

The Role of Unpaid Work in Maintaining Individual and Community Health in Atlantic Canada

A Case Study

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Les auteures examinent les efforts des habitants d'un petit village de la Nouvelle-Ecosse, Parrsborro, pour maintenir la santé et le bien-être des individus et de la communauté dans des circonstances affectées par les mouvances de la population et son vieillissement. Ils'avère que les habitants s'entr'aident et se dépannent gratuitement, organisent des réseaux informels communautaires et sociaux, toutes activités où les femmes assument la majeure partie du travail bénévole.

Our research employs a multi-method approach, including a case study in the small rural town, Parrsboro, Nova Scotia (population 1,529) to examine strategies for maintaining individual and community health. Despite the significant challenges facing the coastal town of Parrsboro, including a declining working-age population, population ageing, a lack of economic diversification and the regionalization of the health services, town residents have gone to considerable effort to maintain individual and community health and well-being. They exhibit good will, a positive attachment to their community and a willingness to engage in unpaid work, considered here in three specific locations: households, informal networks and formal organizations. Based on our research in Parrsboro, we demonstrate that residents have been able to maintain

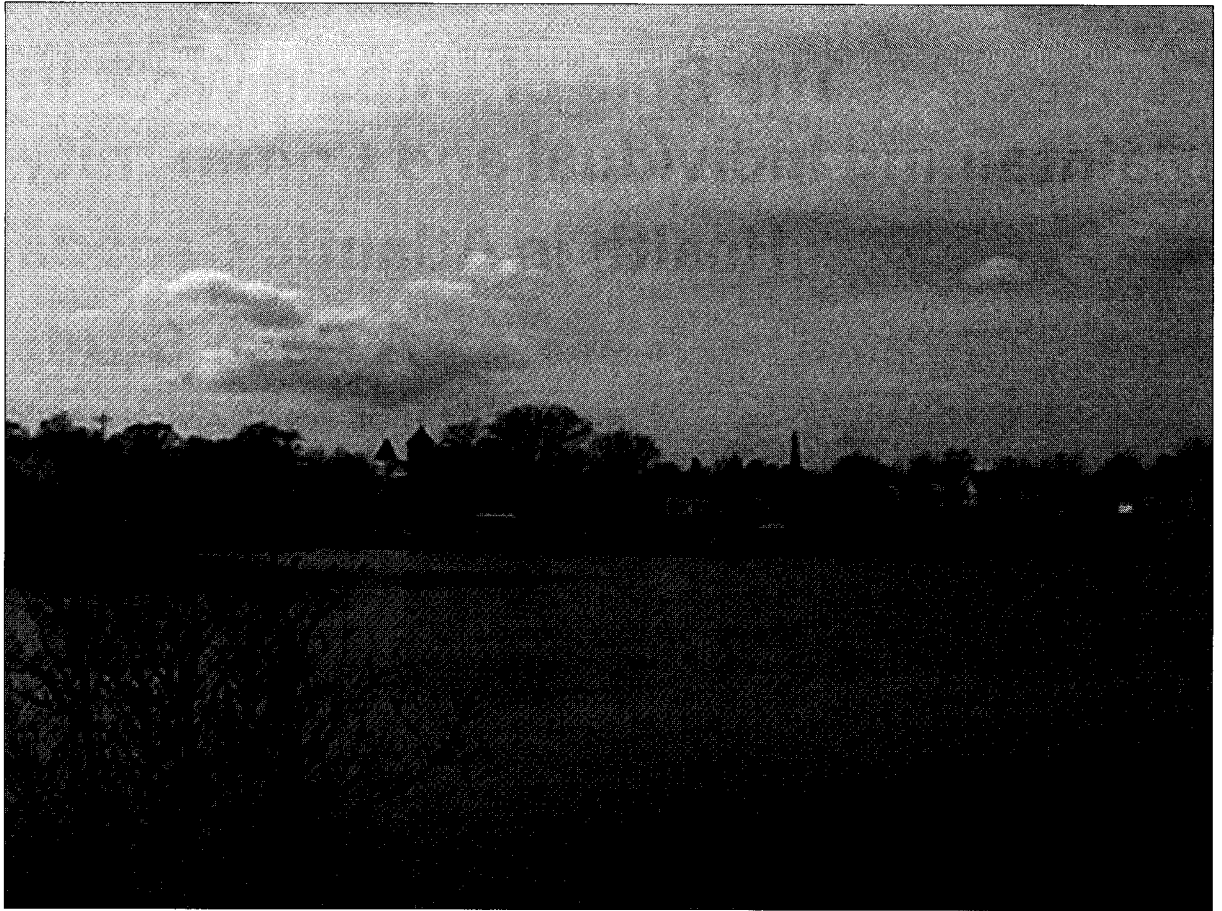
their health and well-being largely through their unpaid labour. However, we also identify a confluence of factors, including a declining population base and population ageing, that are likely to detrimentally affect their ability to continue providing unpaid labour in future and creating a situation whereby the maintenance of rural health and well-being will likely become a pressing issue.

These research findings are significant for their recognition of rurality as a determinant of health, for the ways that they demonstrate some of the benefits as well as drawbacks of rurality for health and well-being (Sutherns, McPhedran and Haworth-Brockman), and for their explicit consideration of rural women's health concerns (Sutherns *et al.*). Policy changes in three specific areas could, we suggest, help to maintain individual and community health and well-being in Parrsboro. First, policies intended to address health and well-being could recognize and address social and economic needs as key health determinants. Second, unpaid labour could be recognized as economically productive and its gendered dimensions and implications for health and well-being acknowledged (Statistics Canada 1996a, 2001). Third, because town residents derive an important sense of individual well-being and com-

munity enhancement from their volunteerism, decision-making abilities could expand local resources and control while sharing responsibilities with health care providers and district and provincial health authorities.

Research Methodology

Our research adopts the Rural and Small Town Definition, a town is less than 10,000 individuals and located outside of the commuting zone of larger urban centers. Health is understood here as the subjective experience of individuals and as an important and dynamic constituent of communities. The World Health Organization defines individual health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," a definition that is also employed by Health Canada (2002, 2003). Community health refers to the ability of communities to balance barriers to health with factors that encourage health, relying on reciprocal relationships among people with their environment (Ryan-Nicholls, Racher, Gfellner and Annis). The Ministerial Advisory Council on Rural Health Canada understands healthy communities as those that encourage citizen participation and have safe environ-



View of the town of Parrsboro, Nova Scotia. Photo: Christine Kennedy

ments, diverse economies, sustainable ecosystems and appropriate health services.

Quantitative and qualitative research methods are combined in our research to investigate intersections among population change, regionally specific demographic, social and economic factors, and individual and community strategies to maintain health in Atlantic Canada. Quantitative research methods include a targeted review of population change based on Statistics Canada secondary data and analysis of the *1996 General Social Survey, Cycle 11: Social and Community Support* to more closely investigate helping behaviours (Keefe and Side). In this article, we draw specifically on data collected from a qualitative case study of a single rural community that is currently experiencing population loss and population ageing to demonstrate how health is maintained under

these circumstances. While the case study approach is limited in its generalizability, adopting this approach allows us to analyze relationships among a number of factors related to rural health (Reinharz), to account for locally specific social and economic circumstances that affect how health is experienced and counters the prevailing tendency to aggregate data from across this region.

The Town of Parrsboro was selected as the case study community based on its rural locale, moderate population loss and situation of population ageing, its location in the under considered region of Cumberland County, Nova Scotia and the proactive position that the community took in addressing local health needs, prior to the province-wide formation of Community Health Boards. We utilized previous contact with a community member in Parrsboro to schedule a

meeting with the leaders of five community-based groups and access to the community and cooperation from Parrsboro residents in the research was facilitated through this meeting. The research project also received approval in principle from the Parrsboro Town Council.

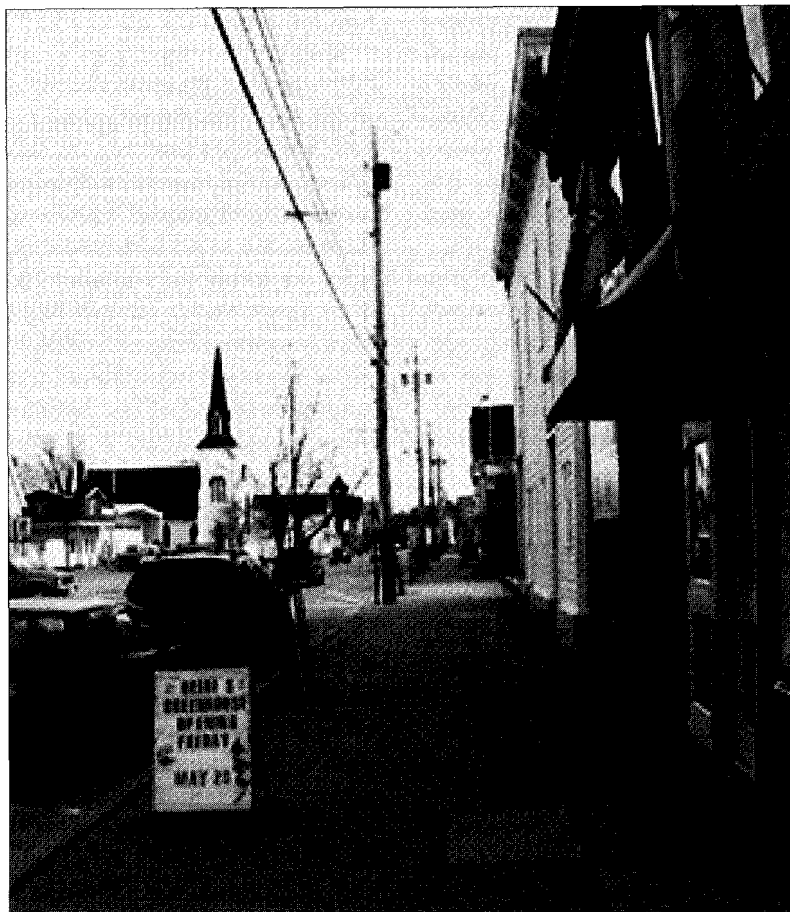
Qualitative data were collected during community visits over a five-month period during 2003. In total, we spoke with sixty-one residents and former residents of Parrsboro in focus groups and semi-structured interviews. Almost two-thirds (63 per cent) of participants were women. Initially, focus groups, intended to gather community-level data about population change and its effects on health services and needs, were conducted with four community groups, including a seniors group and a youth group. Ten further semi-structured interviews were conducted with residents and previous residents

contacted through snowball methods. Semi-structured interviews examined social networks and relations, helping behaviours, community-based services and individual and community health needs. Additionally, six semi-structured interviews were conducted with key informants, individuals who held professional positions in health and social services. Focus group transcripts, semi-structured interview transcripts and researcher field notes were coded using QSR NUD*IST 6 software and a second researcher ensured coder reliability.¹

At the project's conclusion, research findings were presented at a public town forum and to the local Community Health Board; a public presentation of research findings in Halifax, Nova Scotia also included participation from a community member. A town profile that was produced from government sources, published reports, community newspapers and World Wide Web based resources, also provided us with an important context through which to better understand the town of Parrsboro.

Town of Parrsboro, Nova Scotia

Located on the Bay of Fundy, the Town of Parrsboro's year round residents were once engaged in the area's rich maritime, logging and mining capabilities. Economic change over the past five decades, however, has resulted in a dramatic shift away from a reliance on primary resources and a more diversified economy. Coal mines in the nearby community of Springhill closed in 1970 (Brown). A local sawmill closed in 1992 (Kyte) and the commercial fishery is limited in this area.² Presently, employment is primarily based in sales and service occupations related to seasonally-based tourism and blueberry production. Seasonal employment, underemployment and unemployment, and financial insecurity have a detrimental affect on individual



Main St., Parrsboro, Nova Scotia. Photo: Christine Kennedy

and community health and well-being.

With limited opportunities for full-time, year-round employment, the town's working age population, 25 to 54 years, is declining, resulting in an increase in the median age of the resident population. Between the 1996 and 2001 Censuses, Parrsboro's moderate population loss (5.4 per cent) exceeded the average for rural Atlantic Canada (two per cent) during the same period (Statistics Canada 2002). Between 1996 and 2001, the median age rose from 42 to 44 years, almost six years higher than the Nova Scotia average (Statistics Canada 1996b, 2001). Changes to the provincial planning, management and delivery of health services have resulted in a reduction and relocation of health services (Canadian Centre for Analysis of Regionalization and Health 2003). Five rural hospitals in Nova Scotia

have been closed or converted into long-term care facilities, including the former Parrsboro Hospital, now the South Cumberland Community Care Centre.³

Despite these demographic changes and changes to and health services, the majority of Parrsboro residents whom we interviewed (84 per cent) report good health (Keefe and Side 95).⁴ Additionally, they demonstrated a strong sense of attachment to their community and to its rural landscape and the benefits of the close proximity of supportive social networks, espousing "the folk model" of their community as one where residents know and care for one another, in households, informal social networks and formal organizations (Gra-ham).

Unpaid Work in Households

Measures of unpaid work in households consistently indicate

that women spend greater amounts of time than men doing unpaid household work (Bakker; MAW; Statistics Canada 1995, 1996a, 2001). Women in Nova Scotia spend greater amounts of time doing household unpaid work than men in Nova Scotia (McFadyen),⁵ and women living rurally in Nova Scotia spend greater amounts of time doing unpaid work in households than men living rurally in Nova Scotia (Keefe and Side).⁶ Circumstances that may be shared by rural women shed some light on the gendered dimensions of these responsibilities. Rebecca Sutherns *et al.* find that rural women, as a group, “have appreciably lower labour force participation rates, higher fertility rates and a higher likelihood of being poor than their urban counterparts” (2004, B5).

Unpaid work in households, shaped by dimensions of gender and rurality, can foster and hinder health. Unpaid work in households affirms the worth of workers, ensures that the needs of household members are met, helps to cushion circumstances of poverty (Mawhiney; Bezanson and Noce; Luxton and Corman) and bolsters self-sufficiency and self-reliance as often cherished values in rural communities (The Northern Secretariat, British Columbia Centre of Excellence for Women’s Health; Moulaison).

The majority of research participants in Parrsboro lived in households where regular care was provided to household members, including spouses, parent(s), in-law(s) and children; only eight percent of research participants lived alone. One focus group participant whose elderly mother resides alone regarded the ability of elderly individuals to live independently and to complete their own household work as evidence of their good health, and she offered her mother’s situation as an example, “My mother is 81 years old and she is still doing all her own housework

and everything. It’s wonderful.”

Responsibility for unpaid household work can, however, also negatively affect health and an examination of the gendered implications of unpaid work suggests that greater numbers of employed women in Canada, compared with employed men, report unpaid household labour as stressful (Lethbridge, MacDonald and Phipps).⁷ Not surprisingly, household labour was more often identified as stressful in the case study in interviews rather than in focus groups, where expectations about familial obligation and emotional attachment may have been assumed to be shared expectations.

Despite the persistence of the gendered dimensions of this work, women often overlooked the contributions their unpaid household work made to individual and community maintaining health and well-being. Only one woman identified her unpaid household work as a concerted strategy to maintain health and well-being, but she quickly countered this by stating, “But, I assume that you don’t need to know about that because that’s pretty typical for most people.” Research participants, women and men, when explicitly asked about strategies to maintain health and well-being, more readily identified their unpaid work in informal social networks and formal community-based organizations.

Unpaid Work in Informal Social Networks

Unpaid work in informal networks is defined as voluntary assistance based on social ties among extended family members, friends and neighbours, and proximity that are not mediated through formal organizations (Colman 2003). Quantitative data from the *General Social Survey, Cycle 11 Social and Community Support* indicate that giving and receiving six types of assistance, as measured by four in-

strumental and two expressive tasks, is more common among rural Atlantic Canadians (80 per cent) than among their rural, non-Atlantic Canadian counterparts (71 per cent) (Keefe and Side 2003, 52).⁸ In particular, rural Atlantic Canadians are more likely to give and receive emotional support (40 per cent) than their rural non-Atlantic Canadians counterparts (21 per cent) (Keefe and Side 58).⁹

While qualitative data do not compare unpaid work in informal social networks of rural Atlantic Canadians, with rural non-Atlantic Canadians, participants in focus groups and interviews repeatedly depicted Parrsboro as a caring and supportive community where people were actively involved in providing help to one another, as demonstrated by these three, separate characterizations of the community,

She knows that she can call us and we’ll be there. But I think that happens throughout the community, that people know that there are others that they can call. And I think that’s an important part of community life when you get into rural areas. And I think it’s something that has to exist.

It doesn’t matter what kind of catastrophe happens here, we all help. We are a community that gets together and we help. That’s one’s thing I’ll say about this community.

Everyone watches out for each other. If you do need help, there’s always someone you can call to help you, and there is a lot of support here if anyone does really need it.

Participants provided individual examples of helping in social networks that maintained health and well-being, such as the person who mowed his neighbour’s grass because his neighbour suffered from

asthma, as well as community-wide examples, including fundraisers to assist community members with the cost of travel to medical treatment and with the loss of a home due to fire. Expectations about the presence of informal social networks may also have contributed toward feelings of health and well-being, and may be facilitated in rural Atlantic Canada by the presence of

informal networks, often based on expectations of reciprocity, may disadvantage individuals without resources to reciprocate (Side).

Unpaid Work in Formal Organizations

Unpaid work in formal organizations refers to voluntary work performed without pay or the ex-

HPAC, a voluntary, community group was formed in 1994 to address social and health needs. It received some financial support from the provincial Health Promotion Volunteer Fund and established a storefront presence on the town's main street and hired a paid Coordinator. Organized primarily through a voluntary sub-committee structure, HPAC conducted a

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strong kin networks, as this woman suggested in an interview,¹⁰

You do have closer family ties, definitely. I think you see people who are much closer, you know, extended families that would be in other places. It seems like a lot of people associate with their families whereas in a big centre, you sort of forget your family and you associate with everybody else. Family ties are very close.

This folk model of mutual support also poses some limitations. Concerns about confidentiality was identified by one woman as a possible consequence of calling on support from informal networks,

You have to be careful who you trust with your details; otherwise, you'll be "the theme of the week." My friends have been great, but it requires a bit of prudence ... to figure out who's who and who's connected with who, and all that stuff.

Informal networks are not always easily engaged and those positioned outside of them may feel shame and embarrassment at their exclusion (Sutherns *et al.*). Also, assistance in

expectation of pay for charitable, not-for-profit and community organizations (Colman 2003). Health Canada (1999) recognizes volunteerism as a key indicator of a "supportive social environment that can enhance health" (60).

Gender and region are important variables in patterns of volunteerism. More women (35 per cent) than men (32 per cent) are volunteers. Atlantic Canadians volunteer at higher rates than non-Atlantic Canadians. Nova Scotia's volunteer rate is the highest among the Atlantic provinces.¹¹ Except in Nova Scotia and Prince Edward Island, volunteerism in Canada has declined between 1997 and 2000.¹² While these two provinces are experiencing a decline in volunteerism in formal organizations, increases in informal voluntary activities play a compensatory role that results in "a net gain in volunteer hours per capita" (2003: 5).

While many community organizations in Parrsboro maintain health, two organizations, the Healthy Parrsboro and Area Committee (HPAC) and the Southampton, Parrsboro, Advocate and Regions (SPAR) Community Health Board, have specific mandates to promote health and well-being.¹³

health needs assessment and organized community-wide events, such as local dances.

The SPAR Community Health Board was formed by the Province of Nova Scotia in 1997 as a direct result of health care regionalization. Community Health Boards are mandated to submit plans to District Health authorities whose responsibility it is to identify local needs, set health care priorities, coordinate health initiatives, control community input and advance the interests of the provincial health plan (Clow 2001; Canadian Centre for Analysis of Regionalization and Health 3). Activities of the SPAR Community Health Board have included a health needs assessment and the ongoing management of monetary support for short-term community projects.

While HPAC's funding was renewed once, it was unable to continue funding the Coordinator position and closed its office. The commitment of volunteers waned and the sub-committee structure ceased to exist. Efforts to maintain health once evident in the community-based structure of HPAC have shifted to the SPAR Community Health Board. However, some town residents, such as this employed

mother of young children, expressed concern over issues of representation on the SPAR Community Health Board,

The unfortunate thing with the Community Health Board is that a lot of people are retired or older, so you don't have the whole spectrum of youth and the middle aged and so forth, because most of the activities with the Community Health Board occur during the day so any seminars, any meetings, any involvement happens during the day. So, for a working person, obviously you can't attend.

Her concerns may be substantiated, to some extent, by scholarly findings that volunteers in health promotion and reform tend to be older with more discretionary time and income (Higgins; Jewkes and Murcott). Key informant interviews revealed both frustration from current volunteers about their inability to recruit younger people as engaged volunteers, as well as frustrations from younger people that their perspectives were not included. We also spoke with one member of the Community Health Board who recognized the limitations of the Board's provincially mandated managerial role. She recognized the Board's ability to fund important community projects, among them training for the area's Search and Rescue Team and a skateboard park for town youth, but concluded, "It's not very much, but yet we've been helping and those things have been successful and we've managed some good projects. But as far as influencing the trend in health? No."

Limitation and Contributions of Volunteerism

In their examination of the role of voluntary organizations in rural communities, David Bruce, Paul Jordan and Greg Halseth found that the presence of volunteers is "a

strong indicator of the importance of social infrastructure in the community" (iv). Volunteerism, however, is a fragile foundation on which to build long-term strategies for maintaining rural health and well-being. Population loss and ageing and the declining work age population in Parrsboro will likely reduce the future availability of volunteers, detrimentally affect the effectiveness of the unpaid work volunteers provide, and result in the loss of locally based knowledge. Over the long term, waning volunteerism may result in increased costs for health services to rural communities.¹⁴

Among the benefits of volunteerism are supportive household relations, enhanced feelings of community belonging, locally-based provision of health services, and positive interactions with local health care providers (Bruce, Jordan and Halseth). Many volunteers with whom we spoke in focus groups and interviews reported that they derived personal satisfaction and a sense of accomplishment from their unpaid work. A long-time community volunteer suggested,

You do receive as much back, satisfaction back from giving your talents to support organizations. I guess in a small town you do see the results of your work perhaps a little more than in a larger community.

Conclusion

Policy changes could be instituted in ways that would better support the voluntary efforts of rural community members to maintain their health and well-being in the face of disadvantageous circumstances. In the case of Parrsboro, social and economic opportunities such as improved access to full-time, year-round employment through economic diversification, would enhance local

opportunities and counter the negative effects of poverty on health and women's primary responsibility to cushion the effects of poverty on household members. Similarly, policies that impute unpaid household labour with value would begin to acknowledge unpaid work as an important source of productive economic activity in rural Atlantic Canada that is assumed disproportionately by women, expose its role in subsidizing the formal economy in Atlantic Canada (Colman 1998; Ommer) and make evident the implications of this work for women's health and well-being. Because volunteers report that their unpaid work contributes to their sense of individual and community well-being and because the presence of informal networks likely offers community benefits, policies that support and not usurp, local initiatives and control and better support volunteers would further promote rural health and well-being as the shared responsibility of volunteers, health care providers, and district and provincial level health authorities. In the instance of Parrsboro, resources to better assist community volunteers might include equipment, space, and administrative and technical support, as well as replacement costs for lost wages, childcare, and transportation.

Ample statistical evidence is already available demonstrating that women typically assume greater responsibilities than men for unpaid labour in households, informal networks and formal organizations. Qualitative data from this case study examination of the maintenance of individual and community health and well-being in the rural town of Parrsboro, Nova Scotia contributes to these data by helping to further understand how unpaid work across various settings can contribute in the short-term, to rural women's health and well-being by providing some rural women with personal satisfaction

that derives from fostering supportive relationships and the sense of a caring and cooperative community. It remains to be determined, however, whether these benefits will be enough, under difficult circumstances, to maintain rural health and well-being over the long term. Further integrated analyses must be undertaken in ways that recognize rurality as a key health determinant, acknowledge its discursive intersection with other health determinants such as gender, age, and income in rural contexts and account for the heterogeneous nature of rural experiences.

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¹The data from six key informant interviews were coded separately given that their positions likely provided then with information that was not readily available to town residents. Our analyses of these interviews served as further validation that data from the focus groups and semi-structured interviews were representative of community experiences. Credibility in the data was further assured through consistency in data collection and the presence of more than

one research team member, in most instances during its collection. Presentation of the research findings to two separate community fora, and participation for a community member in another presentation, assured that findings were a fair, honest and balanced account of social life as we observed it (Neuman).

²In 2004, only six fishing vessels were actively registered in Parrsboro in (Transport Canada Vessel Registration Query System).

³The South Cumberland Community Care Centre currently provides six Level II long-term care beds, two palliative/ restorative/acute care beds, limited emergency services and diagnostic services such as x-ray and laboratory services. It offers some visiting health services, such as foot care clinics, optometry and psychiatric services and is equipped for Tele-Health services.

⁴Focus group and interview participants also completed a survey about their individual health status. Twenty-four per cent of participants reported their health as "good." Thirty-six per cent reported their health as "very good" and 24 per cent reported it as "excellent."

⁵Census data in 2001 indicate that Nova Scotia women, age 25 to 44, spend three times as much time as Nova Scotia men, age 25 to 44, doing unpaid housework. In 2001, Nova Scotia women, 25 to 44, spend two and a half times as much time as Nova Scotia men, age 25 to 44, doing unpaid child care (McFadyen).

⁶Semi-customized tables, based on 1996 and 2001 Census data, confirm that women who live rurally in Nova Scotia assume a disproportionate share of unpaid work in households (Keefe and Side 161-164). There is some indication that between 1996 and 2001 the amount of time that women living in rural Nova Scotia spend doing unpaid labour has decreased and the time that men living in rural Nova Scotia spend doing unpaid labour has increased. It is possible that women are decreasing their contributions because men are

making greater contributions. Alternatively, Meg Luxton and June Corman in their examination of gendered labour at home and on the job suggest, "women decrease the amount of work that they do because they rely on other women, either unpaid exchanges with female friends and relatives, such as mothers and daughters or, if they can afford to, pay for help" (158). An increase in informal economy activity in Nova Scotia, between 1997 and 2000 (Colman 2003), lends some support to their suggestion.

⁷General Social Survey data in 1992 find that 45 per cent of employed women in Canada, age 24 to 44 years, 37 per cent of employed men in the same age range, report experiencing unpaid household labour as stressful. In 2001, 51 per cent of women and 41 per cent of men reported experiencing this work as stressful (Lethbridge, MacDonald and Phipps).

⁸Instrumental tasks include: 1) child care, 2) household instrumental activities of daily living (i.e., child care, meal preparation and clean up, house cleaning and house maintenance), 3) non-household instrumental activities of daily living (i.e., shopping for groceries, banking and providing transportation) and 4) personal care. Expressive tasks include: 1) checking up on someone and 2) emotional support (Statistics Canada 1998).

⁹Gender, age and living arrangements are key variables across all six types of assistance. Those who give help, but do not receive help are more likely to be women; those who receive help, but do not give help are more likely to be men (Keefe and Side 59). Those who are younger, age 15 to 29 years, and older, over 80 years, are more likely to receive help from others, and those who live alone represent a larger proportion of those who do not give or receive assistance; presumably, living alone presents fewer opportunities to help others with tasks.

¹⁰Almost half (48 per cent) of the town residents we interviewed were

born in Cumberland County.

¹Volunteer rates are for Nova Scotia, in 2000 (Colman 2003; McFadyen).

²Declining volunteerism between 1997 and 2003 resulted in 74,000 fewer volunteers in Atlantic Canada (Colman 2003: 5).

³Southampton and Advocate are neighbouring towns; both are within forty-five kilometers of Parrsboro.

⁴While the costs of off loading responsibility for health to individuals may be apparent, the costs to employers are often less visible. Employers absorb the costs of employees who are distracted and whose work is disrupted by the demands of caregiving.

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