adjustments – they're gonna happen – and so for a time in your life you were fairly stable - you know - but now you know just like you were saying M – you moved from a house into a smaller place – most of us are going to have to do this – or we may get health problems that we've never had to cope with but now we're going to have to cope with not being quite as fit or as active or whatever. Lots of adjustments I think are going to come."*

The following section outlines the various transitions and adjustments participants referred to as having significant impact on their health and wellness.

Sandwich generation.

The concept of the sandwich generation is based on the fact that women provide the majority of the care in families, including both child care and care for ill and/or aged family members. The stresses associated with caregiving are numerous and have a significant impact on women's health and wellness.

"You know there's the parents that have all these expectations of you, they need all this help, then there's the children and the grandchildren, have great expectations of you too… and it's hard to balance and find time for yourself, especially if you're still working and trying to fit all that in…"

"I don't know about this being universal, but when I was raising children very often I knew that I wasn't getting enough exercise, I knew that I wasn't eating as well as I should but I was just so focused on these kids that I'd say to myself, yes, but I'll do it when I get the time… which was never…"

The National Coordinating Group on Health Care Reform and Women (2002) reports "as mothers, daughters, partners, friends, volunteers and as employees or self-employed professionals, women provide the overwhelming majority of care in the home".

Empty-nest.

There were different views, both positive and negative on the empty-nest stage of life for women, however there was agreement that it was a stressful time requiring a great deal of adjustment. For some it was a time of new found freedom and a return to hobbies and self-care, which was long overdue. For others, this was a time of real loss and grief, requiring emotional strength and healing.

"Back to the empty nest… if the only thing you valued yourself for was being a mother… and that goes, then that's a really huge… um… well you're identity is fractured."

The variety of responses around the transition and adjustment to the empty-nest stage of women's lives found in this study is consistent with research by Dresden-Grams (1989) who suggests that for almost all women there is a period of reorganization of relationships and reshaping of their lives. The impact of this stage of life is dependent on circumstance, personality, life-styles, support systems and expectations about the future.

Menopause.

Historically research on women's health had more of a focus on the bio-medical issues specific to women, including reproductive health and menopause. Recent literature

has shown a shift toward a more holistic view of women's health and wellness, including emotional, social and psychological domains, (Morrow, Hankivsky, & Varcoe, 2007). That being said, the transition through menopause and the stress and anxieties that often accompany it emerged as a sub-theme impacting women's health and wellness overall.

> *"I think women as they age… women are going to be going into menopause which carries a whole realm of other things, so it brings a whole different group of stress and health issues…"*
>
> *"From 40 to 60 you've lost your sex drive, you've lost your sleeping ability, you gain weight very easily, you stress over health because it's deteriorating."*
>
> *"I didn't know the visible signs, the memory loss and fatigue and all of these other conditions were part of menopause."*
>
> *"Wild peri-menopause… I don't even know who I am some days."*

Participants who commented on their experiences with menopause also noted that a great source of information and support for them during that time was found through social support networks with other women.

Although there was little data on the issue of women's retirement and its impact on health and wellness, participants did refer to the retirement of their spouses as being a stressful time of life.

> "*I think one of the problems is when a man retires if he hasn't prepared himself to fill that void that's a heck of a lot of stress on the woman."*
>
> *"You go from 40 or 50 years of living together where one or both of you are at work outside of the home and then 24-7 together… that definitely creates some interesting things."*

Becoming a caregiver.

Although only 32% of survey respondents (122 women) indicated that they were caregivers, it is quite likely that this number is higher based on current research (National Coordinating Group on Health Care Reform and Women, 2005). One potential

discrepancy is based on the fact that many women do not consider themselves caregivers, despite being mothers, wives and daughters who spend much of their time looking after children and ill or aging family members. The impact of caregiving, either through raising children or caring for spouses or other family members, was a common theme, especially among focus group participants.

> *"You don't even think about it while you're doing it… it's after it's over and then you find out how much damage it's done to your health because you're just going and going 24:7."*
>
> *"I can't describe how tired I was, it's impossible for anyone to know how tired I was."*
>
> *"I mean nobody knows unless they've gone through it what the hell it's like… the caregivers are usually the ones that die before the person who has the disease because they're so worn out that they just can't take it anymore."*

Interestingly, in an examination of the quality of life, health and social support of older caregivers, one study conducted in northern BC revealed that older married caregivers generally felt younger physically, mentally and socially than their chronological age (Hubley, Hemingway & Michalos, 2003).

Becoming a non-caregiver/ widowhood/ learning to live alone.

After dedicating the majority of their time and physical and emotional energy to caring for a family member (often a spouse) for many years, some women felt the loss of this role and the transition to being alone as having a significant impact on their overall health and wellness. There were mixed opinions on how this shift impacted women's lives; some positive and some negative, however there was no debating the fact that the impact was significant.

> *"I was just thinking of another thing… speaking personally but I know that it doesn't affect all of us… but learning to live alone. I think as we get older we've got the potential that we might have to learn how to do that."*

"It's incredibly important – it totally changes your life in more ways than just being single all of a sudden. It changes it so that when you've done that… is going to have a certain feeling of guilt… and you feel freedom. I believe in some cases criticizing the person for feeling happy… I think that has a profound effect on someone's life… you want to be happy but you don't."

"I met someone else that this happened to and they looked very unhappy, and I commiserated with her and so on, and she said you know I feel so guilty, and I said why? And she said I felt terribly guilty because I feel relieved and I want to enjoy my life and I'm afraid to because people are saying that I should be unhappy and so I don't even smile."

Moving / downsizing.

A number of the older participants (65 years and older) made reference to the stress and anxiety around having to move out of their family home and down size into a smaller apartment or move into senior's housing. The move itself was often reported as a source of stress, as was the process of having to go through enormous collections of "stuff" that had accumulated over many years, and having to dispose of many personal possessions.

"The only thing I'd say as for moving is that people as they get older, like I was fortunate that I moved when I was younger – I'm 79 now but I've been about 10 years or more since I moved, but I do think that knowing some of my friends now who are in their houses alone and are older they don't get out quick enough. No they don't want to make that move and I have a friend who is 82 years old and she is in her house and she is beginning to think now that she should move and she is all alone and to get rid of all that stuff – as you say 'stuff' and we all know the stuff – it's a big undertaking. And I was fortunate enough that I think I moved at the right age when I did."

"*Well if a person is happy and contented and can stay put in one place it's very important to their health… and getting rid of half of it because the place is small, you know it's hard on your mentality."*

"I was thinking of selling and moving, but no place to… so I would have to buy a lot and build and the lots are few and far between… and it really upset me to think about leaving my house… it was the biggest decision I had made in a long time."

"When I moved I was laid out!"

"I would rather die than have to do that!"

An Observation About the Role of Time

A number of participants commented on the important influence of time on their health and wellness. Although not identified as a distinct theme, the concept of time was certainly woven throughout the data in multiple ways.

Interestingly, there were various perspectives on time, which may have been the result of the age and/or stage of life the participants were in. For example, from women in their forties and fifties, who were juggling multiple roles, the most common message was "no time" for themselves to spend on activities such as self-care or exercise. Others from this same age group noted the importance of having to "make time" for themselves. For some of the participants in the "empty nest" stage of life there was a trend towards "finally having the time" to focus on themselves. Some of the older participants who had been primary caregivers to an ill spouse for many years, referred to the feeling of "freedom" and having "lots of time" to think and reminisce after the death of the spouse. In a recent study in northern BC, on the use of information technology to network for women's health and wellness, McLennan, Hemingway and Bellefeuille (2006) highlighted that time (the lack there of) was a very important factor influencing women's participation.

Summary of Themes

It is important to examine the themes that emerged from the data within the framework of the initial research questions used to guide this project. The primary research question asked: "What are the self-identified social determinants of health and health concerns that participants believe are most salient in the lives of women age 45 years and older in northern BC?" The overall themes seem to address the first question quite clearly. The northern women who participated in this study identified access to all forms of health care, affordable supports and information/education as being most salient

in relation to their health. The importance of social supports and community connectedness was also identified as playing a key role in health, and should not be overlooked. The significant ways in which various life transitions experienced by women impact their health is another very important factor to consider, especially when looking at a lifespan approach.

The second research question was: "What are the perceived gaps in services that these same northern women believe currently exist?" Returning to the themes, it is worth noting that access and affordability were seen as gaps in service by many northern women. Where services were available, waitlists were noted frequently as a frustration of the health care system. Where local services were unavailable, the problem of waitlists was coupled with other issues of accessibility including travel expenses and having to leave the support of family and friends in their home communities.

The final research question pertained to recommendations made by participants to achieve better health outcomes for northern women. This question will be addressed in the next section of this report.

The themes of this research are consistent with the findings of Denton, Prus and Walters (2003) who argue that health is determined by complex layers of intertwined forces, with behavioural and psychosocial determinants of health growing out of the social context of people's lives, suggesting that social structural factors indirectly determine health and wellness. Similar work as this has been done in other northern Canadian communities, with similar findings.

Wakewich and Parker (2006) conducted a thorough review of the literature regarding women's health in northern Ontario, revealing gaps in health services for women in the north, and highlighting how northern environments (social, cultural, economic,

political and geographical) influence women's health beliefs, practices and access to care in unique ways. It was also discovered that there was very little published research which explored the social, cultural, political, economic and geographical aspects of northern women's experiences and understandings of health and health behaviors. These authors suggested that "women's voices and perspectives on their health and the health of their communities are muted in existing studies and would be more centrally drawn out by complementing existing quantitative studies with more in depth qualitative research projects" (p. 6).

In a similar study by Madrid, (2003) it was noted that various factors are commonly cited as having an influence on women's health and wellness in northern BC including; isolation, expense, lack of health care services/resources, accessibility of resources and northern/rural community connection. This study lends support to the work of Madrid in that many of the same factors continue to be identified as influential to women's health and wellness, and in particular with respect to women 45 years and older.

Interestingly, Prus (2003) found that as the health-related impacts of financial deprivation, unhealthy lifestyle, and social and psychological deficiencies grow for those with lower socio-economic status, their health generally deteriorates faster relative to their counterparts over the life course. This research highlights the potential impact of the feminization of poverty on the health of women and they age.

It is important to recognize that a study of northern BC is far from homogenous. Not only are there differences to consider between urban and rural communities, there are also significant differences from one rural community to the next. At the same time, as noted by Thurston and Meadows (2003), some rural people have more in common with their urban counterparts than with their rural neighbours. For the purpose of this report, the

data collected from women across northern BC has been dealt with as an aggregate of the entire Northern Health region.

Recommendations

This section will highlight the recommendations which have emerged from the data and represent as accurately as possible, the voices of the northern women who participated in this research project.

1) Group delivery of health care

The issue of access to health care may be addressed through a more efficient and creative delivery system for existing services**.** *It is recommended that Northern Health explore the idea of "group doctoring", and group health care delivery.* This method of delivery involves a small number of people with similar conditions (e.g., diabetes, arthritis, menopausal symptoms) attending medical appointments as a group. Tests and screening are completed, and information and advice is provided by a physician, a nurse, a social worker or other appropriate health care practitioner. A major efficiency with this approach comes from treating more than one patient at a time, but it also provides the opportunity for social interaction and sharing of experiences.

Similar innovations in health care delivery have already been trialed in the area of women's gynecological health. For example, at a recent women's health gathering in Prince George one public health nurse reported on a successful new way in which the importance of pap exams and gynecological health were promoted to young aboriginal women at a "Pap-o-ramma". This creative event brought together young women in a way in which they could be comfortable learning about this important health issue. Medical exams and screening were conducted by physicians; education and information was provided by nurses, and the advantages of social support was something that naturally

emerged through the camaraderie of a number of young women coming together for a common purpose in a fun and relaxing atmosphere.

Given the theme from the data regarding the need for improved access to specialists, extended care, complimentary and preventative health care measures, it is recommended that group delivery for these types of services also be explored. Ideally, providers offering group health care delivery, would also factor in the need to address childcare, caregiver relief, transportation and other challenges related to access.

An added bonus of the group approach (that also addresses another major theme of this research), is the natural encouragement of group interaction and socialization with others. Participants of this research have highlighted the importance of socialization and connection with other people as significant to their health and wellness. This may be a natural benefit emerging out of the practice of "group doctoring", or group health care delivery. Providing a number of health care services through a group approach could go a long way in addressing the issue of extensive waitlists, as well as improving access to information and resources, while at the same time providing a forum for increased social supports and reduced social isolation.

2) Community capacity building

In an effort to better address some of the social determinants of health, *it is recommended that financial support and in kind resources be made available to existing organizations with mandates to provide various social supports in their communities*. This could be implemented through a multi-level government partnership whereby federal and provincial dollars, as well as Northern Health funding is used to match those funds raised within each local municipality and regional district.

For example, many communities have small seniors' centres, women's wellness resource programs, and non-profit societies, where ambitious and well intentioned people gather to socialize and support one another around a particular cause. Modest financial contributions to these organizations could assist them in potentially hiring educated and skilled volunteer coordinators or other staff. This small step, involving relatively little funding, would allow these organizations to function as stable and reliable resources within their communities, as well as contributing to both capacity building and sustainability planning.

In kind resources could also be made available, including such things as meeting space, and the use of computers and internet services. These are extremely valuable resources which could make a big difference in the services that a non-profit agency could provide. At the same time, making these resources available would involve a minimal contribution from Northern Health's operational budget.

This process of capacity building could potentially provide much needed educational resources and other social supports to northerners, as well as encourage social engagement and community involvement resulting in increased social supports, and decreased social isolation.

3) Improve on the "information highway"

Women in this study stressed the need for improved access to quality information and education on issues related to health and wellness. Given the multiple roles that most women play, and the limited amount of time women have to dedicate to themselves, *it is recommended that Northern Health undertake a review of their public awareness and communication practices.* There was acknowledgment from study participants about some of Northern Health's unique programs and services, such as the downtown Women's

Health and Wellness Programs, and the Elderly Service program. However, there was a stronger message indicating a limited awareness of these and other valuable Northern Health initiatives.

There also seems to be a limited awareness of services and supports available through other agencies and organizations throughout the North. Therefore, the review undertaken by Northern Health should also include a review of how information about resources outside Northern Health are communicated to women across the North. Once again, Northern Health may want to collaborate with existing women's health networks (e.g., the Women North Network) as part of further developing and improving health information access.

4) Build on what's already working well

One of Northern Health's initiatives which generated a number of positive reviews was the recent launch of the health bus. Participants reported how it saved them from financial strain when having to travel out of town for medical treatments. For some, the bus made medical treatment accessible, where it may not have been otherwise.

Returning to the themes, it is evident that health is far more than simply accessing medical appointments; it means being socially connected, having access to education and information related to health and wellness, among a variety of other psychosocial factors. Building on the positive supports provided by the health bus**,** *it is recommended that Northern Health consider using this service to allow northern women better access to other social support services.* As examples, the health bus could be used to allow women from smaller northern communities to come to Prince George to attend appointments with counselors, take part in support groups, exercise classes, meet with naturopaths, participate in health and wellness conferences or other educational forums.

Helping to support women to have access to “non-medical”, health and wellness related services would result in improved health over the long term through health promotion and prevention.

5) Personalized health and wellness allowances

Using the framework of the already existing provincial CSIL program (Choice in Supports for Independent Living), *it is recommended that funding be made available to women with flexibility to personalize the ways in which their health and wellness could be supported.* For some women, a modest monthly “health and wellness allowance” could mean not having to choose between groceries and medication, or between bus fare and diapers for her children.

One of the more “senior” study participants suggested the government implement an exercise credit, so that those who engaged in active healthy living through exercise were rewarded with some type of tax relief. The primary message this recommendation is based on is that women want choices, and recognition of the fact that what makes one woman healthy may not be helpful for another woman.

6) Support aging in place

The final recommendation relates to the notion that older woman want very much to be able to remain in their home communities throughout their lives. Ideally, adequate supports would be put into place to keep older women in their own homes, including appropriate levels of home care and home supports. However, in light of the fact that most people require more supports than are available to them in their own homes; *it is recommended that every effort be made to equip all northern communities with the resources to allow people to age in place*. These resources include adequate numbers of

affordable and accessible seniors housing units, assisted living and long term care facilities.

Researchers from the Community Development Institute at UNBC (http://www.unbc.ca/cdi/research.html) have conducted a number of seniors needs assessments across northern BC, and have suggested a number of ways in which communities can prepare for an aging population. It is recommended that Northern Health take advantage of the valuable research that has already taken place across the North.

Challenges / Limitations

There were a few limitations inherent in this research project. First and foremost was the issue of sampling. Although efforts were made to be inclusive of all women living within northern BC, for numerous reasons this was not possible. Some of the challenges related to sampling included potential participant difficulty with access to the internet (to obtain the electronic surveys) and access to the public venues where paper surveys were available. In addition, the survey was available only in the English language.

A second limitation related to sampling involves the demographic details of the participants. The Canadian Research Institute for the Advancement of Women (2005) reports that approximately half of women in Canada (51.6% of lone parent families headed by women), and 41.5% of single, widowed or divorced women over 65 years of age are living in poverty. The majority of survey respondents in this study reported an annual household income of $40,000 or higher, indicating a non-representative sample according to this particular demographic. The majority of survey respondents were also fairly well educated, including both college and university graduates. These statistics are not necessarily representative of education levels and household incomes for all northern women.

Future Research

It is hoped that this study provides a broad, yet preliminary look at how women 45 years and older in northern BC perceive their health and those elements of their lives that affect their health and wellbeing. The results may prove useful to health care policy and service delivery decision makers who seek to identify more effective ways to meet the health needs of northern women. Given the challenges of sampling for the current study, future research should concentrate on specialized populations of northern women who may be considered more vulnerable to poorer health, such as elderly and aboriginal women, as well as those living in poverty, and/or with a disability.

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Appendix A

Demographics of survey respondents

Age range	***Actual***	***%***
45 – 54 years	156	38%
55 – 64 years	138	34%
65 – 74 years	68	17%
75 years and older	44	10%
Highest level of education		
Secondary school incomplete	31	8%
Secondary school completed	44	11%
Some trade, technical, business, community college	51	13%
Diploma/certificate - trade, tech, business, community college	87	21%
Some university	50	12%
University degree at bachelors or any higher level	142	35%
Annual household income		
Less than $25,000	68	18%
$25,000 - $39,999	57	15%
$40,000 - $79,999	140	37%
$80,000 or more	116	30%
Primary employment status		
Employed full time	180	44%
Employed part time	65	16%
Retired	130	32%
Not employed	20	5%
Other, e.g. self-employed, medical leave, child-minding, student	11	3%
Marital status		
Currently married / live-in / common-law partner	253	62%
Single – never married	14	3%
Divorced / separated	82	20%
Widowed	57	14%
Sexual orientation		
Heterosexual	377	93%
Bisexual	6	2%
Lesbian	13	3%

Appendix B

Importance of preventative healthcare measures

	Not important 1	Somewhat important 2	Neutral 3	Very important 4	Extremely important 5	NA	Mean score out of 5
Vision	7 2%	13 3%	16 4%	134 34%	220 56%	1 0%	4.40
Breast cancer screening	12 3%	20 5%	30 8%	92 23%	237 60%	1 0%	4.34
Cardio-vascular, heart health checks	12 3%	20 5%	35 9%	125 32%	199 51%	1 0%	4.23
Dental	23 6%	21 5%	23 6%	136 35%	185 48%	3 1%	4.13
Cervical cancer screening	25 7%	28 7%	33 9%	94 25%	197 51%	6 2%	4.09
Osteo / bone density testing	17 4%	23 6%	63 16%	129 34%	150 39%	1 0%	3.97
Cholesterol testing	16 4%	38 10%	47 12%	140 36%	142 37%	3 1%	3.92
Diabetic testing	38 10%	43 11%	80 21%	101 27%	114 30%	5 1%	3.56
Gastro-intestinal, stomach checks	36 9%	37 10%	98 26%	100 26%	102 27%	6 2%	3.52
Memory / cognitive checks	44 12%	40 11%	88 23%	100 26%	102 27%	4 1%	3.47
Depression anxiety screening	51 13%	42 11%	87 23%	95 25%	100 26%	7 2%	3.40
Urinary continence health checks	46 12%	38 10%	102 27%	94 25%	89 24%	7 2%	3.38

The top number indicates the actual number of responses to each measure, the bottom number represents the percentage of the total respondents selecting the option.

The last column indicates the mean score out of a maximum of 5 using a Likert Scale.