“That’s what they do!” The impact rural isolation has on young people’s health decisions

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The authors would like to thank all the participants of this study who shared their stories and experiences. In addition, we thank the local school for permission to access students and the University of Melbourne for funding.

Abstract

Policies designed to optimise the future health of young people must be based on a sound understanding of their health behaviours. Although young people hear and understand the health promotion messages\(^1\), many of them take their health for granted or continue to make health decisions that impact negatively on their health in both the short and long term. With the current trend towards increasingly unhealthy lifestyles that result in significant economic cost to both the individual and community, an understanding and analysis of young people’s health decisions is particularly crucial. Since health outcomes are the product of a complex social process\(^2\), it is important to address health decisions at an individual, structural and sociocultural level.

Rural and isolated young people are of particular importance, since many of their determinants of health predispose them towards poorer health outcomes.\(^3\) These people must navigate the sociocultural influences of rurality in all its aspects—isololation, opportunity, relationships, social norms and local and broader cultural issues.

This study used a mixed methodology to analyse young people’s decisions and the ways social context influences their behaviours in a small and isolated rural community in Victoria. Twenty young people (aged 16–20) were interviewed twice about their diet, physical activity, smoking and alcohol consumption; and they each completed a questionnaire and a food diary for seven days. In addition, one parent of each respondent and selected key informants from the local community were also interviewed. The survey data were analysed using SPSS, and transcribed interviews analysed thematically with triangulation of data from different sources enabling the individual, family and community influences to be identified.

The study findings and the key issues influencing young people’s health decisions are described in context to their rural isolation. The complex and interrelated nature of rural youth issues including friendship groups, social norms, local culture, social hierarchy, gender, identity and self esteem are discussed in relation to their health decisions.

Young people’s perspectives of health largely revolved around “constrained” choice, reflecting the ways in which various barriers and limits associated with rurality delimited their opportunities and relationships. A better understanding of the barriers to healthy decisions of rural youth may lead to more targeted intervention in order to address the current trend towards lifestyle related diseases such as obesity, diabetes, heart disease and potential mental health issues relating to the added complexity of isolation.

Introduction

Australian research shows that the further you live from urban areas the poorer one’s potential health outcome is likely to be.\(^4\) In rural and geographically isolated settings, young people face particular risks that may predispose them towards poorer health outcomes.\(^4\) They must navigate the sociocultural influences of isolation with issues of rurality, opportunity, relationships, social norms and local and broader cultural issues influencing their health decisions.\(^5\) It is also important to understand the
strengths and advantages of rural communities with respect to facilitating healthy behaviours and lifestyles.\textsuperscript{13}

Adolescence is a time where young people begin to make health decisions that impact on both immediate and long term health, attitudes and behaviours. Planning effective health promotion strategies for young people must consider the influencing factors on current trends of increasingly unhealthy lifestyles and the resultant individual, community and economic costs.

Evidence suggests that young people hear and understand health messages\textsuperscript{9}, but still make decisions within their locus of control that contradict this knowledge, often taking their health for granted. Understanding the full complexity of health and wellbeing as a social process, with health outcomes as the product of this process\textsuperscript{10}, is important. This knowledge is fundamental to addressing people’s health behaviours at an individual, structural and sociocultural level, and contextually to the rural environment they live in.

Exactly how isolation impacts on young people’s health decisions in rural communities is important but not well understood. Many rural areas are characterised by high levels of unemployment, poverty and low incomes, poor access to health care, lack of transport, availability of goods, services and recreational activities.\textsuperscript{11} Hence isolation, both physical and social, plays a core role in determining wellbeing, especially for young people.\textsuperscript{9} While physical isolation can be mapped relatively easily, social isolation is less easily measured. Nonetheless, social networks are important for individual and group consciousness, communication and collaboration, or navigating day-to-day life.\textsuperscript{12,13} Family and community have been shown to have significant influence on young people’s wellbeing.\textsuperscript{9,16}

The objective of this study was to identify the impact rural isolation has on the decisions young people make about their health in relation to physical activity, diet, tobacco use, and alcohol consumption. The four key areas examined in this study are known to be significant contributors to health outcomes and the development of lifestyle related chronic diseases. The four key areas involve decisions influenced by sociocultural factors at an individual, family, environmental and community level. Through understanding these factors, a better appreciation of the barriers to healthy decisions for these young people is developed. Such evidence enables more targeted intervention to address the current trends of increasingly unhealthy behaviours that often lead to lifestyle related diseases such as obesity, diabetes, substance dependence and heart disease.

\textbf{Method}

To enable a comprehensive investigation and analysis of young people’s pathway of health related decision-making, a mixed methodology was adopted in this study, comprised of semi-structured qualitative techniques, a closed question survey and food diaries. It was important to identify the wide range of influences, motives and reasons underpinning the way young people negotiated decisions and social constructs.

Purposive sampling techniques were used, commencing with the selection of an isolated community. The community (population 1001) was selected because it is rural and isolated. The town had no public transport, one independent primary school, one state school to year 12 with 320 students from a wide catchment area, one doctor, a small hospital, two hotels and an active football/netball club. Characteristic of many communities, the population is ageing, with only around 60 residents between the sample target ages of 14 to 18 years of age at the 2001 census. The community had an unemployment rate of 11\%, the rural agriculture workforce was 12\% and many residents commuted to neighbouring towns or regional centres (minimum 40 minutes drive) to work.\textsuperscript{14}

A small group of young people, their parents and community key informants were included in the study in order to examine in-depth individual, family and community influences on young people’s decisions, including some understanding of how the community was organised and operated.\textsuperscript{15} Ten key informants, 20 young people and 9 parents were recruited for the study. 17 young people were recruited through random selection from year’s level 9–12 at the local school, after being identified as living within a 15 km radius of the town. 16 completed all aspects of the study. Five young people, who
were no longer at school, were recruited through snowball sampling within the community. Of these, three completed participation, all of whom were unemployed. The combined sampling technique was designed to ensure inclusion of a diversity of young people living in the community.

Confidentiality and anonymity of participants was maintained, data de-identified and due care taken in analysis and reporting to avoid all identifying data in line with National Statement on Ethical Conduct in Research Involving Humans guidelines. Semi structured interviews were conducted investigating lifestyles, health behaviours, social participation, health decisions, negotiation of decisions and factors influencing behaviours relating to smoking, drinking alcohol, diet and physical activity levels.

Young people completed a short questionnaire measuring health, wellbeing and a range of sociodemographic characteristics. The closed questions were analysed using Statistical Package for the Social Sciences (SPSS), enabling identification of any group differences related to age, gender, behaviours, education employment and beliefs, identified frequencies and determined means.

The young people also completed a seven-day food diary that identified the types of foods eaten and at what time of day, not amounts. In addition, two semi-structured interviews were conducted with the young people. The first focused on their health behaviour and decisions around the four target behaviours, exploring the reasons and beliefs. The second interview undertaken later, asked them to reflect on their health behaviours, focusing in particular on their lifestyle, health decisions, reasons for their behaviours, ways they negotiate these decisions and the influences parents, family, friends and community have on their decisions. In addition, the young people were given four specific scenarios and asked to comment on the health decisions make by young people in these scenarios.

All interviews with open ended questions and were tape-recorded, transcribed, coded and analysed thematically, along with interview notes and researcher observations. This triangulation of data from the different sources enabled the individual, family and community influences to be identified and critically appraised. Clear themes and issues emerged in relation to the complexity of influences, social processes and decision making.

Parents and key informants were interviewed only once. These semi structured interviews facilitated an understanding and insight into the family and community context, setting and influences. The information gained provided a framework of social and cultural factors that influence young people’s decisions.

Ethics approval was granted by The University of Melbourne and Department of Education and Training. Informed consent was gained from all participants and where the participant was below the age of 18, guardian consent was also obtained.

Findings

Of the 20 young people who participated, seven males and 13 females, ranging in age from 14 to 22 participated in the study. The average age was 16 years. Seventeen participants lived with their immediate family, one participant lived with their step-grandparent, one participant lived with extended family in town and one participant had been living independently since age of 14. The questionnaire sought to measure self reported health, wellbeing and life satisfaction, using a five point scale. The study found that they rated their health as 15% below the national average. Nine indicated that they would change their lives given the opportunity to live it over again, two participants reported a high level of life satisfaction, ten as satisfied, six were neither satisfied nor dissatisfied, two reported that they were dissatisfied, one with a high level of dissatisfaction.

All participants identified both physical and social isolation as factors influencing the decisions and behaviours of young people and the community. No one issue was singular in nature but interconnected and interrelated. For example one young person described needing to leave for employment reasons, but it appeared narrow social norms, social isolation and loneliness were also factors.
Physical isolation was identified through lack of services, education, training and employment opportunities, and knowledge about ways of accessing available services. Issues of transport, distance, time, cost and resources encompassed all layers of the community at the individual, family and community level. The young people still at school focused on a lack of recreational and sporting options as compared to the unemployed group who spoke of isolation in terms of employment, training, housing and social opportunities. Future study or employment was linked with relocation, significant travel costs and required support in financial, social and emotional terms. This relocation process was not considered an option by some young people.

Social isolation evolved from several identified factors. A strong sense of social structure, norms and hierarchy were influenced by history and longevity of some families, identified by almost all participants. There was a distinction between ‘born and bred’ and ‘blow ins’ which exemplified the social structure and social norms. One participant described “we don’t get involved in those sort of um, new things I guess. That, they’re the newer people to town...” Other factors identified were based on income, status, length of residence and family history or perceived social status. The football club crossed these boundaries to a certain degree but formed a division in itself within the community of being part of ‘the club’ on not. Some identified the strong social structure as supportive and nurturing, whereas others saw it as stifling and repressive.

Young people identified family and friends as core factors influencing the way they make decisions. In this respect any influence of isolation (social or geographical) on these factors is central. Young people identified family as important people in their lives, as somewhere to go with a problem and where they get their health information from; only two participants did not list family as important in their life. Four participants listed grandparents as important in their lives. Interestingly when asked about sharing a secret only five believed they would share it with family, mostly siblings.

Friends were identified as the next most significant factor, 16 listed friends as who they would share a secret with before family, 13 identified friends as someone they would go to with a problem. Interestingly only ten listed friends among the important people in their lives. Friends were an important factor influencing decisions. Ten participants listed socialising and friendships as an engaging factor in sport and physical activity. More importantly social isolation was listed as a reason for not engaging. “They’re all sort of like a tight little community and I didn’t really feel like I don’t know, welcomed to. I don’t know, so I just really didn’t really get into sports”.

Physical activity was divided into structured and non structured activities. Ten young people were involved in local structured sport over the year, football or netball (5), cricket or tennis (3), and badminton (2). One young person was driven one hour each way to participate in the chosen sport each week, with considerable time, effort and cost to parents in facilitating this. The reasons given for involvement were enjoyment, social interaction, friendships, and fitness, with two participants stating that it was something that they were “good at”, thus identifying the link with self esteem and wellbeing. The nine participants not engaged in structured sport, maintained some level of physical activity, with only one stating s/he disliked it, but used exercise to “work off” food. Four participants identified lack of transport as reason for walking, three of these were unemployed. Six participants stated that their preferred physical activity was not accessible in their local community.

When asked about overall eating, one participant stated that they “didn’t eat well”, 15 rated diet as “o.k.”, and four felt they had a healthy diet. Most ate three meals a day, but 16 participants stated that they skipped meals, at times usually because they were “not hungry”, “sleeping in”, “too busy”, “to lose weight”, or “not having the money”. Nine participants had dieted in the last year.

In discussing ‘day-to-day decisions’ about eating, only four participants considered factors other than what food was immediately available. Of these four, two were responsible for shopping and preparation of their own meals, another stated that budget was a factor and the fourth made a decision based on a healthy choice. The other 16 participants stated that the main factors influencing what they ate were simply, “what was there” in the pantry, fridge or readily available, “what they felt like” or what was easy and quick. They were happy to eat whatever was being cooked for the evening meal,
usually by a parent. One participant said that s/he tried to eat healthily but generally ate “whatever was in the cupboard”.

Friends and socialising were significant influences on their diet. It was observed that the cafes became a ‘hang out’ place for young people after school and on weekends; that eating junk food was a social aspect of being together and part of young peoples’ culture or “what they do”. Exactly how the young people defined junk food was somewhat ‘grey’. Nonetheless, it was clear that ‘junk food’ and ‘takeaway’ was a major part of young people’s diet, usually connected with being with friends. The greater the level of social connection, the higher the level of junk food consumption.

Availability of food played a significant role in what young people decided to eat. Where participants had access to ‘junk food’ it was often the first choice; for example on weekends young people often chose to eat café food, or major retail chain fast foods, if it could be accessed. Given the major factor influencing the decision young people make about what they eat is “what is there”, meaning what is available in the fridge or pantry when they are hungry, then the role of supplying food in the fridge and pantry is highlighted as important. Since the role of choosing healthy food options starts with shopping, therefore the person who shops has a significant role in influencing the decisions about their diet.

Friends and social connections played a significant role in decisions young people made about smoking behaviour. Six participants smoked, four regularly and two as social smokers. The two social or occasional smokers were both female. Reasons for smoking were, being with other people who smoked, smoking when you are drinking, being at a party, or “I just do it because I think well if it can relax other people, it can, it maybe do it for me”. The four regular smokers interestingly had low levels of social connection, all had been unemployed, two of which had returned to school, three of the four wished they did not smoke. Some social connections discouraged smoking. One young person described how at a party “I didn’t see one person smoke” and s/he only had one friend who smoked. Social connection was both a facilitator and a barrier to smoking, indicating the sociocultural nature of smoking and the complexity of social norms that young people experience.

Friendship groups were also a facilitating factor in drinking alcohol. All young participants stated that they had experienced alcohol; all stated that their friends drink alcohol. The dominant reason for choosing to drink alcohol was to be social and be with friends, indicating a high level of peer group and social norms influenced decisions and resultant behaviour. Most of those who drank alcohol indicated that they drank at parties or gatherings with friends. Statements like “if friends are doing it, you just join in” or “yeah, I don’t know, just because you can, I suppose with everyone else drinking you just drink too, if that makes sense, sort of,” or another seventeen year old stated that; “Um, I’m not too sure really, I suppose maybe just cause everyone else is doing it. It sort of gives you a bit of, ah, it sort of maybe a bit of a release from everything, .. pretty much yeah cause everyone else is.”

These comments provide evidence of the strong relationship between drinking alcohol and social connection. The more socially connected the young people were within the community the more likely they were to drink alcohol. The young people who were socially isolated were less likely to drink alcohol, which again supported the social and cultural influences on alcohol consumption. Other reasons given for deciding to drink alcohol were that it “relaxes me” and “I can talk to people I don’t know easier and meet people cause I can be more outgoing”.

Discussion

Although the four key areas of diet, physical activity, alcohol and smoking have been identified independently, they are by nature interrelated. Their impacts on health are often collective in effect, contributing to complex and multi-faceted pathways of young people’s health and wellbeing. The factors are contextual to locality, time and a dynamic social process where the physical and social isolation influence the decisions young people make.

In relation to the study findings, the impact physical isolation had on young people was discernable—notably limited sporting and recreational activities, limited educational, employment and training
opportunities, lack of and high cost of transport, and a smaller ‘fish bowl’ of peers that limited opportunity for interaction. There was no support system for the next potential volleyball champion; there was no team, no tram and therefore no option. Research shows that inactivity is a major factor contributing to obesity, cardiovascular disease, diabetes, hypertension, cancers and mental health problems.\textsuperscript{17,18} It is estimated that inactivity is associated with 8000 preventable deaths and accounts for a direct cost of $400 million per annum in Australia.\textsuperscript{17} Adolescence is a critical time in which the steepest decline occurs in physical activity levels.\textsuperscript{18,23}

The sociocultural nature of diet and the significant role family and friendships play in the decisions young people make was exemplified in this study. Considering this influence is imperative to addressing the dietary role in wellbeing and chronic diseases. The Australian population trend towards being overweight and obese places over-consumption as the most important dietary issue involving decisions about consumption type and amount.\textsuperscript{4}

The widespread acceptance of alcohol consumption and the intrinsic nature of drinking in the Australian culture is well documented.\textsuperscript{19,20} Drinking was clearly influenced by peers and social norms, “that’s what they do” especially for young men. Excessive alcohol consumption is considered a major risk factor for morbidity and mortality in Australia and is estimated to contribute 2.2% of total burden of disease.\textsuperscript{4,21} For young people, concerns about increasing rates of high risk drinking and the associated harm is of particular concern when young people appear to have little understanding of the health problems associated with drinking alcohol.\textsuperscript{21}

Smoking was not common and many young people held anti-smoking attitudes, those that did smoke tended to be more marginalised and less involved in sport. Smoking is a major risk factor for vascular disease, cancer, and stroke, it is considered to be responsible for about 12% of Australia’s burden of disease.\textsuperscript{4} Given that one in six Australians smoked cigarettes daily in 2004, with higher rates for males in every group except for 14–19 year olds\textsuperscript{22}, understanding the influences on decision making is imperative.

The impact that social isolation had was less tangible, but equally if not more powerful. The limited social breadth and diversity led to a narrow band of social norms and structured social hierarchy, which influenced young people in different ways depending on sociocultural factors and narrow social norms. If they were a member of the football team they may well have been physically active but also exposed to and engaged in a high level of alcohol consumption because the strength of social norms “that’s what they do”. If you were unemployed the hierarchical nature of the social structure left you socially isolated, marginalised and more likely to smoke. If you were young and socially connected, a known health benefit, you were more likely to have high level of junk food intake through socially interacting with your friends outside the cafe. If a young person’s family was not considered ‘local’ then they may not have felt welcome to join the local netball team, consequently increasing social isolation and further reducing physical activity options. For some young women the decisions they made around drinking needed to take account of safety (including sexual safety), and trust, significant issues for a 15 year old trying to establish an identity.\textsuperscript{10} Such examples reveal the complex nature of sociocultural factors and how they are magnified by the intensity of isolation.

Many young people appreciated the tenuous nature of social connections. The notion of “one mistake and everybody knows” is hardly a nurturing environment for young people to grow and develop in. The nature of a small isolated community could be supportive and nurturing if the young person landed within the net of accepted social norms (which may not be conducive to healthy behaviour), but isolating and exclusive if the young person landed outside the net. Clearly the effects of physical and social isolation are significant in the lives of young people as they commence navigating their life path and making decisions likely to impact on their behaviour and health.

Despite these important findings, it is important to recognise the limitations of this study. These include the small sample size, the problem of ensuring participant anonymity in a small community, the difficulty in engaging some participants particularly parents, and in providing a suitable environment for interviews.
Conclusion

Case studies such as this one highlight the need to incorporate consideration of the complex array of influences that impact upon the decisions of young people to engage in healthy behaviour or not. While some influences may seem to be within their locus of control, many others are outside this ambit—a function of parent, family environment, peer group pressure, and community norms and expectations. For young people in small, isolated rural communities, such impacts can be exacerbated, as opportunities to engage in activities conducive to healthy behaviour are more restricted. Clearly more research is required to ensure that health promotion campaigns can target their populations in a way that takes account of barriers to healthy behaviour and facilitates their uptake in constrained circumstances so that young people are not made to feel that their decisions and subsequent healthy behaviour do not set them apart from their family, peers and community and possibly result in other socio-psychological problems. The interesting finding that social connectivity is linked to decision making needs to be repeated and considered in health promotion campaigns.

References


**Presenter**

_Fiona Lukaitis_ is an experienced nurse and midwife who is completing a masters of rural health. Her current study is looking at health behaviours of rural and isolated youth and the impact isolation has on the health decisions they make related to the four key areas of physical activity, diet, smoking and alcohol consumption. Fiona has a particular interest in research and population health and has been involved in both rural and metropolitan research and development related to midwifery, education, family health, wellbeing and diabetes prevention.