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The Graying of Rural America: Community Engagement and Health Promotion Challenges

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Background. *Although social participation has been linked to positive physical and mental health outcomes, elderly people in rural areas remain highly disengaged. Also, few studies have examined community residents' perceptions of the barriers and opportunities for the elderly to participate in community activities.* Purpose. *This article highlights the perceptions of rural community residents regarding their understanding of the following: (1) community leadership, (2) barriers and opportunities for the elderly to engage in leadership, and (3) potential community-based solutions for promoting more social participation.* Method. *Individual interviews were conducted with 16 community members. Content analysis was used to analyze the data. Researchers immersed and familiarized themselves with the data prior to developing codes. Coding was initially done manually and later using NVivo.* Findings. *Four major themes emerged: conceptions of community leadership, elderly resource inventory, barriers to elderly engagement, and potential solutions. Themes collectively illustrated that residents have a clear understanding of the role of community leadership, of available resources for the elderly, and of the barriers encountered when using these resources.* Conclusion. *Our findings highlight a need for health promotion strategies that are informed by community needs and foster healthy lifestyles for all community residents.*

Keywords: *elderly engagement; aging in place; community leadership; rural communities; healthy lifestyle*

Health Promotion Practice
March 2018 Vol. 19, No. (2) 267–276
DOI: 10.1177/1524839917714768
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BACKGROUND

While the world's increased longevity and improved health at older ages are among the most celebrated achievements of the health sector, there are associated substantial challenges, particularly in rural areas (Hartman & Weierbach, 2013). People aging in rural areas experience unique physical and social conditions, such as geographical isolation, and a paucity of physical activity–friendly infrastructure, such as sidewalks, street lights, and exercise facilities. Other challenges include lack of proximity to health care providers and requiring more help due to a chronic condition (Probst & Jones, 2016; Syed, Gerber, & Sharp, 2013). These factors are noted risks for chronic conditions such as heart disease, diabetes, and stress (Syed et al., 2013; Wilcox, Castro, King, Housemann, & Brownson, 2000), repeated falls, and lower participation rates in community activities. Additionally, older people are more vulnerable users of the road having high mortality rates when they are involved in motor vehicle accidents (Farber, Shinkle, Lynott, Fox-Grage, & Harrell, 2011).

Studies on social engagement have shown strong positive association between social engagement and physical and mental health outcomes (Barth, Schneider,

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& von Känel, 2010; Conroy, Golden, Jeffares, O'Neill, & McGee, 2010; Jung, Gruenewald, Seeman, & Sarkisian, 2010; Kåreholt, Lennartsson, Gatz, & Parker, 2011; Lee, Jang, Lee, Cho, & Park, 2008; Sirven & Debrand, 2008). Among rural seniors, physical inactivity was a risk factor for a number of chronic conditions, including heart disease, diabetes, and disability (Durazo et al., 2011). Research on volunteerism has also found positive association between voluntary work and well-being (Haski-Leventhal, 2009; Lum & Lightfoot, 2005) and the building of a vibrant civil society (Putnam, 1995). A lack of social interaction with others can affect health negatively. Studies on social isolation have shown that loneliness is associated with worsening mental and physical health, such as depression, increased chronic illness, and impaired mobility (Grenade & Boldy, 2008; Hawkley, Thisted, Masi, & Cacioppo, 2010).

Research and practice in community leadership and health promotion have increasingly employed the principles of community engagement. Community engagement is "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people" (Centers for Disease Control and Prevention, 1997). It is grounded in the principles of community organization: leadership, justice, empowerment, participation, and self-determination (Chávez, Minkler, Wallerstein, & Spencer, 2007; Wallerstein & Duran, 2006). This study draws on resident leadership and engagement as foundational to creating a shared community vision. Community leadership and engagement work is driven by the principles of collective impact—it increases the collective capacity of a community through pooling together the talents, resources, and skills of residents toward creating a shared community vision. Thus, community leadership and engagement can encourage health professionals, community leaders, and elected officials to work together in creating opportunities that address existing and emerging community challenges (Haas, Doll, Bonzo, Sleet, & Mercy, 2007).

Although research suggests that social participation can exert a powerful influence on health by shaping health behaviors, evidence from rural-specific contexts focusing on elderly populations is limited. More localized research is needed as particular rural settings differ in community engagement and health needs. Proactiveness in understanding and harnessing the aging population's skills and accommodating their expectations will be critical to solving a wide range of social problems at the community level (Mishkovsky, Dalbey, Bertaina, Read, & McGalliard, 2010).

This study explored experiences of residents of two rural U.S. Midwestern towns on community leadership and adult engagement. This research was part of a larger global study being conducted in three phases in rural South Africa and rural United States on community leadership and engagement: qualitative exploratory phase, quantitative phase, and intervention phase. This article reports part of the findings from the exploratory phase in rural America. The first phase focused on the perceptions of rural community residents regarding their understanding of the following: (1) community leadership; (2) barriers to and opportunities for community engagement for youth, adults, and women; and (3) potential community-based solutions for promoting more engagement. This article reports on community participation barriers and facilitators for rural elderly people and how that affects their health. We provide elements of program intervention and best practices that are specific and relevant to the rural, older adult population. Without such knowledge, successful, practical application may be limited.

METHOD

Context and Setting

This article reports on data collected from 16 community members as part of a larger exploratory study being conducted in rural Western Cape, South Africa, and a rural community in a Midwestern state in the United States. The study explored community leadership and adult engagement experiences of community members to develop context-sensitive recommendations for promoting community leadership and social participation for elders in a naturalistic setting (Grove, Burns, & Gray, 2014).

The study was conducted in two rural communities in a resource-limited county in a Midwestern state. The county has a total of 3,804 residents of which 20% are aged 65 years or older. Statewide, 15% of the population is 65 years and older. Eleven percentage of seniors in the county live in poverty, and 64% live with family (Office of Social and Economic Data Analysis, 2011). One community is the capital seat of the county with a total of 1,187 residents. The percentage of seniors in the county is expected to grow by two points to 22% in 2030 (Office of Social and Economic Data Analysis, 2011). Key community resources in the communities include the following: two elementary, middle and high schools (one in each town), a public library, a health department, court house, senior center, hog industry, a dollar general store, indoor swimming

TABLE 1
Participants' Sociodemographic Information

Characteristic	*Number* (N = *16)*	%
Age, years		
30-50	5	31.3
>50	11	68.7
Gender		
Male	8	50
Female	8	50
Marital status		
Married	15	93.8
Widowed	1	6.2
Ethnicity		
White	16	100
Education level		
Finished high school	5	31.3
Some college	3	18.7
Finished college	4	25
Graduate degree	4	25
Employment status		
Employed	16	100
Not employed	0	0
Length of stay in community, years		
<1	0	0
1-5	2	12.5
6-10	0	0
>10	14	87.5

and outdoor pool, park and walking trail, churches, and restaurants.

Participants and Recruitment

Research participants representative of the county's population demographic such as gender, education, and length of stay in the community were purposively recruited. The first author worked with the local extension office of his university to identify potential participants. The contact details of all potential participants were shared with the first author, and interview dates were organized between first author and participants who consented to participate. A total of 16 participants consented and were interviewed. Sociodemographic information of research participants is presented in Table 1. Inclusion criterion included the following: 18 years and older, 3 or more years of residence in the community, and availability and willingness to be interviewed.

Data Collection

Semistructured individual interviews were used to collect data. Interview questions were formulated in two stages. In the first stage, questions were compiled by the research team based on broader research objectives of understanding community members' perceptions on leadership and community engagement. In the second stage, these questions were refined from discussions with community members. Table 2 lists the questions used for interviews with participants. All interviews were conducted and recorded by one of the researchers at places mutually agreed upon with participants. The audio-taped interviews lasted between 25 and 45 minutes and were transcribed in full by an experienced transcriber.

Analysis

Content analysis was used to analyze the data. Two of the researchers first conducted a spot check comparison of five audio recordings to transcripts to ensure accuracy of the data. The researchers engaged in a process of immersion and familiarization of the transcripts to identify codes and themes (Hsieh & Shannon, 2005; Tufford & Newman, 2012). Researchers coded five transcripts together and exchanged notes, and they classified codes into themes (Tufford & Newman, 2012). Data were compared within categories to discover patterns and associations within the data set (Gale, Heath, Cameron, Rashid, & Redwood, 2013) and refine codes and themes. This process of analyzing data continued till further coding was no longer feasible (O'Reilly & Parker, 2013). Independent coding and peer debriefing enhanced the trustworthiness of the findings. The fourth author then applied the final codes and independently coded the rest of the interviews using NVivo 11 software.

RESULTS

Themes from the individual interviews that highlighted the community factors that played a role in elderly engagement in community leadership and health-promoting activities were grouped into four domains as follows: conceptions of community leadership, elderly resource inventory, barriers to elderly engagement, and potential solutions. Table 3 provides additional quotes.

TABLE 2
Community Members' Interview Schedule

1. Please tell me more about yourself: how long you have lived in this community, what you do for a living, etc.
2. Thinking of the health of community members, what are some of the community activities/events that happen here toward promoting the health of community members?
3. Could you explain how the following groups of people in the community are involved in these activities?
   - Youth
   - Adults
   - Women
   - Community leaders
   - Health professionals
   - Government—local/state/national
4. What are the barriers each of these groups face in promoting health in your community?
   - What are the facilitators?
5. When you think of community leadership, what comes to mind?
6. What has been the role of community leaders in improving the health of people in your community?
   - Whom do you consider to be your community leaders?
   - What leadership development resources do they have?
   - What leadership development resources are available for community members?
7. In your opinion, who are the key stakeholders in health promotion?
   - What has been their role in promoting community leadership development?
   - What are some of the challenges they have dealt with?
8. Do you feel you have enough opportunities to participate in health promotion in your community? Explain.
9. What would you want done to help you participate or strengthen your participation in health-related community activities?
10. Is there anything else you would want to say about the health and community leadership here in your community?

Domain 1: Perceptions of Community Leadership

Developing approaches that acknowledge the diversity of rural issues and the interconnectedness of potential solutions require an in-depth understanding of community leadership. Participants showed evidence of converging understanding of what constitutes community leadership across interviews. Common conceptualizations of leadership revolved around people, irrespective of age, gender, and socioeconomic status, who are willing and committed to take action to keep the community stronger. Based on the qualitative coding, most of the participants felt that community leaders are selfless and dependable people interested in the betterment of the community.

> I think of someone that cares about the community, cares about the betterment of the community, is a leader and takes charge in whatever organization to promote activities to build the community and make it better, you know. (MO34)

Community members demonstrated a clear understanding of community leadership as a person(s) who works with others to develop and sustain the health of the community. Participants felt that a healthy community is one in which residents have access to resources that meet basic needs, work together for the common good, and participate in shaping the future. Leaders have specific skills used in building healthy communities, such as being responsible, dependable, visionary, and strategic. These skills are foundational to the identification of community needs, resources, and interventions. An increased understanding of community leadership can prompt residents to be more aware of the needs and barriers faced by different population groups in the community, and recommend or advocate for appropriate action. These steps can influence the provision of resources and participation in activities that improve health and well-being of residents. Participants expressed knowledge of the resources available to seniors and the barriers faced in accessing and using them.

TABLE 3
Elderly Engagement (Additional Quotes)

Domain	*Theme (subtheme)*	*Selected quotes*
Domain 1	Perceptions of community leadership	When I think of community leadership it's really a, a group of people or a cooperative effort among several groups, all going towards a common goal, and I think that's to make the place we live better every day so hopefully when our kids are this age that it's a better place again and that they have a sense of community and betterment. (MO31)
		I guess for me I think of the different organizations or people who, whether it is a need or something that needs to be promoted, you can always count on, you know, being there to, you know, do their part. Maybe not necessarily having to run it but, but to be the behind the scenes help and, and you know, and the support for it. (MO26)
Domain 2	Elderly resource inventory	We have the Stacy Building here which is a multipurpose (recreational) center that has a swimming pool in it, and many people have memberships to that and they do water aerobics. Lots of elderly come in and do water aerobics or, you know, exercise in the pool cause it's much easier on their joints. They have the gym part of the Stacy Building too, that we're actually in the process of remodeling, putting a new gym floor in, and put new baskets (MO34).
		The library has recently started a, the library has recently started a program for senior citizens to come and they had a summer reading program for senior citizens, and I think that's been good, especially for mental health. It gets, gives them something to do, gets them out of the house, someplace to go (MO28)
Domain 3	Disengagement vulnerability (quality)	With the winters being bad it's not good for especially the older people to get out and walk because we don't have good sidewalks. We've worked on that, and we need to have better sidewalks in our area. That would help, but that's a big challenge (in this area). (MO25)
		There's a lot of people that go to the track now, but it's just a dirt track so if it rains like it has been that's not as accessible. But when they get the new track, hopefully in the next year or two we'll have that and that would be great. (MO22)
	Disengagement vulnerability (access—transportation)	I think some of the problems are it's a rural area. A lot of people are out in the country . . . and if they don't have a way to town then they can't participate in a lot of the things that are available. (MO29)
		I would say we are very rural here and we're pretty spread out, and for some people it might be transportation, especially an elderly person. I know there's a gentleman from Mercer that will drive some people down (to the swimming pool). (MO19)
	Disengagement vulnerability (affordability)	But the barriers would probably be like two years ago when fuel prices got to $4 a gallon, they are on such a fixed income that when it got to that level they couldn't do things. Whenever you get large inflation that affects them more than it does anybody else because they don't have the ability to go work more hours or, or pick up another job. (MO24)
		I know it does cost some (money) to get into the Stacy Building. I don't think it was a large amount of, you know, money but even for a kid or something, they might not have the money, you know, to go in. I know you can buy season passes but there again, you know, some families might not have that extra money to spend on that either, you know. (MO19)
	Disengagement vulnerability (lack of community oneness)	I don't think our community works real well together sometimes. Everybody does their own little thing and we don't work together as well as maybe we should because the University does a program on this and we do a program on this and the school does a program on this, and so much of the time if we'd just put all of our stuff together we could have one really big, good program, I think. And it just doesn't happen. (MO23)
		We're a rural community so it's just kind of like everybody works together for one. It's everybody wants their small town to be successful so if you actually get a group of leaders that are excited about something then it can get everybody else fired up and everybody jumps on the bandwagon and goes. (MO22)

(continued)

TABLE 3 (CONTINUED)

Domain	*Theme (subtheme)*	*Selected quotes*
Domain 4	Potential solutions	We do have the Recreation Board, which has enabled us to promote more community activities because money is always an issue. So anything that's community recreation tied they (people) can apply for monies from there. Anything improving the community they are promoting that as well. (MO22)
		I think it would be good if we could work like with the doctor's office to find out, what they feel are the number one issues. . . . I can look on like and find out what our number one health issues are but sometimes the local physicians' take on that is different. They may see something different coming through their office more regularly that we need to target, and I don't think we work real well probably that way, checking on that. Sometimes she does come to us and say "Let's do a little promotion on this," and then we do, but I think we probably ought to make a habit of doing that more often. (MO23)

Domain 2: Elderly Resource Inventory

According to Timonen, Kamiya, and Maty (2011), participation in different social activities can be categorized into four groups: formal organizational involvement outside of work, active and relatively social leisure, passive and relatively solitary leisure activities, and intimate social relations. Examples of formal organization involvement outside of work include attending religious services or meetings at voluntary associations. Active and relatively social leisure activities include eating outside the house, going to movies, and involvement in sport. Solitary leisure activities include playing games on computer or phone and watching television. Examples of intimate social relationships include time spent visiting with family members (Timonen et al., 2011).

Since this study focused on community engagement, the first two categories were used to guide the discussion on resource inventory. Community resources identified by participants included senior center, recreational facilities, public library, walking trails, and churches. Acknowledging the importance of adult socialization to health, one participant said, "I think people are healthier when they are out with other people and are interested in the community instead of staying home and being secluded" (MO25). Another said,

> We (Senior Center) can deliver those (meals) to the elderly or they can come in to the Senior Center and eat. And, we set up activities for them to come in and play pool. We have two nice pool tables and fruits and vegetables there for them, too. So when they come in to have their meal they can also pick up other things. (MO24)

Domain 3: Disengagement Vulnerability of Subject (Elderly)

Most of the participants who had a clear understanding of the role of leadership were able to articulate the challenges faced by elderly people who desire to age in place.

Quality: Bare-Bone Facilities. Most participants reported that the lack of safe places for physical activities like walking and shopping caused older people to be more sedentary. Participants cited lack of sidewalks and food deserts as primary constraints to physical activity and nutrition among older people.

> As far as walking like around town, and a lot of people do walk, but we don't have very good sidewalks so they end up having to walk on the road. . . . It would be neat to have a walking trail that was a concrete walking trail somewhere, that people could use. . . . I think, this kind of sounds bad but, grocery shopping, you know, our grocery stores don't always have the freshest produce so, for elderly, if they don't get out and travel a lot then you're kind of stuck buying their groceries here. (MO34)

For people aged 65 years and older, physical activity consisted of a variety of activities, including leisure time physical activities (dancing, swimming, gardening, shopping, and walking), household chores (cooking and cleaning), transportation (walking and cycling), and sports or planned exercise. Participants stated that older people in rural communities have many challenges due to either the poor quality of available resources or lack thereof.

Access: Transportation. Another factor cited as a primary constraint was lack of transportation. While rural older people may want to engage in social activities, the "rural-ness" of their environments, compounded by the lack of transportation infrastructure, presents a huge challenge.

> One of the biggest challenges that we help people with is they can't get anywhere to the doctor. There are no taxis, there's no bus, there's no public transportation. They're (*people*) always calling wanting to know if somebody will take them to Kansas City or Des Moines. . . . So it's a real challenge to get out of town to a doctor or a dentist. (MO34)

Participants spoke of the connection between health and transportation, acknowledging that transportation remains an important social determinant of health among the elderly in their community. The availability of reliable transportation affects the elderly's ability to access not only health care but also other health-promoting resources, such as senior centers, parks, community events (county agricultural fairs), farmers markets, and grocery stores. In rural areas, distances to resources often require more time and effort. One of the most important factors that limited routine activities such as walking, biking, and socialization by elderly people was lack of accessible transportation options.

Affordability: Access and Utilization Costs. Even when the elderly have necessary transportation to participate in social activities, participants felt that some were often overwhelmed by economic downturns, the prices they had to pay to use facilities, and by the limited hours of operation for some of the facilities, such as the Stacey Center and the open pool.

> The Stacy Building gets limited because it's on school grounds, so parking and things in the daytime become limited, or doing school activities, especially in the winter or the hours because, because of the parking issues. . . . For older people that like to swim and use the water aerobics it would be better for them to park on the front side but right now that's where school personnel park too. (MO22)

When living on a fixed income, it is important to budget carefully and minimize unnecessary expenses. According to participants, seniors who are under financial pressure find it difficult to pay for health-promoting services. They tend to prioritize paying bills, buying food, or necessities over paying for social participation. Also, seniors minimize exposure to places that are less user-friendly, for example, places lacking enough parking spaces.

Lack of Community Oneness. Participants had mixed feelings about the level of collaboration among the different activities that promote more social participation among elderly people. While community members clearly understood the issues faced by elderly individuals in their society, community leaders faced significant challenges building synergistic collaborations that promote healthy aging in place.

> You know as well as I do getting people to do things is like pulling teeth. It's hard to get everybody together to do something. . . .You've just got to take a conglomeration of the people that want to help, and finding them people that want to help is, is a big problem. (MO30)

Collaboration is rarely simple and straightforward. Building collaborative projects can take time and be fraught with challenges as participants go through the process of articulating a common agenda to work out a plan and a timetable for meeting their goals (London, 2012). Such ventures vary a great deal depending on the community issue being addressed, the nature of initiative, the number and diversity of people involved, the time frame, and the available resources.

Domain 4: Potential Solutions to Elderly Disengagement

Most participants expressed one key potential solution to the challenge of elderly disengagement: increased community collaboration.

> At one point the Health Department worked with the Stacy Center. When they did their health promotion you could get a discount because it costs to be a member at Stacey Center. And at one time if someone paid their money to be in the health program at the Health Department then they could have walking privileges at the Stacy Center, and that was really good to be able to have that, and I would like to see more of that. (MO25)

Collaboration is known to establish a give and take process among individuals or parties with different

perspectives on an issue that helps them constructively explore their differences and search for and design solutions that require collective action (Gray, 1989). Research participants in this study believed collaboration facilitates the pooling of resources together in ways that can benefit community members. Examples include developing a common agenda around an issue and obtaining funding for projects targeting specific needs.

DISCUSSION

Although interview questions did not specifically ask about barriers and facilitators pertaining to the elderly, interview responses emerged that focused on elderly engagement. This article highlights the perceptions of community leadership and elderly social engagement held by residents of two rural towns. Our communities have become complex and interconnected, implying a need to find better ways to share power and resources. When community residents appreciate their interdependence, residents can be empowered to create sustainable change that serves everyone in the community. Our findings illuminate the level of understanding of community leadership and elderly engagement among residents of two rural towns.

We support the proposition that today's community leaders must be capable of bringing diverse people together in ways that create collective impact, and heal old and emergent disagreements and estrangements (Kellogg Foundation, 2007). Community leaders must constantly and persistently thrive to unlearn ideas and activities that might have worked in the past but not in current and future settings. Individuals get attached to places and form relationships with neighbors, faith leaders, physicians, elected officials, and mailmen over their lifetimes. They become acquainted to their community life: church fellowships, the annual agricultural fair, ball games at the school, the fish-fry festival, and the best places for personalized greetings. These valuable individual and community associations take time to nurture and are not easy to grow in a new environment. These relationships serve a pivotal role in successful aging (Farber et al., 2011). Participants demonstrated a clear understanding of the role of community leadership by eloquently articulating the needs, resources, challenges, and potential solutions to improving elderly engagement in community life. This understanding is foundational for mobilizing collective action to improve local conditions and the quality of community life.

The great majority of older adults have a strong desire to live in their own homes and communities. Unsupportive community contexts, poor quality, and a lack of access to needed services, however, can thwart this desire. The lack of access to, affordable, quality health-promoting facilities in rural communities is widely acknowledged (Duncan, 2012; Reid, 2010). Since mobility decreases with age, the need for assistance from family and community members to access community resources such as recreational facilities increases (Broome, McKenna, Fleming, & Worrall, 2009). Research often focuses on transportation as a major barrier to health care access (Arcury, Preisser, Gesler, & Powers, 2005; Syed et al., 2013). Transportation also affects access to and utilization of other community resources that promote health. Elderly people are more likely to engage in health-promoting activities if they have access to more places for social participation, such as sidewalks, walking/jogging trails, senior centers, and churches. Social support from friends, family, and community members also increase healthy activities. Our insights from this study confirm the transportation challenges associated with low participation in social activities among the rural elderly population.

Although access to health care is important, there are many other factors that increase community disengagement. Health needs should be examined from the places where people live, learn, work, and play (Lavizzo-Mourey, 2012), especially for those desiring to age in place. Quality, access, and affordability are predictors of utilization. Our findings demonstrated that rural community residents are aware of the factors influencing elderly participation in health-promoting activities. The accessibility and affordability of health-promoting community resources are essential factors to ensure that the elderly can remain actively engaged in their communities.

The findings from this study emphasized that community residents possess potential solutions to address these issues. Participants suggested that community collaboration be increased to prevent elderly disengagement. Participants felt that by creating spaces where connections are made and collective knowledge is developed, collaborative teams can generate ideas and programs that can improve the health of residents. The principal challenges rural development practitioners face in these communities are the lack of leaders and the need for additional human capital (Avant & Copeland, 2013; Duncan, 2012). Rural communities need to create spaces where residents exchange ideas on the future of their community. Understanding one's perspective and that of others' on an important issue, and how the two diverge and converge (Mathews, 1999), is an important starting point in building communities that support their residents. Older residents

can be community experts who can inform the design and implementation of programs that apply to the evolving place. Thus, it is mutually beneficial when partnerships are created to promote research-based programs that benefit both the community and the elder (Hartman & Weierbach, 2013).

CONCLUSIONS

This exploratory study has two major implications for increasing the engagement of elderly people in social participation. First, for efficient and effective deployment of resources in rural settings, it is important that community residents understand the role of leadership and their part in the process of creating change in the community. Lack of leadership understanding retards progress in identifying community needs and addressing health and well-being issues. Second, there is need for rural communities to build community-based collaborations that bring a wide range of stakeholders—commissioners, city officials, health care providers, educators, business leaders, social service providers, community organizations, and clergy—together to prioritize and address community engagement barriers among the elderly population. To this end, findings from this study will be shared with these key community stakeholders to promote the building of community-based collaborations that can assess the quality, access, and affordability gaps in services for the elderly. This knowledge will assist in improving oversight, efficiency on existing programs, and creativity in new programs to reach a more diverse consumer base. We believe it will lead to better facilitation of action.

Though the study is limited to one rural community and may not be generalizable outside of the study community, it validates the assumption that communities have the wisdom they need within themselves to make needed changes and opens the door for future work to focus on developing community-based interventions for elderly engagement. Further research should emphasize more localized studies of the barriers and facilitators of elderly engagement in community life to design and implement interventions that are people and place sensitive.

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