

## **Young Rural Nova Scotian Women: What do we know about their health—and still need to know?**

### **Authors:**

Jackson, Lois; McGrath, Patrick; Sanderson, Lauranne; Stiles, Deborah and Unruh, Anita

**Dr. L. Jackson** is an Associate Professor at Dalhousie University in the School of Health and Human Performance, Health Promotion Program. Her research focuses on the health of vulnerable populations and social relationships in the household and community.

**Dr. P. McGrath** is a Killam Professor of Psychology, Professor of Pediatrics and Psychiatry, and Canada Research Chair at Dalhousie University. He is a leading researcher on pediatric pain and distance treatment aimed at increasing access to psychosocial health care

**L. Sanderson** is an Extension Education specialist and Director of the Rural Research Centre at the Nova Scotia Agricultural College. Her research interests include the behaviours that affect farm health and safety decisions and the role of young farm women in the transfer of health knowledge and safe practice to their families.

**Dr. D. Stiles** is an Assistant Professor in Humanities at the Nova Scotia Agricultural College and a Research Fellow of the Rural Research Centre. Her research interests are in regional, rural and gender history for the 19th and 20th centuries.

**Dr. A. Unruh** a Professor in the School of health and Human Performance with a cross-appointment to the School of Occupational Therapy. Her research interests are in the area of spirituality and health and gender differences in chronic pain.

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### **Abstract:**

#### **Context**

Rural living is seen as less stressful and healthier than urban life, despite the fact that rural citizens face unique health concerns and difficulties accessing health care. Rural restructuring imposes additional stressors on already strained rural residents.

#### **Purpose**

In this paper we present an overview of what is currently known about rural Atlantic women's health focusing, where possible, on rural Nova Scotian women and specifically young rural women. We draw attention to the ways in which current restructuring processes appear to be impacting the health and well-being of rural Nova Scotian women and identify key gaps in the literature that we believe need to be filled. Women's Health in Rural Communities (WHIRC), a new CIHR-funded research group, is addressing some of these areas with an interdisciplinary approach.

#### **Conclusions**

Women typically bear the brunt of health-related problems, and this is truer in rural areas. Collaborative research, such as that undertaken by WHIRC, is necessary to add to the existing body of knowledge about young rural women and their health. Understanding the health issues facing young rural women will aid in the development of strategies to promote healthy practices and social structures

**Keywords:** young rural women, restructuring, health, Nova Scotia, stress

## Introduction

Rural living is typically perceived as less stressful and more balanced than life in an urban setting, yet living in a rural environment (See endnote 1) has significant health risks and costs. Indeed, existing Canadian research suggests that rural citizens fare worse than urban or suburban residents on a number of health indicators<sup>1,2</sup>. Lagace et al.<sup>1</sup> report that rural people in Canada have higher risks of early death than those living in urban areas, and young rural residents are most at risk. Mortality from vehicle accidents, poisoning, suicide, and some chronic diseases are significantly higher for rural than urban dwellers, and these risks are particularly acute for those in the age group 20 to 44 years<sup>1</sup>. Given these data it is perhaps not surprising that rural Canadians perceive themselves as having less robust health than other Canadians. In fact, rural, metro-adjacent regions have the lowest proportion of individuals with excellent self-rated health, with about an 8% spread in rating between rural and urban residents<sup>2</sup>. Moreover, a significantly lower percentage of female youth between 12 and 17 years from rural (17%) and northern areas (15%) of Canada rate their health as excellent compared to girls in major metro areas (33%)<sup>3</sup>.

McGrath<sup>4</sup> has argued that rural restructuring, or the current processes of change that are taking place within rural areas, include three key defining features: “the demise of primary sector employment in agriculture, fisheries and forestry; changing migration trends and demographic patterns, and interests in the countryside based on tourism, residential property, and other lifestyle values” (p. 481). The outmigration of youth is one indicator of the changing demographics within rural areas, and research has indicated that between 1991 and 1996 approximately 30% of Atlantic rural teenagers left their

communities, which is twice the rate for urban teenagers <sup>5</sup> (p. 230). In the farming community, the ‘greying’ of Atlantic Canada’s farm families has been a trend over the last twenty years, and along with the declining number of family farms, the number of farmers under 35 years of age decreased by 51% from 1991-2001 <sup>6</sup>. Restructuring and its consequences—including outmigration and changing employment patterns—are not new to the Atlantic region <sup>7,8,9</sup>, but the current period of change does appear to have significant impact on rural residents including their health. Such impacts need to be understood in order to develop appropriate programmes and policies, and to encourage structures and relationships that are health enhancing.

In this paper we present a brief overview of what is currently known about Atlantic women’s health focusing (where data permits) on Nova Scotian women, specifically young rural women 16 to 39 years of age. We are interested in focusing on rural women, and the ways in which current restructuring processes affect them, because of women’s key roles and responsibilities in caring for family and friends, and their contributions to the social and economic life of rural communities <sup>10</sup>. We know, for example, that women’s work is instrumental in keeping different rural organizations active (such as volunteer fire departments, churches, auxiliary organizations, 4-H clubs, Women’s Institutes, etc.), and such organizations are essential to maintaining community spirit. Women also play an essential role in community recreational activities, fundraising activities, safety issues (especially concerning children), and family and community celebrations, all of which are crucial to sustaining healthy, safe and vibrant communities. The types of roles and responsibilities young women assume in caring for others and in

contributing to the general life of the community are shaped by their health and well-being<sup>11,12,13,14,15,16,17</sup>.

In this paper we also outline key research gaps in the literature on young rural women's health (See endnote 2) that we believe need to be filled. We will also discuss our plan to address these gaps through our multi-disciplinary research programme (funded by the Canadian Institutes of Health Research, CIHR). Our research initiative is a collaboration between researchers at Dalhousie University (Halifax, Nova Scotia) and the Nova Scotia Agricultural College (Truro, Nova Scotia). The team includes researchers from a wide spectrum of disciplines: extension education, health promotion, history, literature studies, occupational therapy, psychology, social work, and sociology. We anticipate that the research we are undertaking will aid in the development of programs and policies that are responsive to women's health issues and concerns, and that it will play an essential role in the building of research capacity within rural communities in Nova Scotia.

### **What do we know about the health of Atlantic rural women?**

The four Atlantic provinces are thought to represent a unique culture<sup>18</sup> (p.29), and the current period of restructuring in Atlantic rural communities—often single resource dependent communities—impacts the lives and health of Atlantic women in some similar ways. A small number of research studies, for example, have consistently documented increased levels of stress that are thought to be related to changing social, economic and employment conditions, underemployment and a lack of local job opportunities, as well as a general sense of uncertainty about the future<sup>19,13</sup>. In 1985, Atlantic Canadian women reported lower levels of stress than men but by 1994-95

women's stress levels had exceeded the male levels by more than 7% <sup>20</sup>. The increase in stress levels among Nova Scotian women is considered "particularly dramatic, rising from 12% *below* the male level in 1985 to 29% *above* the male level in 1991 and with nearly a third more Nova Scotia women reporting high stress levels in 1991 than in 1985" (p. 9). Women engage in almost twice as much unpaid housework as men, and Colman <sup>20</sup> found that 38% of employed mothers reported "severe time stress" levels because they were trying to juggle their paid and unpaid double work burden. These time stressors and long hours are "implicated in cardiovascular, gastrointestinal, neuroendocrinal and other disorders" (p. vi) <sup>20</sup>.

Some types of occupations prevalent within rural areas have been connected to specific occupational disorders and diseases thus drawing our attention to workplace issues within rural areas. For example, crab asthma among crab plant workers, especially processors, is a serious health issue, and women are more likely than men to be processors, thus increasing their risks <sup>21</sup>. The farm population represents a minority of rural residents (approximately two percent of the Canadian population lives on farms), but farm residents are at risk for physical injuries, diseases of the lung and skin, hearing loss, and cancers linked with chemical use and sun exposure <sup>22</sup>. The report Agricultural Injuries in Canada for 1990 -2000, illustrates the magnitude of the problem, ranking farming as the third most dangerous occupation in Canada in terms of fatalities <sup>23</sup>. Farm women's multiple roles—homemaker, care giver, wife, partner, and farm worker—contribute to occupational illness, stress, fatigue and agricultural injuries <sup>24</sup>. Some farm women also engage in wage labour off the farm in addition to their other tasks, thus increasing their stressors.

Recent changes in the health care system, especially downsizing and the centralization of health care resources in urban centres, affect women most directly and immediately, as they are often the unpaid caregivers. As Campbell, Bruhm and Lilley have noted, “a major thrust of Canadian policy on both long-term care and health care reform is to shift care from institutions to communities” (p. 9)<sup>25</sup>. Much of the ‘downloading’ has shifted to women, but only a very small part of the savings from closing hospitals and substituting care by unpaid family members has been allocated to supports and services for family members. Campbell, Bruhm and Lilley’s study<sup>25</sup> of female unpaid caregivers found that many women had given up employment or changed jobs in order to provide care, and argued that “the needs of caregivers are likely to be greatest, and the resources fewest, in small communities and rural areas” (p. 10). The health effects of providing constant care and having few supports include stress and ill health that impairs one’s effectiveness as a caregiver.

In Nova Scotia, rural individuals are also less likely than non-rural individuals to contact health professionals for mental health assistance, and there are major barriers to accessing mental health services, especially specialized services within rural areas<sup>26,27</sup>. A young mother in a rural area suffering postpartum depression, for example, has the universal difficulty of overcoming the stigma of seeking help for her depression, and will also face significant barriers in finding help for this specific form of depression. Specialized assistance for postpartum depression and many other health problems is available only in metropolitan areas. Traveling to a regional centre with the cost of transportation, babysitting, and time from paid or unpaid work are significant barriers. Further, the fear of lack of privacy may even be greater in rural areas than urban centres.

Socio-economic factors are highlighted in analyses of the generally poorer health profile and practices of Atlantic Canadians as compared to the rest of the country<sup>18</sup>. Researchers have referred to rural communities as ‘at risk’ particularly because of their socio-economic make-up<sup>24</sup>. In Canada, Nova Scotia ranks the highest for its rural-urban income disparity, which helps to explain the relatively poor health outcomes in rural areas within the province. Linked to the poorer socio-economic conditions are higher rates of smoking, as well as obesity, both of which are correlated with poor health<sup>2,28</sup>. Recent changing socio-economic conditions within rural areas may be exacerbating the urban-rural health disparities thus creating even more significant health problems in rural areas than hitherto has been the case.

Not only has research linked socio-economic conditions in rural places to poorer health but socio-economic factors inter-relate with gender to shape gender differences in health. Relative to men, women’s health status is poorer on a number of different dimensions in spite of the fact that women live, on average, longer than men. Love et al.<sup>29</sup> have argued that the gender disparity in health may be due, in particular, to the greater economic poverty of women. Within the context of Atlantic Canada, the gendered income disparities are as telling as they are in the rest of Canada. Even given comparable educational qualifications, Atlantic Canadian women earn “just 81%” of what men earn (p. 14)<sup>20</sup>. Further, “more than two thirds of Atlantic region women earn less than \$20,000 a year compared to 48% of Atlantic men” (p. 15), and “only 2% of Atlantic region women earn \$50,000 or more a year, compared to 12% of Atlantic men (and 7% Canadian women)” (p. 15)<sup>20</sup>. The reasons for such income differences are complex, and include women’s higher rates of part-time, temporary, and on-call work which is

typically paid at considerably lower rates than full-time workers (p.15)<sup>20</sup>. Childcare responsibilities weaken women's position in the labour market, and some women 'choose' part-time work to accommodate the demands of their children and other family members, thus creating a cycle of relatively poor income, and reduced benefits, pension plans and job security<sup>30</sup>.

One recent study conducted in Nova Scotia<sup>31</sup>, suggests that young women are "quite sophisticated in their knowledge of healthy foods and the importance of exercise, but their behaviour does not necessarily reflect that knowledge" (p. 58). Day<sup>31</sup> notes an alarming tendency for young women to fast, cut down on the number of meals per day, substitute coffee, tea or cigarettes for food, and even starve themselves in order to lose weight (p. 45). In order to fully appreciate such health practices, we need to understand the socio-economic and cultural contexts that support and shape such behaviors without ignoring women's agency in relation to their health and health-related practices.

There is, indeed, a considerable body of research pointing to women's resiliency and ability to 'cope' with a variety of health and life crises, and this research is important in underlining women's agency<sup>e.g. 32,33,34</sup>. Across studies of different health problems, women consistently report significantly greater use of social support<sup>35,36</sup>, which may decrease isolation, facilitate problem-solving, and support positive emotion-focused coping, all of which may contribute to women's resilience in the face of health and life stress. Women who have difficulty accessing social support may actually have poorer physical and mental health<sup>37</sup>. Further, women who invest too much of themselves in giving social support may have more health problems and fewer positive health-related behaviors<sup>37</sup>.

**What research gaps exist and how will our research begin to fill these gaps?**

Although there is a small but growing body of literature on the health impacts of rural restructuring on women, within Atlantic Canada this literature is still in its infancy, and we know relatively little about the differential impacts depending on the type and nature of the community. There are a number of commonalities related to restructuring across the Atlantic provinces, but there are also specific issues and concerns within each province, and within particular areas, that need to be highlighted as they point to different types of health issues and related interventions. This heterogeneity has been less attended to than the commonalities across rural places. Differences in a community's resource base, socio-cultural makeup, service and commercial sector, and relationship to other centres (especially urban centres) are just some of the factors that have implications for community residents' lives and health. Women (and men) living in a rural environments may, for example, struggle with access to health care services, but the extent and nature of access problems will depend on the community/area/province in question. The heterogeneity in the conditions and composition of the community extends to individuals' and households' responses to changes. Binkley<sup>38</sup> reports, for example, that in one community on the southern shore of Nova Scotia, women in households where the male partner was a fisher responded quite differently to the decline in the fishing industry in the early 1990s. In some instances, women increased their work with their husband in fishing in order to save costs (e.g. so the husband would not have to hire a labourer), but in other instances women became the main breadwinner, taking on increased wage-labour outside of the fishery. Binkley's research did not focus on the health implications of such

changes, but it is likely that these changes differentially affect women's health in a number of ways (e.g. physically, emotionally, etc.).

The collaborative research that we are undertaking is aimed at building upon the existing literature, and developing a more nuanced understanding of the health concerns and issues for young rural Nova Scotian women in diverse rural areas. There are three main research themes within this collaboration: mental and emotional health; rural safety; and, resiliency and change. Comparative studies in different rural settings form a key component of the program of research, as we are concerned with understanding how specific historical, socio-economic, and political conditions affect women's health and shape their responses to current conditions. For example, one study is aimed at comparing and contrasting a community that has historically been reliant on the fishing industry with one that has historically been agriculturally-based to determine if recent changes in the two communities are affecting young women's lives (e.g. division of labour in the household, access to services, etc.) and their health (e.g. stress levels) in potentially different ways. Our research will also build upon existing and planned oral histories of rural women as well as archival research in order to place what we learn about the health of young rural women into historical context.

Our research will also include the development and testing of a cognitive behavioral intervention for postpartum depression as a means of improving access to mental health services for young women in rural areas. The programme will be delivered in the privacy of the mother's home at a time convenient to the mother. This intervention is termed 'MOM: Managing our Mood', and uses a handbook, videos and a telephone coach who problem solves and encourages the mother. We have focused on postpartum

depression, as this health issue is especially important for young women. Linked to this research will be research studies focused on understanding the role of spirituality in coping with depression as well as historical work on the ways in which the terms ‘stress’, ‘anxiety’ and ‘depression’ entered the lexicon of rural Nova Scotians. Other studies will use a historical perspective to examine young women’s conceptualizations of their health. We will be working towards the development or refinement of an instrument to measure sources and levels of stress for young rural women.

Rural safety is also a major component of our work and will include deepening our knowledge of safety factors, particularly within the context of the family farm. Our projects will focus on young farm women and the role of the women’s/family’s attitudes and beliefs, as well as the particular local context, on risk-taking behavior. Working collaboratively with a number of farm women’s groups, and based on an empowerment model<sup>39,40,41,42</sup>, we will be developing an intervention strategy aimed at increasing farm safety. As part of this work we will also be designing credit and non-credit courses on farm safety.

Change in rural communities can place considerable burden on women, particularly if social networks are overburdened or jeopardized. One of our research directions is the exploration of formal and informal social support networks in different rural communities and their relationship to young rural women’s health and resilience. As part of this work, we will be analyzing how changes in rural churches may be impacting young rural women, especially in terms of their volunteer and unpaid work, and comparing this to the work of women in previous generations through historical archival research.

The overall intent of the research collaboration is to add to the existing body of knowledge about young rural women in order to help rural women live healthier and more successful lives. The multiple and cross-cutting studies will be carried out by a multi-disciplinary team of researchers in collaboration with rural women and communities. The research initiative is aimed at improving our understanding of the varied health issues facing young rural women, and supporting the development of potential strategies for reducing the sources of ill health, and promoting healthy practices and structures.

### **Notes**

1. Within the existing literature, “rural” is sometimes defined in terms of distance from urban centres, in other cases according to population size and density, or distance from essential services. Samson (p. 22-27)<sup>43</sup>, drawing on Swierenga<sup>44</sup> and others, defines “rural” in the Atlantic Canadian context as those areas with low population (how low depending on several factors, and the time period under consideration). Rural areas are also conceptualized as where people have some access to and/or engagement with ‘country’ landscapes and lands (coastline, the woods, fields, other open spaces), and where, in some measure, livelihoods have been or are embedded in, shaped by, or defined by, the natural environment and its resources as well as the distance from urban economic centres. Using a definition of rural as “the population living in towns and municipalities outside of the commuting zone of larger urban centres”, a recent Health Canada report argued that the rural-urban mix in Atlantic Canada is “dramatically different than in the rest of Canada” (p. 43)<sup>18</sup>. The Maritime provinces remained more rural than urban longer

than the rest of Canada—until the 1940s (p.10)<sup>43</sup>. The fact of this region’s persistent rurality may help to explain the unique rural characteristics of the region.

2. Making gender and health truly visible, and comprehensible within rural contexts, requires some re-thinking and some creative combining of categories of analyses.

Sandwell (p. 12-13)<sup>45</sup> stresses the importance of viewing rural as “a category of description and analysis” in order to more effectively understand “issues of identity, agency, and power.” Canadian historians have begun to grapple with the complexities of the rural past, and women’s historians, feminist political scientists, economists and others have made tremendous progress in their fields, yet the categories of ‘women’ and ‘rural’ have largely, with some notable exceptions<sup>46,45,47,18</sup> remained ‘two solitudes’. It is within this context of ‘rethinking’ and ‘reconceptualizing’ rural, and the move towards integrating young women, health, and rural, that we aim to add to the existing (albeit relatively small) body of knowledge about young rural women’s health.

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