RURAL SASKATCHEWAN SENIORS: PERCEPTIONS OF HEALTH

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Introduction

Canada has a proud history of rural living, with a landscape that has been in constant flux since the pioneering days. Specifically, in the past few decades rural communities are changing as their young people migrate to urban centres to find employment, and newly retired people move into rural living to escape the rapid pace found in cities (Leipert & George, 2008; Rogers, 2002). Fringe communities surrounding large urban centres are expanding exponentially in some regions in Canada (Thomlinson, McDonagh, Baird Crooks, & Lees 2004). This movement in and out of small town living has meant widespread changes in all aspects of rural life. The economic base of rural communities has either shifted and grown with migrants, or begun to collapse on site. Fewer farms are economically sustainable (Leipert & George, 2008); some communities have faced hospital and school closures and there are shrinking opportunities for shopping as general stores close their doors. As a result, there has been a growing research interest in rural health as communities restructure within the reverberations of this new Canadian rural panorama (Leipert & George, 2008; Rogers, 2002; Thomlinson, McDonagh, Baird Crooks, & Lees 2004).

Rural Canada is aging; predictions of escalating pressures on rural health services continue to rise with the anticipated growth of seniors in Canada. The 2006 Statistics Canada Census revealed that the population of individuals aged 65 years and older has increased and accounts for 13.7% of the overall population. This means that for every seven Canadians, one is aged 65 years or older. A study by Statistics Canada projects that the number of seniors in Canada will increase from 4.2 million to 9.8 million from the years 2005 to 2026 (Statistics Canada 2006, 12). Rural regions in Canada are aging the fastest in terms of their growth in the

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1 For the purpose of this paper a senior is defined as any person aged 65 years or older.
number of seniors (Statistics Canada 2006). The increase in aging populations is due in part to advances in medical and health technology, service and treatment and the impending surge of the baby boomer generation. This growing population of seniors will present challenges for health care social workers. Social workers will find themselves working with a large population of seniors and the families that care for and support them. Gerontology social work will no longer be a specialized area of practice; but rather will encompass a large part of generalist social work practice (Berkman, Gardner, Zodikoff & Harootyan, 2005).

This research report is part of a larger study in which the relationship between social systems and the health of seniors living in rural Saskatchewan was explored. The objective of this larger study was to examine the relationship between social systems and health of seniors living in rural Saskatchewan. The exponential growth of seniors in rural areas makes collecting information on the rural aging imperative. This study will provide new data on rural seniors’ health and rural communities’ capacity and sustainability to care for an aging population.

The objective of this report is to focus on one aspect of the study: an examination of the health beliefs of elderly Canadians living in rural Saskatchewan and specifically, how rural seniors conceptualize health. Increased understanding of how seniors’ conceptualize what it means to be healthy ensures that service programs and delivery of those programs will better meet the needs of the aging population. The findings from this study will assist in informing rural social work practice, service delivery and policy making in the area of rural seniors health.

The purpose of this study then, is to use a qualitative approach to examine seniors’ beliefs about health, and how they define their health. This paper begins with an overview of the literature focused on rural health, seniors’ health and the intersection of these two. Specifically, factors impacting on rural seniors’ health are explored to provide a foundation for the
identification of gaps in our knowledge. The methods section outlines the process and procedures for gathering and analyzing the data. Next, the results of the data analysis are provided using direct quotes. The paper concludes with a discussion about the contribution of this project and suggestions for future research.

Indicators and Determinants of Rural Health

Much of the literature on rural health in North America from the last decade focuses on trying to identify indicators and determinants of community health. According to Hancock, Labonte, and Edwards (1999), conceptual and methodological issues are vitally important to understandings of “community, health…and population health” (p. s22). These researchers state that using such health indicators as the presence or absence of death, disease, and disability is simply taking a slice of a much richer and more dynamic concept. They and many others (Hancock, 1993; Humphreys, Wakerman, & Wells, 2006; Sawicki, & Flynn, 1996, Smith, Littlejohns, Hawe, & Sutherland, 2008), broadened the scope of health indicators by identifying categories of indicators, such as sustainability, viability, livability, prosperity, conviviality, and equity. This work on determinants and indicators inspired advancement in thinking about how best to develop indicators that capture important data. Researchers, now armed with a much more inclusive framework for understanding health, are finding communities rejecting imposed criteria for community health indicators. For example, Smith, Littlejohns, Hawe, and Sutherland (2008) conducted a healthy communities initiative study in Alberta, Canada and found that the formal indicators were not relevant to the participants. The authors state that the community participants, while willing to provide information on the indicators to the health authority, did so out of obligation and responsibility. Participants did not see the relevance and the researchers concluded that the imposition of health indicators may diminish residents’ ownership in any
community health project. Smith et al. suggest that research needs to be community driven. People living in the community must have involvement in the development of indicators, the monitoring system, and means of evaluating the progress toward collaborative goals.

The significance of the above findings has direct relevance to health research generally, and is particularly relevant for research on the health of rural communities. Specifically, in the same way that recognizing that indicators cannot be supplanted onto a community with the expectation of having the community embrace them, imposing pre-determined definitions of health for rural populations runs the same risk of insignificance.

*Rural Health Conceptualized*

In spite of an extensive literature search very few studies specific to health definitions, beliefs, and perceptions of people living in rural communities were found. In fact, only one study reviewed the health practices and beliefs of rural Canadians. Thomlinson, McDonagh, Crooks, and Lees (2004) examined health beliefs of rural Canadians and found that health is a concept that encompasses a multiplicity of factors and facets. The concept of health is not confined only to the physical aspects of health (e.g., the presence or absence of symptoms). When asked to define what health means to them, individuals living in rural communities identify components that range from disease states to the ability to be self-reliant.

Thomlinson et al. (2004) investigated the health beliefs, values and practices of residents in two rural Canadian communities using an ethnographic approach. Semi structured interviews were conducted with 55 people who ranged in age from 19-84. Participants viewed health holistically, as an integration of body, mind, spirit, and social factors. Participants described being healthy as having balance in their life, they also identified coping, enjoyment, busyness and productivity as important aspects of health.
In a cross-sectional survey conducted by Lee and Oakley Browne (2008), rural Australian residents aged 66 years and older self reported a higher level of life satisfaction than those aged 65 years and younger. A large sample of 5,391 participants aged 18 years and older participated in a self-reported questionnaire. The questionnaire assessed such things as socio-demographic factors, life satisfaction, as well as physical and psychological health issues. This study, and the one done by Thomlinson et al. (2004) would suggest that rural people have high levels of life satisfaction and view their health and lives holistically rather than being defined by disease.

Several authors (Beard, Tomaska, Earnest, Summerhayes & Morgan, 2000; Lee & Oakley Browne, 2008; Thomlinson, McDonagh, Crooks & Lees, 2004) suggest that socioeconomic and cultural factors strongly influence the health perceptions of rural dwellers. Thomlinson et al., (2004) describe the Health Belief Model (HBM) that was proposed by Rosenstalk in 1974. The model delineates 4 factors that are involved in making health-based decisions: 1) susceptibility to an event, 2) the perceived seriousness of the event, 3) the benefits of taking action, and 4) the barriers to taking action. Specifically, the model provides a means to understand how individuals interpret physical symptoms of illness, and how they arrive at decisions about what to do next. Simply put, the HBM theorizes that personal beliefs influence health behavior and perceptions. The way one thinks of health, seeks treatment and engages in behaviour change is shaped by personal experiences and societal influences (Rosenstock, Strecher & Becker, 1988). Goins and Mitchell (1999) further suggest that rural life contributes to a resilient attitude of independence. This rural attitude of independence evokes an image of the stoic farmer, tending to the land through rain and sun, good times and bad, and sickness and health.
There are few studies that specifically examine the health beliefs of rural Canadian seniors. In a study by St. John, Havens, van Ineveld and Finlayson (2002) the health status of rural and urban seniors was evaluated. The study found that rural Manitoba seniors reported a higher level of satisfaction with their health than did their urban counterparts. However, the researchers also conducted a comparative analysis using data from the Manitoba Study of Health and Aging that was collected in 1991 and 1992. This older data were based on a sample of 1763 rural Manitoba participants who were aged 65 years and older. When the same analyses were performed on the data from the 1991/1992 sample there was no significant difference in health satisfaction between rural and urban residents. The data from this study did not reveal a significant difference in self-rated health between rural and urban seniors. This was true even though the rural seniors in this sample had a higher overall rate of disability. This would suggest that rural seniors’ health beliefs may differ from their urban counterparts. The authors of the study speculate that this finding may indicate a potential difference in health expectations between rural and urban elderly.

In another study comparing rural and urban seniors, Borders, Aday, and Xu (2004), examined risk of poor health using pre-defined socio-demographic criteria. A telephone survey was conducted with a large sample of approximately 5000 seniors aged 65 years and older. This study revealed, that seniors aged 75 years and older were at greatest risk of being in poor health than those under the age of 75 years. The socio-demographic factors examined were income, education, and work status (e.g., retired or unemployed). Risk of poor health was highest among rural and urban seniors who were of low income and education. These researchers found no difference in risk for poor health between these two groups.
**Rural Seniors’ Health: Ethnicity**

Few studies have examined health perceptions among elderly from different ethnicities. The results from one ethnographic study suggested that ethnicity is not a discriminating factor connected to health beliefs. Specifically, the study compared the health definitions of four different cultures in the United States and found great similarity in the understanding of health and health promotion (Arcury, Quandt, & Bell, 2001). One hundred and forty five participants age 70+ who self-identified as African American, Native American, and European American shared a holistic view of what it means to be healthy. From their responses, four themes emerged: 1) the need for balance and moderation in all things, 2) a whole person approach to health which taps into the physical, mental, and spiritual, 3) social integration, which refers to the need for individuals to stay connected through friends and family, community participation in senior centres or churches, and 4) personal responsibility for health. Within this last theme, the researchers listed such things as making an effort to remain healthy through active engagement in health promoting behaviours such as good nutrition, exercise and social time. For this large group of diverse participants, there were no ethnic-based or gender-based distinctions in terms of responses. In other words, men and women from these three cultural backgrounds identified very similar components of what it means to be healthy. In spite of the ethnic differences of the participants, the authors speculate that these participants are exposed to a common culture as well. Specifically, living in rural counties in the United States with a common economic and religious base may, to some extent, influence ideas about health.

**Rural Health: Gender**

Rural men’s perceptions of health are understudied, specifically the perceptions of senior men living in rural communities. The majority of gender-based studies compare college-aged
women and men’s health behaviours (Kandrack, Grant, and Segal, 1991; Lonnquist, Weiss, and Larsen, 1992; Patrick, Covin, Fulop, Calfas, and Lovato, 1997; Saltonstall, 1993). In these studies, the majority of the participants were white, relatively affluent, and living in urban centres. These studies collectively find that young men are less likely to engage in health promoting behaviours, and more likely to engage in risky behaviours than are age-matched women. In an attempt to fill in the gap, Sellers, Poduska, and Propp (1999) designed a study to explore the “largely unknown health care world of rural Anglo-American adult males” (p. 322). Nineteen men ages 25-49 living in a rural county in Iowa were interviewed using a semi-structured approach. Their analysis suggests that rural men’s definition of health is focused entirely on their ability to work. The authors report that health, while considered important, was not a value that was delineated by the sample. These participants appear to have a narrow definition of health, and one that is physical and symptom based. Specifically, results indicated that men in rural communities typically wait until a health problem either resolves on its own, or it interferes with assumption of work duties before seeking medical assistance. It appears that the reluctance to go to health service providers may be related to strongly held beliefs about autonomy, self-reliance, and masculine identity. Given the lack of longitudinal data, it is not possible to know if health definitions change over time. For example, as these rural men age will their conceptualization of health change to reflect a more holistic understanding of health, or will they remain constant over time? If the latter, then the findings from this study may forecast the need for health promotion to be shaped by the changing attitudes toward health definitions in the pre-senior population. Clearly, further research is needed to sort out this question.

The findings from an earlier study in Montana (Weinert & Long, 1987) were similar to the findings from the Sellers, Poduska, & Propp (1999) study. Weinert and Long’s research used
qualitative and quantitative approaches to examine the health perceptions of 181 men and women aged 50-70 years living in the rural counties of Montana. Like the participants in the Sellers et al. study, health was perceived by rural dwellers as the ability to perform their roles. This again demonstrates a focus on physical status, as opposed to a more holistic and integrated view of health. Health services were accessed only when illness prevented engagement in daily functioning. It is possible that the reluctance to go to health professionals has more to do with the cost of health care to self-employed farmers and ranchers, resulting from the lack of universal health care in the United States. Indeed, Moscovice and Rosenblatt (2000) reported a high prevalence of chronic illness and low utilization of health services among rural dwellers of all ages, including seniors across the United States.

Taking a contrasting position to the above-mentioned studies, Leipert and George's (2008) study found that their sixty-five participants, 6 of which were men, and 59 women, ranging in age from 26 to 65+ years from 7 South Western Ontario rural communities identified the social aspect of rural life as a hindrance to health. The analysis suggested that life in a small community is shaped by a male dominated ethos that serves to keep women in powerless positions. Thus, a common theme in this study was the negative impact on rural women’s health resulting from social and religious dogma that governs men and women’s roles. Although this study did not focus on elderly women living in rural settings exclusively, the robustness of the finding among a broad age sample attests to the relevance for rural women’s perceptions of health regardless of age.

Pullen, Noble Walker, and Fiandt (2001) administered telephone surveys to 102 women age 65+ in rural Nebraska. The survey asked questions regarding perceptions and definitions of health and how health information is gained. The data were then used to explore health-
promoting behaviours. They found that health beliefs that were inclusive of physical, mental, spiritual and social well-being accounted for a significant portion of the variance for engaging in health promoting behaviours. In other words, women whose conceptualization of health was broad were more likely to also report participation in health promoting lifestyles such as eating a balanced diet, attending to the sources of stress in their lives, and engaging in physical activity. In contrast, women whose definitions of health were symptom-based (e.g., the presence or absence of physical symptoms of illness/sickness) were less likely to report health promoting lifestyles.

It appears that there is a dearth of studies comparing health perceptions among rural men and women. The majority of studies in this area focus exclusively on women. Research looking at men’s perceptions of health typically focus on college age men in an urban setting. Thus, there is a significant gap in our knowledge about rural senior men’s perceptions of health.

**Rural Health: Quality of Life and Aging in Place**

Research into health perceptions among the elderly may be intersecting with the growing interest in better understanding quality of life in the aging population (Communities Development Society, 2008). This is due to researchers having identified health as one of seven factors that significantly influence quality of life. Specifically, a research group from Regina, Saskatchewan used a population health approach as its framework for identifying factors that affect seniors’ quality of life (Smith, King, Thomson, & Melville Whyte, 2000). “Population health concerns itself with the living and working environments that affect people’s health, the conditions that enable and support people to make healthy choices, and the services that promote and maintain health” (Smith et al, 2000, p.2). Forty-three percent of their sample was rural Saskatchewan residents aged 65 and older. Their findings suggest that health and quality of life
are inextricably linked for all seniors whether living in a rural or urban environment. In Alberta, a report entitled, *Finding Solutions for Challenges Facing Rural Seniors* (2008) also identified a significant relationship between seniors’ perceptions of quality of life and their physical and mental health (Communities Development Society, 2008).

The interest in quality of life is partly due to the rate at which the population is aging and in the fiscal challenge this poses to health care and society. Seniors aged 65 years and older make up the most rapidly growing age group in Canada. This aging trend is estimated to continue for several decades. "In 2010, an estimated 4.8 million Canadians were 65 years of age or older, a number that is expected to double in the next 25 years to reach 10.4 million seniors by 2036. By 2051, about one in four Canadians is expected to be 65 or over" (Statistics Canada, 2010).

Quality of life is broadly defined throughout the literature (Merchant & Hope, 2004; Naumann & Byrne, 2004) making it multidimensional and ambiguous. Researchers interested in quality of life (QOL) have not yet reached consensus on how the term *quality* should be defined. This is likely attributable, at least in part, to its subjective nature (Naumann & Byrne, 2004). Specifically, QOL is an individual experience based on individual values, beliefs, perceptions, personalities, and so on. The core of what gives life meaning for one individual can differ substantially from the core of life’s meaning for someone else. This inherent subjectivity then, presents challenges to those who wish to define it.

Without a definition of QOL there is an obvious problem: How does one measure something that is not well defined? To complicate the issue further, QOL encompasses multiple areas or domains. There are the more practical domains of appropriate shelter, nutrition, personal hygiene and medical care, as well as the structural attributes of the facility, and the physical space individuals have. These are considered conducive to objective evaluation by
external observers (Naumann & Byrne, 2004). But, there are also the more intangible domains of individual psychological well being and spiritual health. These are part of what is known as subjective QOL.

In spite of the lack of consensus of definition, there is a recent emergence of literature exploring health related quality of life among elderly people living in rural communities (Borders, Aday, & Xu, 2004; Bowling, Banister, Sutton, Evans & Windsor, 2002; Howell & Clearly, 2007). The defining and exploration of quality of life is part of a broader conceptualization of health.

Howell and Cleary (2007) state that quality of life is a construct of personal expectations and perceptions. Personal values and attitudes may have a major impact on seniors’ insights into their own quality of life. In other words, the concept of quality of life is dependent on ones perceptions of how things influence and impact their lives (Bowling, Banister, Sutton, Evans, & Windsor, 2002).

The study by Bowling et al. (2002) explored how seniors defined and prioritized their quality of life in attempt to identify the indicators that seniors utilize in determining their quality of life. The study focused on how self-evaluation of quality of life is influenced by seniors’ perceptions of social circumstances, health, psychological, and social variables. The authors concluded that the objective criteria, such as socio-demographic factors, are much less powerful in explaining the variance in quality of life ratings than the subjective evaluations of seniors’ emotional well being. In other words, factors such as psychological health, perceived independence and self-worth were more powerful determinants of quality of life for seniors.

According to Bowling et al. (2002), public policy needs to be concerned with ensuring older people maintain their independence, mobility, ability to be contributing members of
society, as well as to respond more holistically and effectively to their changing physical, psychological, and social challenges. Greater attention in these areas will permit seniors to age-in-place.

Aging-in-place refers to the ability to grow old and die within the home and community in which the individual lives (Black, 2008; Rosel, 2003). Among the many reasons an aging-in-place philosophy makes sense, is the reality that healthcare costs are increasing and will continue to increase when seniors have no other option than to live in provincially funded facilities. Specifically, aging-in-place promotes autonomy, independence, and emotional well being which, decreases their risk for poor health, thus, reducing the costs of earlier institutional care (Black, 2008). To put this philosophy into action means that health care options, housing options, and care/support options and enhancements need significant attention, especially in rural settings. Rural seniors are most often faced with very limited access to health care and enhanced social support, which means they often have to travel long distances to receive medical care and treatment. This poses additional challenges due to the absence of public transportation in most rural communities. Currently, aging-in-place means that many rural seniors are forced to rely on family members to provide the support and services they require because of the lack of services in rural communities (King & Dabelko-Schoent, 2009).

Understanding how seniors conceptualize their quality of life and their beliefs about health helps us to better understand what services and supports are required to allow for age-ing-in-place to be a reality.

Implications for Rural Social Work

Most of the literature on rural aging and social work practice focuses on dual relationships, mental health disorders, and clinical strategies for intervention (Kaufman, Scrogin,
Burgio, Morthland, & Ford, 2007; Halverson & Brownlee, 2010). While these issues are important to general social work practice in rural communities, there is a dearth of research examining the relationships among rural seniors, health, and social work practice. Bisman’s (2004) article was one of the few papers specific to social work models and interventions with rural seniors. In her paper, she proposes four theoretical models and interventions for social workers working with rural seniors. The models include social support, family systems, case management/community practice, and group work. It is beyond the scope of this paper to review in detail the theoretical models Bisman outlines. Suffice it to say that each of the models describes concepts as frameworks for understanding seniors’ complexity in rural settings, and interventions attached to each. One aspect of Bisman’s models that is relevant for the present study is that a biopsychosocial approach to practice with rural seniors is necessary for guiding social work practice. Green (2003) also suggests that a broad knowledge base is needed to address the complex needs of rural seniors including the relevance of the economics of the area, public policy and politics, and the geography of the rural landscape for optimum utilization of a variety of therapeutic interventions. The works by Green and Bisman provide similar conclusions about the role of social work with an aging rural population, specifically, the adoption of a biopsychosocial framework and the profession’s broad-based generalist knowledge.

Providing social work services in small rural communities presents challenges. In addition to the multiple layers involved in working with seniors, such as extended family issues, the reality of client as both recipient and giver of care, the physical and cognitive changes inherent in aging, the psychological impact of transitioning through multiple losses, there are also challenges with respect to social work practice. The challenges of rural social work include
a lack of clinical supervision, limited resources, and the ethical dilemmas that can arise from the reality of dual relationships, such as the lack of anonymity (Halverson & Brownlee, 2010). When social workers are employed in rural areas in Canada, it is not unusual for them to be providing similar services as those provided by community mental health workers (Berkman, Gardner, Zodikoff & Harootyan, 2005).

Summary of Literature and Focus of Present Study

Health beliefs of people living in rural communities, and specifically the health beliefs of rural seniors, have been understudied. Although some studies have revealed that commonalities exist in the ways that people living in rural communities talk about health, there also seem to be some differences reported. Specifically, some researchers’ findings suggest that there is a holistic understanding of health (e.g., Arcury et al., 2001; Leipert & George, 2008; Thomlinson et al., 2004), while others found that health was conceptualized primarily in terms of ability to perform work-related roles (e.g., Sellers et al., 1999; Weinert & Long, 1987). It is possible that this distinction is specific to differences in age, gender, religiosity, geography (e.g., USA versus Canada, rural versus remote/Northern), culture or ethnicity. While research has begun to address rural residents’ ways of understanding health, more work is needed in order to tease apart the factors that influence and shape peoples’ conceptualizations.

Among the gaps in our knowledge of health perceptions is the lack of understanding about the extent of differences in the health beliefs of rural dwellers. Specifically, research examining the health perceptions of rural male seniors, rural seniors in different socioeconomic classes and cultures is missing.
The present study begins to address the paucity of research on rural seniors. In particular, it seeks to enhance our understanding of rural seniors’ health beliefs and the way in which health is conceptualized among this understudied group.

Methodology

The purpose of this study was to explore the health beliefs of elderly Canadians living in a rural Saskatchewan area with a specific focus on how rural seniors conceptualize health. The findings from this study will assist in informing rural social work practice, service delivery and policy making in the area of rural seniors health. The research questions were: 1) What are the health perceptions and beliefs of rural Saskatchewan seniors? 2) What does being healthy mean to rural seniors?

Semi-structured interviews were conducted with 21 volunteer participants aged 65 years and older living in a rural Saskatchewan town and an adjacent village. In 2006 the town had a population of 1,743, a median age of 38.7, with 29.79% of the population aged 60 years old and above (Statistic Canada, 2007). The town is centrally located in the prairie province of Saskatchewan which allows for reasonable access to two of the provinces major cities, Saskatoon and Regina. The adjacent village had a population of 263 in 2006 and 80% of the population were at or above 60 years of age (Statistic Canada, 2007). The village has few services available so residents often travel to the nearby town to shop and access services.

As mentioned previously, this research report is part of a larger study in which the relationship between social systems and the health of seniors living in rural Saskatchewan is explored. What follows is a discussion of the methods used in the larger study followed by those used specifically in this study.
The larger study was conducted in two rural Saskatchewan communities, but the present study examines only the data from one of these sites. This research project was a joint project with researchers from both the University of Saskatchewan and the University of Regina. Accordingly, ethics approval was obtained from the University of Saskatchewan on February 12, 2010 and the University of Regina on March 9, 2010.

**Background to the Larger Study**

In October 2009, a literature review was conducted to develop a broad overview and understanding of the current research on social support and rural seniors’ health. From this review, the conceptual framework for the study was constructed drawing on Cantor’s model of social care. Cantor’s (1989) social care model is based on a systems approach and provides a framework for examining the multiple individuals, various levels (e.g., family-neighbours, friends–government, etc.,) and the different networks (formal and informal) involved in the provision of care and services.

**Development of Interview Guide**

Community leaders played a significant role in the development of the research objectives and methodology. Two community partners were recruited to assist the research team to help ensure that the study and its objectives were representative of the challenges facing seniors in this community. The community partners and academic team members were asked to sign a memorandum of agreement that outlined their role in the research project and acknowledged their commitment as team members. The team met several times over a four-month period (October 2009 – February 2010) to construct the interview questions (see Appendix A).
The initial interview questions were created through an examination of the existing literature and identifying gaps in current research on rural seniors. By employing interview questions that have been previously used researchers can avoid preventable misinterpretations and error. Accordingly, question wording from existing interview guides and surveys on seniors were used as models for some of the interview questions utilized in this study. For example, some support questions replicated question wording from the study funded by Veterans Affairs Canada, entitled “Caring Contexts of Rural Seniors: Phase II” (Dobbs, Swindle, Keating, Eales & Keefe, 2004). Other questions measuring instrumental support were based on the “Lawton Instrumental Activities of Daily Living Scale” (Lawton & Brody, 1969).

Cantor’s model of social care was also used in construction of the interview questions regarding the different types of care. The interview questions were designed to gather information on what support systems exist for seniors on a personal level as well as at a community level. More specifically, the interview guide was constructed to cover multiple areas including social networks, instrumental support, emotional support, personal care, medical care, satisfaction with support, support provided to others, quality of life, health, health services, general services, transportation, housing and finances. Further questions examine what support seniors receive and what support they may need but do not receive. Additional questions probe for perceptions on health and concerns regarding growing old within their community.

Three specific questions from the interview guide used in the analysis for this report: 1) What does being healthy mean to you? 2) How would you describe your current health? and 3) Compared to other people your age how would you say your health is? Responses to other questions within the interview guide were also examined to determine if respondents spoke of health perception or beliefs at other points during the interview.
Pilot Interviews

When a final draft of the interview guide was completed, four pilot interviews were conducted with seniors within an age range of 65 and 90 years. The intent of the pilot interviews was to determine the approximate length of time an interview would take, as well as to assess the clarity of wording. The pilot interviews took approximately 45–60 minutes to complete. The pilot interviews revealed changes necessary to improve wording clarity with some of the questions. Changes to the identified questions were made as well as minor grammatical changes; the interview guide was then finalized. Data collection began in February 2010.

Participant Recruitment

The community partners assisted with recruiting potential participants for the study by distributing posters of the study that included contact information and a brief overview of the project. Potential participants contacted the project coordinator by telephone. The study objectives and interview process was explained and the invitation to participate in the study was extended. If the potential participant agreed to participate, an interview date was then scheduled. Participants were given the choice of where they would like to be interviewed; all participants chose their own homes.

Participants

21 individuals were interviewed for this study. Participants included 13 women and 8 men, ranging in age from 71 to 90 years of age.

Process of Informed Consent

The interviewer reviewed the consent form with each participant and the participant and interviewer signed two copies. One copy was given to the participant and the second copy was
retained by the researcher. Participant names were recorded only on the consent form. All references to participants who were interviewed were replaced with a code.

Data Collection

The semi-structured interview was conducted with each participant. Interviews ranged from 45 minutes to 1.5 hours in length. The interviews were audio taped with the permission of the participant.

Following some of the initial interviews, the researchers noted participant discomfort in being audio recorded. For example, participants responded with statements such as, “oh good, it’s off now” following which they spoke more candidly. In addition, the researchers noted that for some participants, conducting the interview at the kitchen table resulted in a more formal atmosphere, which appeared to increase anxiety, in comparison to participating in an interview in an easy chair in the living room. After a short debriefing, the researchers agreed to encourage respondents to participate in the room where they felt most comfortable such as sitting in their easy chair in the living room with the tape recorder less visible at a side table. This seemed to put the respondent more at ease in responding to the interview questions.

Data Transcription

The data were transcribed and imported into the software program ATLAS.ti Version 6.0. The coding strategy was determined in two group working sessions with the research team. The first working session involved the group developing a list of code words drawn from the literature and reflecting Cantor’s model. Further codes were assigned as the analysis proceeded and all coding changes and additions were shared among the coding team members to maintain consistency. The second working session focused on more technical aspects such as how to operate and navigate the ATLAS.ti Version 6.0 software. The first 4 interviews were coded
collaboratively by the research group to ensure consistency in coding. Attention was paid to clarifying code definitions and reliability of the application of codes.

The following section will present findings related to the research questions reporting this study. The research questions were: 1) What are the health perceptions and beliefs of rural Saskatchewan seniors? 2) What does being healthy mean to rural seniors?

Results

This section is organized around the four core themes that emerged in this study around how rural seniors define health. The four themes were: Independence, Mobility, Cognitive Wellness, Being Pain Free. The theme of independence is an overarching theme that is present in each of the others. Each theme is identified and interspersed with quotes to provide enhanced descriptions. Following this, the responses to seniors’ self-rating of health are presented and discussed.

Theme 1: Independence

A prevailing theme emerging from the coding of the data was the concept of independence. Many of the respondents in the study linked self-reliance to health. Indeed, independence was described in several ways, and this concept was woven throughout all of the themes as being fundamental to maintaining good health and perceiving oneself as being healthy. The different ways in which the respondents spoke about independence have been organized into three subthemes: Physical Self-Care, Instrumental Activities of Daily Living, and Lack of Need for Assistance. Each subtheme is described next.

a) Physical Self-care. This subtheme refers to the everyday activities that are private and intimate in nature. These things typically are unique to the individual and things that individuals are accustomed to doing for themselves. It includes such things as brushing teeth, putting on
deodorant, bathing, styling hair and so on. For example, one woman states that health is about being able to

"...feed yourself and wash yourself, and dress." (79 year-old woman)

The ability to do these very personal and private activities for oneself is something that older rural seniors consider as fairly central to their understanding of health.

b) Instrumental activities of daily living (IADLs). This subtheme represents the activities that allow individuals to function more fully in their homes and communities. IADLs include such things as managing money/medications, telephone use, traveling within the community, housekeeping, meal preparation and so on. Several respondents identified the ability to perform IADLs as being fundamental to their definition of health.

"I'm Okay; I can still do my work." (86 year-old woman)

For this woman, doing her “work” referred to such things as cleaning her home, doing her own banking, and making meals. Her sense of her own health is defined in terms of continuing to engage in these activities.

The man below describes money management and responsibility as being central to his understanding of personal health.

"...to make my own decisions when it comes to finances and things like this because I have always done that sort of thing and I guess the day somebody has to start to tell me they're going to have to pay my bills for me and sign my cheques for me, that's going to be the hard part."

(76 year-old man)

It appears there may be a link between money management and identity for this man. He identifies himself as someone who has always taken care of his own financial business.
This man was able to articulate the importance of making his own financial decisions and how difficult it would be to lose this ability. It is as though the loss of financial management signals a change in how he sees himself and his overall health status.

In the two following quotes, the first man takes a more global approach when he links health and independence, whereas the woman’s quote reveals more specific details.

"Being healthy is being able to... carry out your life independently" (74 year-old male)

"...being able to do your jobs and make your own meals" (81 year-old woman)

This 81 year-old, like the 86 year-old woman earlier refers to "your jobs" and she makes that more specific by naming one of those jobs as meal preparation.

Another 81 year-old woman spoke about her feeling of pride at still being able to drive independently.

"...they said, ‘did you drive yourself?’ I said, "yes I did" [and] I felt really good about going there myself." (81 year-old woman)

For this woman, the ability to drive is a very specific source of independence. The expression in her voice when she declares, “yes I did”, gives the impression that for this woman, independence is joyfully linked to the freedom found in getting around town without relying on others.

The following participant also links driving to health.

"There have been a couple [of seniors] that had to give up their license and then you lose your independence." (79 year-old woman)

This woman talks about the prospect of losing the ability to drive and the negative impact that would have on independence, and subsequently, health. For rural seniors, limited resources,
such as public transit and support services can be isolating. It makes sense in the context of rural living that driving is connected to independence and health.

c) **Lack of need for assistance.** This subtheme speaks to the respondents’ identification of not requiring help as a part of their understanding of health. A 79 year-old woman states health is being able to "do your own thing and not need help". This woman links health to independence in a different way from the content the other respondents spoke about in the subtheme IADLs. The link to health is through not needing assistance from others.

One participant brings in the idea of ‘waiting for others’ when she talks about not requiring help.

"I guess being able to do what we want to do when we want to do it rather than have to wait on somebody else to do it for us." (74 year-old woman)

For this woman, it appears that relying on self rather than others means that there are no restrictions imposed. There is freedom and autonomy that is an important component of living without need for assistance from others. The quote from the man below also touches on the idea of autonomy. He does not talk about “waiting” as did the woman above, rather, for this man it is the loss of independence of making one’s own choices and as he says, the “style of living”:

"Well, not being bossed around. Like I see where some of these older people have their relations looking after them, and they get too much bossing around. It kind of spoils the style of living." (89 year-old man)

Lack of need of assistance then, encapsulates concepts of freedom and autonomy as important aspects of what it means to be healthy and maintaining quality of life.

Each of these subthemes suggest that for older people living in rural communities, health is about being self-reliant in the domains of private and personal care, as well as being able to
more fully function in the home, and managing to meet their needs without assistance from others.

**Theme 2: Mobility**

The second theme emerging from the data regarding how seniors’ define health was mobility. Mobility refers to the ability of the individual to get around their homes and communities independently. This theme did not include the concept of transportation; but rather focused on how individuals are able to move their bodies from one place to another.

Some respondents discussed mobility as integral to their definition of health:

"...as long as I've got my mobility I'm fine and that's what it would mean [to be healthy] to every senior I think." (86 year-old man)

This man clearly articulates the link between mobility and his perception of health. Indeed, he generalizes his perception to "every senior".

For some, mobility, or the ability to move around independently, was the defining feature of their conceptualization of health. The quote below captures this.

Being healthy means "being mobile" (71 year-old woman)

For others, mobility is only a part of their perception of what it means to be healthy.

"As long as your health is good and you can get around." (79 year-old woman)

The quote from this last woman suggests that health and mobility are connected but not interchangeable.

Another striking component of mobility is the concept of adaptability. For several participants it appears that they have accepted the physical decline in their mobility and have adapted by either changing their expectations or enhancing their ability through the use of mobility aids.
The quotes from the women below exemplify adaptability through changing expectations:

"I just hang on and go slow." (86 year-old woman)

"...we're a little slower but we get there." (74 year-old woman)

For these women, the point is about getting to their destination on their own, and not about speed.

The following quotes speak to the use of mobility aids:

"...so then if I want to go anywhere I get on the scooter and away I go." (80 year-old man)

“I generally make it around with a walking cane." (89 year-old man)

"Sometimes when I'm out in the yard, if I've got to walk that far into the yard then I have an old [cane] sitting outside that I use outside." (85 year-old man)

"I have two scooters, so I use a scooter [outside]in the summer." (75 year-old woman)

"In the morning I'm stiffer and I get from the bedroom to here, it's good to hold the walker." (86 year-old female)

For these participants, the use of canes, walkers, and scooters allow them independence in getting to where they need to go. For some, it is getting from the bedroom to the kitchen in the morning, for others, it is about being in the yard. There is a sense of independent decision-making about when to use mobility aids, or to mobilize independently. These individuals have adapted to the use of aids as options for improved mobility, which for them, allows them to maintain their health.
**Theme 3: Cognitive Wellness**

The third theme that was identified as being connected to health perceptions was the concept of cognitive wellness. This theme refers to the ability to think and to manage verbal information. This theme also included the absence of cognitive disease processes. For some respondents, cognitive wellness was an important part of their perception of what it means to be healthy.

The quote that follows is from a man who separates body from diseases that affect the mind. For this man, it appears that "having your faculties about you" supersedes physical health.

"I think…having your faculties about you and having your mind. It’s important to have a healthy body, but I think some of the saddest things are when people [have] dementia or Alzheimer’s." (76-year-old man)

The quote from the woman below talks about mental capacity but differently from the man above. For her, physical wellness outweighs cognitive wellness.

"Being physically and mentally capable of doing things for yourself. More so I think doing physically." (79 year-old woman)

The following quotes also link perceptions of health to mental capacity.

"...it means that I can still understand – as long as I’ve got my marbles!"

(86-year-old man)

"That you are capable of remembering and making your own decision." (79 year-old woman)

For some of the participants, the emphasis appears to be on the mental processes of decision-making and remembering as an indicator of health. For these individuals, retaining the ability to think clearly and the autonomy of decision making characterizes what it means to be healthy.
One woman discloses being fearful of losing mental capacity; a deterioration in cognitive wellbeing that she believes is happening for her:

"My memory is failing me a bit. It scares me." (81 year-old woman)

The participants who spoke about the relationship between cognitive wellness and health did so in three ways: body-mind comparison, memory and decision-making, and the emotion attached to losing capacity for memory. These are all part of the concept of cognitive wellness, yet they reflect different and specific aspects of cognitive function (i.e., memory versus abstract thought needed for decision-making).

**Theme 4: Being Pain-Free**

The fourth theme focuses on how participants connected absence of pain to their perceptions of health. The individuals who made the link between health and being pain-free did so in different ways. For some, being pain-free is only part of their definition of health. The quote from the woman below speaks to this:

"I think being without pain would be there (part of the definition of health). I don't take pain very good." (79 year-old woman)

For others, being pain-free refers to living without being restricted by pain. Specifically, this woman talks about making choices about activities without pain being a limiting factor.

"Well being able to do the things I want to do without being in pain all the time."

(74 year-old woman)

The quotes from the two individuals below equate health with having no pain at all.

"Being healthy just means that maybe I don't have any pain." (75-year-old woman)

“…not hav[ing] pain.” (90-year-old man)
With respect to definitions of health, being pain-free is conceived differently by participants ranging from having no pain to not being in constant pain, which could negatively affect participation in activities.

**Seniors’ Self-Rated Health**

Two of the items on the questionnaire asked participants to rate their health using a scale. The first question asked participants to describe their health using a scale rating of 'excellent', 'good', 'fair' or 'poor'. The second question asked participants to then rate their health in comparison to other people their age, this question used a scale rating of 'better', 'about the same' or 'worse'. The intent of these questions was global in nature, and used in order to get a general view of participants’ self-rated health, first on an individual basis and then in comparison to their peers.

When asked to describe their current health as excellent, good, fair or poor, several respondents rated their health as being "excellent" or "good". Interestingly, half of those respondents who identified as being in excellent or good health also identified as having a heart condition, cancer, or arthritis. Suffering from a medical condition did not appear to negatively influence their self-reported health rating.

"The heart condition is a very minor thing in a sense; I know how to cope with it. You know about heart condition, you carry nitro and so on and so forth." (86-year-old man).

It appears that having knowledge about how to manage a medical condition provides reassurance and perhaps increases a sense of agency. For this individual, it appears that knowledge gives him a sense of control over coping with his condition.
In the quote below, the woman rates her health as excellent despite a condition that led to an invasive surgery, and a mechanical device.

"I’d say probably excellent. I mean I’m really lucky, I have no problems. I have this pacemaker put in, but I mean I wasn’t sick before I had it in and I don’t feel any different. At least I don’t feel one bit different since I had it put in." (73-year-old woman)

Indeed, this woman perceives herself as being "…lucky" and having "…no problems".

A few respondents rated their health as being fair; these same respondents then rated their health in comparison to other people their age as being better, adding that a lot of people their age "are dead" or "no longer here". It is therefore understandable that their health would be better in comparison. One 90-year-old man states:

"Because I have diabetes, I have high blood pressure, I’ve got arthritis, and as I say, I feel sorry for myself quite often, so that’s why I said ‘fair’" (90 year-old man)

This man talks about feeling sorry for himself because of his conditions, whereas the two previous individuals perceive themselves as being in excellent health and even "lucky". It is possible that having knowledge about the conditions, tools for coping, and severity may play a role in perceived health ratings.

The respondents in this study did not focus the discussion of how they define health exclusively on illness or disease, and there were no references to the number of medications or getting to doctor visits, nor did they provide a litany of their ailments. Rather, their perception of health was identified by concepts of independence, mobility, cognitive wellness, and the absence of pain. Although most respondents referred to the physical aspects of health their focus was on
the link between health and independence. Health, for this group of seniors, was about how much they were able to do for themselves.

Discussion

Analysis of the data revealed four main themes among the rural seniors, with the theme of independence as an overarching and key concept for seniors in their perception of health. The discussion of independence had three subthemes capturing the physical ability to perform self-care, the ability to function more fully in their homes and communities, and the absence of the need for assistance from others. In addition to independence, the analysis of the data from the rural seniors in this study identified mobility, cognitive wellness, and living without pain as key components in their perception of health. Seniors’ self-ratings of health were also identified and discussed.

The results from this study are consistent with other research that has found broad-based conceptualizations of health among seniors (e.g., Lee & Browne, 2008; Thomlinson, McDonagh, Crooks, & Lees, 2004). Rural seniors appear to use a more holistic approach to defining their health rather than restricting their view of health to whether or not they suffer from physical symptoms. Unlike these other studies though, the rural seniors in this sample did not identify spiritual factors (e.g., feeling at peace or contentment) or psychosocial factors (e.g., emotional health) as part of their perception of health. It is possible that the more spiritual aspects of health did not get identified in this study as no specific questions were asked about this in the interviews. It is important to remember that this study was part of a much larger study on the relationship between social systems and health for rural seniors. Thus, interview questions specific to health perceptions were only a small part of the interviews.
The findings in this study support research that is beginning to define health in terms of how it fits into a larger and more inclusive concept of quality of life (Merchant & Hope, 2004; Naumann & Byrne, 2004). It will be important therefore, to continue the work in this area and develop consensus regarding how quality of life should be defined. Also, as discussed earlier in this paper, defining health in terms of QOL is only one of the issues; developing measurement tools for such a subjective concept will likely prove to be as challenging.

Aging-in-place as a philosophy of health emerges from the results of this study. The seniors in this study identified health as the ability to continue to live independently. Aging-in-place promotes the development of supports and services that enable seniors to remain in their homes and in their communities longer than they may without the supports.

Advocating for resources that promote independence for seniors may be a key part of a rural social worker’s role. Without the support of in-home services such as laundry and cleaning services, home and yard maintenance, personal and medical care, and meal assistance among others, seniors risk either having to rely heavily on their family for support or being displaced from their home. Rural social workers can play a vital role in lobbying for changes to health care policy and service provision that would support aging-in-place and seniors’ desire to maintain independence in their homes.

Limitations

The results from this study were extracted from data collected for a larger study examining the relationships between social systems and rural seniors’ health in Saskatchewan. The interview guide was primarily focused on the social factors; just two questions were inserted into the guide to tap into rural seniors’ perceptions of health. Practical concerns with time,
travel, and participant fatigue resulted in less time being devoted to digging deeper into the
seniors’ responses to the health-perception questions.

Summary of Findings and Future Research

This study explored health perceptions of rural seniors living in one rural community in
Western Canada. The results support the findings of studies from other parts of Canada and the
United States, which suggest that rural seniors’ perceptions of health are holistic and not limited
to a clinical (i.e., a disease or symptom based) approach to health. Rural seniors in this study
defined their health in terms of four themes. The first theme, independence, includes the ability
to attend to their personal needs, engage in the instrumental activities of daily living, and
function without assistance in their homes. The theme of independence was overarching and
woven into the fabric of the other three themes: mobility, cognitive wellness, and being pain-free.

The rural seniors in this study conceptualize health in terms of maintaining independence,
mobility, cognitive wellness, and reducing pain. Future research is needed to determine how
rural seniors’ definitions of health could shape how service delivery and support is provided. It
seems that a multidisciplinary approach to health is warranted to address the multidimensional
needs.

The complexity of seniors’ lives was reflected in the observations made during the
interview process. Bisman (2004) and Green (2003) suggest the requirements of social work
practice for a rural senior population will need to change in order to better meet the needs of
rural seniors. Researchers should take the opportunity to advance the discipline of social work
by investigating more fully the practice of social work currently, and what gaps social workers in
rural areas identify as key to maintaining and enhancing seniors’ health and independence.
References


APPENDIX A

Role of Social Systems in the Health of Seniors Living in Rural Saskatchewan

Rural Seniors’ Interview Guide

SPHERU

06 May 2010

RECORD RESPONDENT’S GENDER
[DO NOT ASK]
01 – Male
02 – Female

CAREGIVER PRESENT
[DO NOT ASK]
01 – Yes
02 – No

Main Questionnaire

Social Networks

A1) How long have you lived in Watrous/Preeceville? _______________

A1.1) [IF LESS THAN 5 YEARS] Why did you move to Watrous/Preeceville?

01- Closer to family
02 - Medical condition or poor health
03 - Closer to medical services
04 - Closer to services
05 – Retirement
06- Other _________________________________
07 - Refused
A2) Do you have family members who live in Watrous/Preeceville?

01 – Yes [GO TO A2.1]  
02 – No [GO TO A3]  
03 – Don’t know  
04- Refused

A2.1) What is their relationship to you: [RECORD DATA IN TABLE, DO NOT RECORD NAMES]

| 01 - Spouse                  | 18 - Nephew                   |
| 02 - Common-law partner      | 19 - Niece                    |
| 03 - Ex-spouse/Ex-partner    | 20 - Uncle                    |
| 04 - Son/Stepson             | 21 - Aunt                     |
| 05 - Daughter/Stepdaughter   | 22 - Cousin                   |
| 06 - Father                  | 23 - Same Sex Partner         |
| 07 - Mother                  | 24 - Close Friend             |
| 08 - Brother                 | 25 - Neighbour                |
| 09 - Sister                  | 26 - Co-Worker                |
| 10 - Grandson                | 27 - Non-Governmental Organization |
| 11 - Granddaughter           | 28 - Paid Employee/Worker     |
| 12 - Son-in-law              | 29 - Government (all levels and taxes) |
| 13 - Daughter-in-law         | 30 - Acquaintance             |
| 14 - Father-in-law           | 31 - Organization, specify_________________ |
| 15 - Mother-in-law           | 32 - Other, please specify_________________ |
| 16 - Brother-in-law          | 33 - Don’t Know               |
| 17 - Sister-in-law           | 34 - Refused                  |

A2.1) If yes, what is their relationship to you (for example, son, daughter, grandson)? [DO NOT RECORD NAMES]  

A2.2) About how often do you talk to or visit this family member — just about every day, several times a week, several times a month, once a month, several times a year, once a year or less, or never?
A3) Do you have friends who live in Watrous/Preeceville?

01 – Yes [GO TO A3.1]
02 – No [GO TO A4]
03 – Don’t know

A3.1) What is their relationship to you? [ENTER DATA IN TABLE, DO NOT RECORD NAMES]

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A3.2) About how often do you talk to or visit with this friend — just about every day, several times a week, several times a month, once a month, several times a year, once a year or less, or never?
A4) Do you participate in any kinds of activities on a regular basis outside of your home?

Probe: Did you used to participate in any activities

01 – Yes, please specify what activities ______________________
02 – No, why________________________
03 – Don’t know
04 – Refused

A5) Do you belong to a community organization or a church group?

Prompts: Royal Canadian Legion, Lion’s Club, Kinsmen, Kinettes, Rotary Club, Knights of Columbus

01 – Yes, [GO TO A5.1]
02 – No, [GO TO A5.2]
03 – Don’t know
04 – Refused

A5.1) Please specify what community organization or church group


A5.2) Did you used to belong to a community organization or church group?


A6) Have you volunteered in the past 12 months?

Prompt: By volunteering, I mean any unpaid work you’ve done to help others.

01 – Yes – [GO TO A6.1]
02 – No – [GO TO A6.3]
03 – Don’t know
04 – Refused
A6.1 If yes, where do you volunteer?  

A6.2 About how often do you volunteer for this organization?

A6.3) Did you used to volunteer?

Help and Support

The purpose of this section is to understand who is involved in your everyday activities, such as house cleaning and home maintenance. In answering the following questions, please consider any household members such as a spouse or partner, family members outside the household, close friends, neighbours and co-workers. Also, consider any organizations from whom you receive help from whether paid or unpaid.

A7) Some people require help with different tasks or activities, such as household chores, shopping, finances, personal care, transportation or errands. Do you require help with any tasks?

01 – Yes [GO TO A7.1]  
02 – No [GO TO A8]  
03 – Don't know  
04 – Refused

A7.1) What kinds of help do you receive?

A8) If you required help, who would you contact?

01- Spouse  
02- Common-law partner  
03- Ex-spouse/Ex-partner  
04- Son/Stepson  
05- Daughter/Stepdaughter  
06- Father  
07- Mother  
08- Brother  
09- Sister  
10- Grandson  
11- Granddaughter  
12- Son-in-law  
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28- Paid Employee/Worker
29- Government (all levels and taxes)
30- Acquaintance
31- Organization, specify_________________
32- Other, please specify_________________
33- Don’t Know
34- Refusal

A9) Do any community or religious organizations (church, legion, Lions Club, Kinsmen Kinettes and Kins, Knights of Columbus) provide you with help?

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<tr>
<th>A9.1 If yes, what organization/organizations?</th>
<th>A9.2 How does this organization provide you with help?</th>
<th>A9.3 Length of help?</th>
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EMOTIONAL SUPPORT

A10) Do you have any family members or friends that you feel at ease with and can talk to about personal matters or call on for help?

01 – Yes [GO TO A10.1]
02 – No, Probe why____________________________________ [GO TO A11]
A10.1) Who would you talk to about personal matters or call on for help? (ENTER DATA INTO TABLE BELOW)

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<td>Uncle</td>
</tr>
<tr>
<td>21</td>
<td>Aunt</td>
</tr>
<tr>
<td>22</td>
<td>Cousin</td>
</tr>
<tr>
<td>23</td>
<td>Same Sex Partner</td>
</tr>
<tr>
<td>24</td>
<td>Close Friend</td>
</tr>
<tr>
<td>25</td>
<td>Neighbour</td>
</tr>
<tr>
<td>26</td>
<td>Co-Worker</td>
</tr>
<tr>
<td>27</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>28</td>
<td>Paid Employee/Worker</td>
</tr>
<tr>
<td>29</td>
<td>Government (all levels and taxes)</td>
</tr>
<tr>
<td>30</td>
<td>Acquaintance</td>
</tr>
<tr>
<td>31</td>
<td>Organization, specify_________________</td>
</tr>
<tr>
<td>32</td>
<td>Other, please specify_________________</td>
</tr>
<tr>
<td>33</td>
<td>Don’t Know</td>
</tr>
<tr>
<td>34</td>
<td>Refusal</td>
</tr>
</tbody>
</table>

A10.1 If yes, who would you talk to about personal matters or call on for help? (Spouse, family member, friend, neighbor, organization)

INSTRUMENTAL SUPPORT

A11) I am now going to read to you a list of different activities. Please tell me if during the last 12 months, you have *received* or *needed* help for any of the following activities:

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>Activities</th>
<th>Received</th>
<th>Needed</th>
<th>Probe - Who provided the assistance</th>
<th>Probe - How often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Managing Money</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### PERSONAL CARE

A12) I am now going to read to you a list of different activities related to personal care. Please tell me if during the last 12 months, you have *received* or *needed* help with any of the following activities:

<table>
<thead>
<tr>
<th>Task</th>
<th>Received</th>
<th>Needed</th>
<th>Who provided the assistance [RELATIONSHIP,</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bill Paying</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yard work (snow shoveling, snow removal, cutting grass, weeding, lawn care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grocery Shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking and meal preparation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal clean-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing Laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sewing or mending</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the phone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbing Stairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferring from bed to chair, and back</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>NOT NAME]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shampooing or hair care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair Dresser</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing Medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Care (Brushing teeth, Denture care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring for your feet and cutting toenails</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help going to the bathroom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A13) Are there any other kinds of support that you receive or you would like to receive that I have missed?

**MEDICAL CARE**

A14) Have you had any medical procedure? [IF NO, GO TO A15]

    Probe – how long ago?
A14.1) Did you need assistance before and after a medical procedures?

01 – Yes
02 – No
03 – Don’t know
04 – Refused

A14.2) Did you receive assistance before and after a medical procedure?

01 – Yes
02 – No
03 – Don’t know
04 – Refused

**SATISFACTION WITH SUPPORT**

A15) You have told me about some of your contacts with your family and friends. How do you feel about the help you get from these people?

A 16) Do you feel that you are getting all the help you need?

01 – Yes, please specify__________________
02 – No, please specify__________________
03 – Don’t know
04 – Refused

**SUPPORT PROVIDERS**

Now we would like to know more about these family members, friends, neighbors or co-workers who have provided you with help

B1) Are the people who provide you with help mostly older than you, about the same age as you, or mostly younger than you?

01- Older than you
02- About the same age as you
03- Younger than you
04- Don’t know
05- Refused

B2) Why do you think people provide you with help? (Select all that apply)

01- That is the way these activities are shared in your house
That is the way things are done with your family/friends
They do things for me
I have long-term health problems or physical limitations
I am going through temporary difficult times
Time constraints did not allow me to do it for myself
I did not have the knowledge/skills to do it
I did not have the supplies/equipment needed
It is part of their volunteer activities

B3) What are your options if you need assistance with your daily activities, and your family and friends are unable to provide you with help? [READ LIST]

01- Meals on Wheels
02- Physiotherapy
03- Home care nursing
04- Other_______________________________
05- Don’t know
06- Refused

B4) Does anyone come into your home from an outside service to help you?

01 – Yes [GO TO B4.1]
02 – No [GO TO B4.2]
03 – Don’t know
04 – Refused

B4.1) If yes, what service? ______________________
_____________________
_____________________

B4.2) If not, would you need any outside services to help you?
Prompts: Home care nursing, meals on wheels, housekeeping

01 – Yes, please specify ______________________
02 – No, please specify why___________________
03 – Don’t know
04 – Refused

SUPPORT GIVEN BY RESPONDENT

B5) During the past 12 months, did you provide any help to others? [IF NO, MOVE TO QUALITY OF LIFE SECTION]

01 – Yes[MOVE TO QUESTION B5.1]
02 – No [MOVE TO QUESTION C1]
03 – Don’t know
04 – Refused
B5.1) What did you do to provide them with help? Probe -long term health condition

B6) In the past 12 months, have you received a break from care giving?

01 – Yes, please specify how __________________________
02 – No
03 – Don’t know
04 – Refused

B6.1) In the past 12 months, have you needed a break from care giving?

01 – Yes, please specify how __________________________
02 – No
03 – Don’t know
04 – Refused

B7) What was the main reason for why you provided help?

01- That is the way these activities are shared in your house
02- That is the way things are done with your family/friends
03- They do things for me
04- They have long-term health problems or physical limitations
05- They were going through temporary difficult times
06- Time constraints did not allow them to do it for themselves
07- They did not have the knowledge/skills to do it themselves
08- They did not have the supplies/equipment needed
09- It is part of my volunteer activities
10 - Other

QUALITY OF LIFE AND HEALTH

C1) What does independence mean to you?

C2) What aspects of rural community life affect your or other seniors’ ability to live independently?

[READ - CODE ALL THAT APPLY]

01- Functional independence
02- Health
03- Socialization
04- Affordable medications
05- Strong support systems
06- Living without pain
07- Transportation
C3) What community services and programs should be provided to help seniors maintain their independence? [READ - CODE ALL THAT APPLY]

01- Recreation and Leisure Programs
02- Community Clubs and Organizations
03- Social Events
04- Library
05- Volunteer Groups
06- Meals on Wheels
07- Shopping services
08- Personal Care Services (help with bathing, dressing, grooming, toileting)
09- Transportation services
10- Financial services
11- Respite Care or Adult day care
12- Help with Medication
13- Housekeeping services
14- Other __________________________
15- Don’t know
16- Refused

C4) How would you describe your sense of belonging to your local community?

01- Very strong
02- Somewhat strong
03- Somewhat Weak
04- Very Weak

C5) In general how satisfied are you with the adequacy of the services available to you?

C6) Overall, how would you rate your community as a place to grow old — excellent, good, only fair, or poor?

01 – Excellent
02 – Good
03 – Only Fair
04 – Poor
05 – Don’t know
06 – Refused

C7) Do you think there is a difference between growing old in rural communities compared to growing old in urban or city communities? Please specify.
PROBE: Do you think rural people value independence differently from others?

HEALTH

C8) What does being healthy mean to you?

C9) Do you have any long term health conditions or disabilities?

01 – Yes, please specify __________________________
02 – No
03 – Don’t know
04 – Refused

C10) In the last year, have you had a serious fall related injury?
CCHS – serious fall injury is described as a fall related injury serious enough to limit normal activities

01 – Yes [GO TO C10.1]
02 – No [GO TO C11]
03 – Don’t know
04 – Refused

C10.1) If yes, what was the injury? _________

Probe – Does this injury limit or change your normal activities?______________

C11) How would you describe your current health? [READ LIST TO RESPONDENT]

01- Excellent
02- Good
03- Fair
04- Poor
05- Don’t know
06- Refused

C12) Compared to other people your age how would you say your health is? [READ LIST TO RESPONDENT]

01- Better
02- About the Same
03- Worse
04- Don’t know
05- Refused

Health Services

D1) Please tell me where you go to receive the following services: READ…

<table>
<thead>
<tr>
<th>Where do you go to see a…</th>
<th>How do you get there</th>
</tr>
</thead>
</table>


<table>
<thead>
<tr>
<th>Medical Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor/ family physician</td>
</tr>
<tr>
<td>Medical Specialist</td>
</tr>
<tr>
<td>Pharmacy</td>
</tr>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>Dentist</td>
</tr>
<tr>
<td>Denture Clinic</td>
</tr>
<tr>
<td>Optometrist</td>
</tr>
<tr>
<td>Chiropractor</td>
</tr>
<tr>
<td>Physiotherapy</td>
</tr>
<tr>
<td>Hearing Clinic</td>
</tr>
<tr>
<td>Foot Doctor or Podiatrist</td>
</tr>
<tr>
<td>Lab work blood work/x-rays</td>
</tr>
<tr>
<td>Massage Therapy</td>
</tr>
<tr>
<td>Reflexology</td>
</tr>
<tr>
<td>Alternative medicine</td>
</tr>
<tr>
<td>PROBE – acupuncture, acupressure, reiki</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

D2) Within the last year, has a lack of transportation ever delayed or prevented you from accessing medical services?

01 – Yes [GO TO D2.1]
02 – No [GO TO D3]
03 – Don’t know
04 – Refused

D2.1) If yes, which medical services? ____________________________
___________________________
___________________________
___________________________
D3) Are there specific issues facing health care that are particularly important to you and that you would like to see Saskatoon Health Region (Watrous)/Sunrise Health Region (Preeceville) focus on? [READ LIST – CODE ALL THAT APPLY]

01. Waiting times for treatment
02. Recruitment and retention of staff
03. MRI/CT Scan/diagnostic availability/wait times for testing or test results
04. Access to emergency services/emergency room
05. Improve/Fair treatment of elderly
06. Improve health care administration
07. Access to family physician
08. More special needs/home/palliative care
09. Medical doctor and staff who understands elderly
10. Better educate population on health issues
11. Improved staff training
12. Health system being stretched to the limit
13. Access to specialists
14. Access to medical lab facilities (x-rays, blood tests)
15. Other, please specify __________
16. Don’t know
17. Refused

GENERAL SERVICES

D4) Please tell me where you go to receive the following services: READ…

<table>
<thead>
<tr>
<th>Where do you go…</th>
<th>How do you get there?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groceries</td>
<td></td>
</tr>
<tr>
<td>Clothing</td>
<td></td>
</tr>
<tr>
<td>Furniture</td>
<td></td>
</tr>
<tr>
<td>Hardware</td>
<td></td>
</tr>
<tr>
<td>Garden Centre</td>
<td></td>
</tr>
<tr>
<td>Building Supplies</td>
<td></td>
</tr>
<tr>
<td>Liquor Store</td>
<td></td>
</tr>
<tr>
<td>Hairdresser</td>
<td></td>
</tr>
<tr>
<td>Church</td>
<td></td>
</tr>
<tr>
<td>Community Centre</td>
<td></td>
</tr>
<tr>
<td>Seniors Centre</td>
<td></td>
</tr>
<tr>
<td>Post Office</td>
<td></td>
</tr>
</tbody>
</table>
D5) Do you leave Watrous/Preeceville to receive any other services?

PROBE – Are there any services that I missed?

_______________________________________________________________________

How do you get there?

_______________________________________________________________________

D6) What concerns do you have as you age living in Watrous/Preeceville,?

PROBE - Policing, services

PROBE - Do you think local services currently meet the needs of seniors in Watrous/Preeceville?

D7) In the past 12 months, has anyone checked up on you to make sure that you were okay by visiting, telephone, internet or any other ways of contacting you?

01 – Yes, please specify method ______________________________

PROBE - – about how often ______________________________

02 – No

03 – Don’t know

04 – Refused

D8) Do you use the internet?

01 – Yes [GO TO D8.1]

02 – No [GO TO D8.3]

03 – Don’t know

04 – Refused
D8.1) Why do you use the internet? (To access health info, or to keep in touch with people?)

D8.2) Does your internet have high speed access or satellite access?

D8.3) If no, would you like to use internet?

D9) Do you use a cell phone?

01 – Yes [GO TO D9.1]
02 – No [GO TO D9.3]
03 – Don’t know
04 – Refused

D9.1) Why do you use the cell phone? Prompt emergency, keep in touch with people?

D9.2) How is your cell phone access and coverage?

D9.3) If no, would you like to use internet?

TRANSPORTATION

E1) How do you usually get around your community? [DO NOT READ LIST - CODE ALL THAT APPLY]

01- Walk
02- Bicycle
03- Driven by family
04- Driven by friends
05- Taxi cabs
06- Public transport
07- Drive
08- Other, please specify _________________________
09- Don’t Know
10- Refused
E2) Do you currently drive?

01 – Yes [GO TO E2.1]
02 – No [GO TO E2.2]
03 – Don’t know
04 – Refused

<table>
<thead>
<tr>
<th>E2.1) Where do you usually drive?</th>
<th>Probe: How often do you drive there?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E2.2) If no, has not driving affected you ability to socialize?

01 – Yes
02 – No
03 – Don’t know
04 – Refused

E3) Are you usually able to walk around without difficulties and without walking aid such as braces, a cane, or crutches?

PROBE – Are you able to walk around only in the house or also outside?
- Weather dependent

01 – Yes
02 – No
03 – Don’t know
04 – Refused

E4) What do you think are the key transportation concerns for seniors in Watrous/Preeceville?

Housing

E5) Do you or any other seniors who you know plan to move out of their own home in the near future?
E5.1) Are they moving into a care home, in with family, a private care home, or an assisted living home?

01 - Care home
02 - Family
03 - Private care home
04 - Assisted Living
05 - Other

E6) Do you think there is a senior's housing shortage in Watrous/Preeceville?

01 - Yes
02 - No, please specify why
03 - Don't know
04 - Refused

FINANCES

E7) Looking at your future, do you think your income and investments will satisfy your needs?

01 - Yes
02 - No
03 - Don't know
04 - Refused

HISTORICAL QUESTION

E8) In order to understand how health care services for seniors in rural Saskatchewan have evolved into the system we have today, we also need to understand how they were provided in the past.

Can you tell me how your grandparents were supported with their healthcare needs when you were a little girl/boy?
E8.1) How do you think your Great-grandparents were supported with their healthcare needs?

SOCIO-DEMOGRAPHIC QUESTIONS
1) Would you mind telling me, how old are you?
   01 – SPECIFY ______________
   02 – Don’t know
   03- Refused

2) Are you currently single, married, living common-law, separated, divorced, or widowed?
   01 – Single
   02 – Married
   03 – Living common-law
   04 – Separated
   05 – Divorced
   06 – Widowed
   07 - Refused

3) What is the highest level of education that you have completed? [READ…]
01 – Completed Elementary School
02 - Some high school or less
03 – Completed high school diploma
04 – Some technical
05 – Technical diploma
06 – Some university
07 – University Degree
08 – Post graduate Degree
09- None
10 – Refused

4) Are you currently employed? [READ…]

Probe- do you farm?

01- Employed part-time Probe – where do you work?
02- Employed part-year Probe – where do you work?
03- Employed full-time Probe – where do you work?
04- Retired
05- Not employed
06- Other______________

5) Do you receive any of the following? [READ…]

01- Old age security
02- Canadian Pension Plan
03- Company Pension
04- Guaranteed Income Supplement – GIS
05- Friends
06- Family
07- Other please specify

6) Do you rent or own your home? [DO NOT ASK IF IN CARE FACILITY, BUT RECORD AS CARE FACILITY]

01- Own
02- Rent
03- Care facility
04- Other, please specify______________________________________________
05- Don’t know
06- Refused

Concluding Question

7) Is there anything that has not been touched on here that you would like to comment on?