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# Application of a gender-based approach to conducting a community health assessment for rural women in Southern Illinois

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ABSTRACT

Rural populations in the United States experience unique challenges in health and health care. The health of rural women, in particular, is influenced by their knowledge, work and family commitments, as well as environmental barriers in their communities. In rural southern Illinois, the seven southernmost counties form a region that experiences high rates of cancer and other chronic diseases. To identify, understand, and prioritize the health needs of women living in these seven counties, a comprehensive gender-based community health assessment was conducted with the goal of developing a plan to improve women's health in the region. A gender-analysis framework was adapted, and key stakeholder interviews and focus groups with community women were conducted and analyzed to identify factors affecting ill health. The gender-based analysis revealed that women play a critical role in the health of their families and their communities, and these roles can influence their personal health. The gender-based analysis also identified several gender-specific barriers and facilitators that affect women's health and their ability to engage in healthy behaviors. These results have important implications for the development of programs and policies to improve health among rural women.



## 1. Introduction

Rural populations in the United States experience unique challenges related to health and health care. Residents of rural areas suffer from high rates of cancers and chronic health conditions, including diabetes, overweight/obesity, and cardiovascular disease (CVD) (Bennett, Olatosi, & Probst, 2008; Gamm, Hutchison, Dabney, & Dorsey, 2003). A number of factors interfere with rural residents' abilities to prevent and manage these health conditions. These include difficulty accessing health care due to lack of insurance and shortages of health care providers (Casey, Thiede Call, & Klingner, 2001; Coughlin, Leadbetter, Richards, & Sabatino, 2008; Merwin, Snyder, & Katz, 2006), travel distance to providers (Buzza, Ono, Turvey, Wittrock, & Noble, 2011), and lifestyle behaviors that contribute to chronic disease conditions, including smoking (Vander Weg, Cunningham, Howren, & Cai, 2011), poor dietary habits (Boeckner, Pullen, Walker, Oberdorfer, & Hageman, 2007), and physical inactivity (Patterson, Moore, Probst, & Shinogle, 2004).

Rural women in particular face specific challenges in the prevention and management of disease. Researchers have shown that health behaviors among rural women are affected by their lack of knowledge about disease and disease risk (Flynn, Gavin, Worden, Ashikaga, & Gautam, 1997; Hamner & Wilder, 2008). In addition, women often cite work and family commitments as interfering with health care visits or engaging in health programs and behaviors (Eyler & Vest, 2002; Perry, Rosenfeld, & Kendall, 2008). Finally, rural women are often challenged by environmental barriers to healthy behaviors, such as lack of sidewalks and limited accessibility to fresh foods (Ainsworth, Wilcox, Thompson, Richter, & Henderson, 2003; Eyler & Vest, 2002; Liese, Weis, Pluto, Smith, & Lawson, 2007).

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Our research targets women in rural, southernmost Illinois. The "southern seven" counties form a region with a population of approximately 69,000 over 2000 square miles (US Census Bureau, 2010). Compared to Illinois women overall, women in the southern seven region experience higher rates of heart disease mortality, diabetes, high blood pressure, high cholesterol, and obesity (Illinois Department of Public Health, 2006, 2010). The Southern Seven Coalition for Women's Health (SSCWH), a group of community-based organizations and public health and health care agencies, was developed in 2007 to improve women's health in these southern seven rural counties.

To understand and determine how to best address health issues faced by women living in the southern seven region, SSCWH conducted a community health assessment (CHA). CHA is an important component of public health that involves collecting, analyzing, and using data to inform and engage communities and to develop health priorities and collaborative action plans to improve health (Friedman & Parrish, 2009). Disaggregation of CHA data by demographics, including sex, race, ethnicity, and age, is important to understanding health needs and identifying health disparities. However, this level of analysis is insufficient for understanding the full scope of factors that may affect women's health, including social, economic, and political factors as well as differences *among* women (Nowatzki & Grant, 2011). For this reason, SSCWH conducted a gender-based analysis (GBA) of the CHA.

According to the World Health Organization (2002): "Gender analysis identifies, analyzes and informs action to address inequalities that arise from the different roles of women and men, or the unequal power relationships between them, and the consequences of these inequalities on their lives, their health and well-being" (pp. 6). Reports of studies that incorporate gender analysis to understand or improve health are limited. A small number of studies, mostly conducted outside of the US, report gender-based approaches to examining risk factors for chronic diseases. For example, in one study, researchers found that young women in the US with an incarcerated parent were at an increased risk for obesity (Roettger & Boardman, 2012). In an examination of leisure time physical activity across Europe, greater gender-based equity in a country was directly correlated with women's participation in leisure time physical activity (Van Tuyckom, Van de Velde, & Bracke, 2012). In Canada, researchers reported that smoke-free policies often had unequal or unintended effects on disadvantaged women, such as greater exposure to secondhand smoke and limited ability to manage secondhand smoke exposure (Greaves & Hemsing, 2009). The findings of studies such as these can have important implications for public health programs and policies that strive to address gender-specific health disparities.

To identify, understand, and prioritize the health needs of women living in the seven southernmost counties of Illinois, we conducted a comprehensive gender-based CHA with the goal of developing a plan to improve the health of the women in this region. This paper describes this gender-based analysis in the rural seven southernmost counties of Illinois and the implications for program planning.

## 2. Methods

SSCWH researchers designed the CHA to broadly identify and examine women's health issues across the lifespan. Based on the health priorities previously identified by the local health department in the region, the CHA had a particular focus on cancer, cardiovascular disease (CVD), obesity, and diabetes among women. The researchers developed the CHA based on the Liverpool School of Tropical Medicine's Gender Analysis Framework (Liverpool School of Tropical Medicine, 1999). This framework provides guidelines for a situation-specific gender analysis for use in health planning, implementation, and research. The framework offers a guide for constructing patterns of ill-health, identifying factors affecting who gets ill, and identifying factors affecting responses to ill-health. The framework includes several social, cultural, and economic categories for understanding how gender affects health. We adapted the Liverpool Framework to ensure that we would examine the various community factors that were specific to the southern seven region and that were appropriate for the coalition to address. Our adapted framework sought to understand women's health by examining access to health care, community resources, organizational factors, families and relationships, environmental factors, health behaviors, high-risk behaviors, knowledge, attitudes, and gender norms.

We used the adapted framework to develop the CHA, which included both qualitative and quantitative data collection and analysis. The quantitative component included secondary analysis of data collected from the US Census, the Behavioral Risk Factor Surveillance System, and the Illinois Project for Local Assessment of Needs.

Qualitative data included key stakeholder interviews and focus groups with women throughout the region to identify factors affecting who gets ill and how individuals respond to ill health according to the gender-analysis framework. Qualitative methods also focused on identifying community assets and strengths, examining issues related to access and availability of health care, and determining potential strategies to improve the health of women in the region. We used the qualitative data to conduct the gender-based analysis, the focus of this paper. The Institutional Review Board of the University of Illinois at Chicago approved this research.

### 2.1. Key stakeholders interviews

The researchers defined key stakeholders as representatives of organizations, including health care providers, business owners, community organizations, and community leaders, that are affected by or can affect change in women's health in the region. We asked SSCWH coalition members to identify professionals who met this definition. Eighty-nine names of potential interviewees were collected. Because of limited resources, the list of 89 names was reduced to an initial subset of 51, selected to achieve a broad representation of perspectives based on geographic location and area of expertise. We contacted the 51 potential interviewees via US mail to explain the purpose of the interview. A follow-up phone call was made to each potential participant to schedule an interview.

Of the 51 individuals identified, 28 (26 women, 2 men) agreed to participate in an interview. The remaining 23 individuals either declined to participate or could not be reached by phone. Of the 28 interviewees, 12 (43%) were health professionals (health care providers, health educators) working at local hospitals, health clinics, rehabilitation centers, or the local health department. Ten interviewees (36%) were administrators or staff of governmental or nongovernmental organizations, educational institutions, or local businesses. Six interviewees (21%) were administrators of health agencies. One participant from this latter group was retired. After the 28 interviews were completed, we conducted a content analysis and based on the information gathered from the interviews, we determined we had reached saturation and we did not need to recruit any additional participants.

Trained staff from the Southern Seven Health Department and the Center for Research on Women and Gender staff conducted the interviews either in person or by telephone. Interviewers obtained informed consent from interviewees prior to each interview. All interviews were audio recorded except one, in which the recorder malfunctioned. Immediately following this interview, the