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Community involvement in health (CIH) as a conceptual base for gerontological health-care research[1]

Eugenie Hildebrandt *
The University of Illinois at Chicago

Abstract

Community involvement in health (CIH) is a conceptual base for effective primary health care that involves every level of a community. CIH empowers people by facilitating the sharing of information and control, and thereby giving individuals, families and groups that make up a community, the ability and encouragement to be active, effective participants in managing their health. Elderly people are an integral part of a community; it is functional to view their needs and capacities within the context of the larger group. This article is based on research that used the perspectives of self-care and CIH to assess and implement solutions to problems identified by elderly residents of a black township. CIH is a flexible process that can make major contributions to care delivery and the health of people by creating a partnership between the health-care professional and the community. The process develops over time as people increase their ability to manage factors that affect their health. This study indicates that considerable time, effort and resources are needed to help the people of a community to become effectively involved in the improvement of their health status.

Much of the gerontological research in South Africa has been done from a sociological or a medical perspective. By contrast, this study from a community nursing perspective takes advantage of the special contribution that nursing has to make to understanding ageing in a community context. The study was done in a black Transvaal township.

A community is more than a physical setting. It "... is a 'living' organism with interactive webs of ties among organizations, neighborhoods, families and friends" (Eng, Salmon & Mullan, 1992: 1). Although definitions of community vary, they do include the four essential elements of people, social interaction, area and common ties (Clemen-Stone, Gerber Eigsti & McGuire, 1991). These four elements form the concept of commmunity as used in this article. A community has been defined by the World Health Organization as a social group determined by geographic boundaries and/or common values and interests (WHO, 1974). The WHO concept of community involvement in health, or CIH, connotes the idea of people being involved with their health care; CIH is interpreted in this way in this article. Morbidity and mortality statistics alone do not represent the health of a community. Community health is a complex blending of socio-economic, cultural and environmental factors (Stoner, Magilvy & Schultz, 1992).

Primary health care, delivered within the context of a community, is the core of a country's health system, and an integral part of the overall social and economic development of the community (American Nurses' Association, 1986). Community health-care providers work with individuals, families and the resident population. In this context, the elderly are not viewed as an isolated needy group but as part of the fabric of the community. In effective community nursing practice there is a partnership between the nurse and the community; a goal is to empower members of the community to improve the health of the entire community.

Community involvement in health

The community involvement in health (CIH) concept as defined by the World Health Organization (WHO) is useful for developing strategies for health care (WHO Report 809, 1991). CIH starts with people in a community identifying the needs and strengths of the community. The people determine the priorities, and develop and support health programmes that incorporate community strengths to meet community needs. Participation can take many forms. It can be by way of contributions by people of the community; organization that assures that the community's interests are represented; or empowerment of the members by developing the skills needed to enable them to deal with their lives within their environment, and to plan and take action (WHO Report 809, 1991: 4). This approach promotes self-reliance and involves people as partners, rather than making them passive bystanders. It gives people a sense of control over their lives. The approach is seen by WHO as fundamental to the rapid achievement of improved health services. It represents a rethinking of conventional development strategies.

The WHO report suggests that health development strategies lose impact when

- they do not encourage people to think and act for themselves;
- they do not address sustainability;
- the people of the community contribute labour and resources but are not involved in the design or implementation of programmes, and do not develop a sense of commitment to the programmes; and

* *Address correspondence to*
Dr Eugenie Hildebrandt, The University of Illinois at Chicago, College of Nursing, 2525 24th Street, Suite 202, Rock Island, IL 61265, United States of America.

- the strategies are directed toward meeting only medical needs identified by health professionals rather than including health-related needs, such as water, housing and transportation, as determined by the people themselves (WHO Report 809, 1991:6).

Anderson and McFarlane (1988) refer to "community ownership" of a programme, and the need for health-care professionals to develop an attitude of "... *doing with* people, not doing things to them or for them" (1988:300). McElmurry, Swider, Bless *et al.* (1989) based their work on the thesis that "... if the health problems found in low-income, urban communities are to be addressed, the community residents must be empowered to assume appropriate self-care responsibilities and to help shape community responses to their health needs. Concurrently, health providers must learn to view human health and illness within the context of an interaction of social and health conditions. An approach to health services which addresses the importance of this social-health interaction and collaboration between health providers and community residents, is primary health care" (McElmurry *et al.*, 1989:3).

There are numerous barriers to community involvement and participation in health-care programmes within communities. One of these barriers is the use of dysfunctional approaches, such as viewing health in purely medical terms rather than as a state of physical, psychological and social wellbeing. A second group of barriers are factors present in the country and subsequently the community, such as a negative political climate, inadequate economic resources and their distribution, and limited administrative and managerial skills available to address the needs. A third set of barriers are the factors that influence the psychological responses to change, such as illiteracy, cultural practices and inappropriate patterns of leadership and authority (WHO Report 809, 1991:9).

The change-agent role has traditionally been adopted by professionals who are from outside the community; all too often the agenda that is used, is also the agenda of the "outsiders". In CIH, the community is an equal partner and people in the community have an equal opportunity to contribute appropriately. Not all partners participate in the same way or to the same extent. Knowledge and expertise are transferred from the professional outsider to the people of the community. The change then becomes stabilized, or institutionalized as the new norm. As a result, many people in the community are empowered to enter into the maintenance of health, rather than one person, a health-care professional, controlling the entire activity within the community; such empowerment frees the people from dependence on the professional's continued presence in the community.

The CIH concept is summarized as the empowerment of people through the sharing of information and status; clients are thereby given the ability and encouragement to be active, effective participants. This empowerment is a flexible process that creates a partnership between the health-care professional, or change agent, and the community.

CIH at the community level becomes self-care at the family level and the individual level. Both self-care and CIH require a partnership with health-care professionals. Neither abandons the responsibility for health to health-care professionals. The self-care nursing theory (Orem, 1985) parallels the CIH concept, and is well established and widely used to structure provider-patient partnerships, especially at the individual level.

Self-care

Lawton (1981:235) cautions service providers not to make assumptions that any particular group takes care of its aged. Care for elders was a strong value in African "traditional" culture, where respect for seniority was maintained by what this researcher interprets as a careful balance of power. From this perspective, as aged individuals lose physical power to control their environment, they gain the mystical power of access to the ancestors whom they believe are capable of causing great good or great harm. As a society's world view expands beyond tradition and mysticism, and as urbanization and limited resources erode the practice of caring for one's elders, the elderly stand to suffer greatly. This erosion of traditional status might be offset by elderly individuals' "earning power" as pensioners. A practical consequence of the high unemployment rate in the black urban population is that in many extended families, the elderly person who receives a monthly social pension is the only adult with a reliable income.

An interesting way to look at the concept of self-care is from the point of view of who is responsible. Brickman, Karuza, Cohn *et al.* (1985) contend that one's orientation to the world determines whether or not one holds people responsible for causing their problems and/or solving them. They describe four models that are used to define how care is approached. National policy responses as well as individual responses are grounded in these models:

- The moral model, where people are responsible for their problems and the solutions.
- The compensatory model, where people are not responsible for problems but are responsible for solutions.
- The medical model, where people are not responsible for problems or solutions.
- The enlightened model, where people are not responsible for solutions but are responsible for problems (1985:290-97).

Lawton (1981:235) writes of "...the South African conviction that the effort and determination of the individual should ultimately be the source of the solution of most problems." Tibbit (1983) also states that South Africa is not a welfare state and residents are expected to take responsibility for themselves. Weaknesses in the implementation of primary health care in rural South Africa have been pointed out (Health Services Development Unit, 1986; Health Services Unit, Department of Community Health, University of the Witwatersrand, 1986). Buch (1989) describes the primary health-care approach in South Africa as one that innovatively works toward community support, socio-economic improvements and accountability, but is required to essentially work outside the government sector and with inadequate resources.

Within the health professions, concern has been expressed that terminology, such as self-care, self-help, community involvement and primary health care, can be inappropriately used to shift the burden of providing services from the government onto communities. Zwi, Marks and Anderson (1988) state that this national stance has led to an inappropriate interpretation of community involvement and self-help. The result is that "The burden of actually providing services is shifted onto communities under the guise of 'community participation'. Thus in South Africa, primary healthcare becomes an opportunity for the South African State to provide second-rate care for what are effectively 'second-rate' citizens – the urban and rural poor" (Zwi *et al.*, 1988:665).

Anderson and Marks (1988) describe this possibility as part of making health care a political issue in South Africa. De Beer (1986) cautions against victim-blaming strategies that absolve governments of the responsibility to reverse the dispossession, exploitation and oppression of which poor health and poverty are symptoms. Mountford (1990) states that South African authorities began to accept some responsibility for public health and ill health in South Africa when it became evident "... that squalor and disease endanger the lives of rich and poor alike; and that productivity was directly related to the workers' health" (1990:42).

Sociopolitical philosophies and arguments aside, it is simplistic to attempt to solve health problems without giving attention to the influences of poverty and the social supports or infrastructures of communities. It is also short-sighted for individuals or a community not to give attention to self-care, because it is viewed as someone else's responsibility, or the responsibility of the government.

The South African Department of National Health and Population Development acknowledged the importance of CIH at a Forum on Community Participation in May 1991. The forum utilized work groups to look at priority needs, stumbling blocks, available resources, and the roles and realities involved in implementing CIH (South Africa (Republic), 1991). It developed a declaration of intent, defined the participation of people in communities, and resolved to seek state commitment to facilitate it.

Purpose

The purpose of the study reported in this article was:

- To gather baseline data on a township geriatric population, relating to the maintenance of the health status and well-being of the elderly residents.
- To develop a community participative process model for health education and community services that would facilitate self-care efforts in the township.
- To implement one or more programmes using the process model.

Study design

The study was conducted in two phases. In Phase 1 a survey was done to assess the needs and capacities of the elderly of a specific township community. In Phase 2 a broad spectrum of people from the township, in partnership with the researcher, identified programmes that could meet some of the needs prioritized by the elderly in that community. A process model was designed to structure the development of the programmes. The model provided practical guidelines for the transfer of information and expertise from the outside professional person to people and groups in the community.

Phase 1: Survey

Sample and procedure

A representative cluster sampling procedure was used to select a sample in a black township of 100 000 residents, from whom descriptive data could be gathered. The sample comprised 309 residents of an eastern Transvaal township, who were 60 years or older.

Residents of the township were recruited to carry out the survey. It was felt that

- elderly residents would be less suspicious and more likely to participate if asked to do so by someone whom they knew, or at least whom they knew belonged to their community;
- they would communicate more readily and freely with someone of their own ethnic background; and
- the use of indigenous workers would help to remove the barriers of distrust, race and language.

This approach can be costly from the perspective of a researcher's time and commitment. More training and supervision are required to support the use of indigenous fieldworkers than is usually the case when professional or experienced fieldworkers are used. Sustained commitment and the continued presence of the researcher in the township before and during the survey were required. Workers were closely supervised and supported, in an effort to address the skepticism about this approach. The researcher felt that the positive factors of the approach outweighed the negative factors; the quality of the data obtained was superior to that which would have been obtained if outsiders were used, especially fieldworkers from race groups other than that of the survey population. Political instability in any research setting makes the gathering of data difficult, whether it is done from within or from outside the setting.

A fieldwork training manual was prepared. Fieldworker training sessions were held over a two-day period. A further training session was held with each fieldworker after the first questionnaire had been completed. Thereafter, each time a fieldworker completed five questionnaires, the researcher reviewed the questionnaires with the fieldworker. Maps of individual clusters were given to the fieldworkers to orient them to their cluster areas. To do this, a large map of the township was duplicated and this copy was cut up into the cluster areas. The fieldworkers could see where their individual clusters fitted on the map of the township, and could then take the cut-out pieces with them as they canvassed their clusters. Random checks of the fieldworkers were made by repeating the interviews using a different interviewer, or by visiting homes to verify that the interviews had been done. The researcher reviewed the completed survey tools with the respective fieldworkers and paid them only when the survey tool was correctly completed. The training and supervision of the fieldworkers are detailed elsewhere (Hildebrandt, 1991). A profile of the community and a summary of the data follow.

Profile of the community

The township was established in 1964, following the relocation of the population of a township near a white city. Discontent over a lack of amenities, rent increases without subsequent improvement in facilities, and distrust and disillusionment with the township management grew until the 1980s. At this time, various community organizations such as the Civic Association and the Youth Congress were organized. Violent school, consumer, bus and rent boycotts occurred. The township was an anti-apartheid centre of activity during this time (Seekings, 1990; Mashabela, 1988).

It was estimated that by 1987, 10 % of the township was electrified and over 66 % had access to the sewage system. An estimated eight to 13 people occupied a household (Mashabela, 1988). Homes were built of cement blocks, bricks, or varieties of sheet metal, stone and mortar. Between 1989 and 1991 the township more than doubled in size, to approximately 100 000, as large numbers of people arrived from the rural areas, or from other urban areas where they were less welcome. The township management responded to the influx by purchasing surrounding land, having it plotted, and settling the "squatters". Area manufacturing companies, township retail shops and small businesses made up the economic base.

The unemployment rate was high. During the time that this research was done, an outside administrator was assigned to the township by the Transvaal Provincial Authority (TPA) because pressure by political groups had forced the local counsellors to resign.

The community had one nursing clinic. A mobile clinic was added and another permanent clinic was planned during the years that the research was conducted. The clinics were staffed by up to 14 qualified nurses. The emphasis of the clinics was on preventive and promotive maternal-child health. The clinics were poorly utilized by the elderly people in the community. Curative care and medication were available to the residents at a hospital 10 km from the township. Few services for the elderly were evident. A newly-formed Society for the Care of the Aged was not yet functioning effectively.

Working in a black community as a white researcher from outside the community required, and will continue to require, sensitivity to strained relationships and conflict among the political, social and cultural factions of the area. Because of the conflict between the Civic Association and the township government, the researcher repeatedly dealt with both sides, by discussing the intended survey, the subsequent survey results, and the potential projects that could be used to test the community development process model. Both groups were also kept informed of the progress of the projects. Each group was told of the researcher's interaction with the other group. The underlying assumption was that communication fosters trust.

The process model that was developed especially emphasized the involvement of lay people and interested individuals or groups, rather than involving only the officials of the community. A lack of success is reported in the literature when researchers target only the leadership levels where authority usually lies (Tumwine, 1989; Pan-American Health Organization, 1984). Too often the benefits of a programme are enjoyed only by the people in those leadership positions and their friends. In high-conflict settings, such as was the case in this community, it is important to seek a broad base of interest and involvement. A wide representation of people and needs increases the probability that programmes will be developed by, and benefit a broader spectrum of people in the community.

Profile of the elderly

The sample of elderly residents had a ratio of three females to each male, which is broadly consistent with local and international population data. Over half the respondents were widowed. Over half the respondents or their spouses were the head of the household in which they lived. Most eligible respondents received a social pension. Most respondents lived with at least one child or grandchild. Almost all the respondents had children; the mean number of children was 4,9. The number of children which the respondents had varied inversely with their years of education.

The respondents reported that they felt less respected and cared for by their children and the community as a whole, than were elders in the past. Over half the sample had no schooling; a slightly greater proportion was illiterate. The majority were Zulu-speaking; the next largest group spoke Sotho. The respondents had strong religious ties; many regarded their faith, church or ancestral affiliation as a strength that helped them to cope with day-to-day life. The respondents were largely ambulatory but a lack of transportation was a major problem for them.

There was a general disappointment among the sample in the way that their lives had turned out. Poor health, economic difficulties and family problems were the major reasons cited by the respondents for the difference between their expectations and the reality of their situations. Many expressed a desire to learn, and cited specific learning needs which included reading and writing, sewing and pattern making, the making of saleable items, and small business skills and job skills. They also indicated a need for a facility where they could socialize and participate in hand crafts and activities.

The nutritional status profile of the group indicated major deficiencies in the diets of the elderly residents. These deficiencies appeared to be related to personal food choices and a lack of information on nutrition, as well as to their economic situation.

There was general dissatisfaction with health-care services. Preventive health services were underutilized by the group. Cardio-respiratory and musculoskeletal symptoms predominated among the health problems that the sample reported experiencing within the past year. Depression appeared to be a problem for a number of respondents. Poor dentition and impaired visual acuity were prevalent among the sample. Self-care practices were apparently based on a mixture of traditional and Western beliefs and treatment models; the sample demonstrated limited understanding of health problems or knowledge of effective treatment for health conditions. The survey data are detailed elsewhere (Hildebrandt, 1993a).

Based on the data collected, the elderly people in this study were perceived as needing

- preventive and curative health-care services that were acceptable and accessible to them;
- knowledge of basic self-care management of their health problems;
- nutrition knowledge and an adequate diet;
- organized activities and a communal place where they could participate in them;
- economic resources to meet basic needs for food, clothing and shelter; and
- role and status development within the present culture-in-transition.

Some of the needs can only be met by national policy changes, an expanded economy to which all have equal right or access, or other macrolevel structures which are beyond consideration in this study. Other needs can be met by provincial or local authorities through a re-organization of current resources. The needs that could be appropriately addressed at the community level were considered for the second phase of the study.

Phase 2: Development of a process model for programme development

Sample and procedure

Since most of the elderly repsondents lived in multigenerational households, intergenerational approaches to meeting their needs were appropriate in contrast to isolating their needs and solutions from their support systems. Four sample programmes were directed toward the entire township population in this phase of the study.

As was the case in this study, the needs that the residents of a community choose to address may not be those that would be deemed to be most important by health-care professionals, or by a specific health-care discipline. It is important to the

success of CIH that priorities are not determined from the outside.

Model

During the second phase of the study, a process model was developed and refined, by using it to structure the start-up and maintenance of four community projects over the course of the research period. The model that was developed followed the process of assessment, planning, implementation and evaluation. This relationship is detailed elsewhere in the context of the projects (Hildebrandt, 1993b). The model was designed to function in settings where strong opposing elements, distrust and conflict should be taken into account. This design made the model functional, given the level of socio-political instability in the country at this time. The model design also took into account the socialization of many of the people in black communities, which is generally not strong in long-range commitment to community-level, independent, assertive self-care action for health. The model placed particular emphasis on

- developing trust through communication;
- determining restraining forces, or barriers in the community;
- determining enabling forces, or assets of the community; and
- careful and prolonged nurturing of the programmes that had been launched.

The survey analysis, and possibilities for programmes and approaches were shared with the groups and individuals who had been contacted prior to the survey by the researcher. These included school principals and teachers, nurses, both young and elderly interested individuals, leaders and members of elderly social groups, physicians, ministers, people in township government, civic association representatives, social workers, and business people in the community. An open meeting and follow-up meetings were held with groups and individuals who had shown an interest, or who had a vested interest in the programmes. Political authorities and their political opponents also attended the meetings, or were kept informed of the developments.

Individuals interested in specific projects made a commitment to work toward meeting the identified needs relevant to a programme. Goals and objectives were formulated. These were again shared with the groups and contacts within the township, to assure the researcher and the residents that their ideas had been faithfully incorporated. The plans were modified to incorporate the additional input. This planning approach was regarded as part of educating the people of the community, by giving information, creating an awareness of problems by articulating them, promoting an awareness and expectations for new programmes, and giving opportunities to become involved in them.

Four programmes were chosen for implementation in partnership with the people of the township. These programmes became the basic vehicles used by the researcher to introduce a structured approach for starting services that the people in the community felt were needed. The programmes are described below:

- **An intergenerational reading programme, or library story hour.** A group of elderly people in the community expressed a need for a recognized, respected role. The data also indicated that less than half the elderly women in the township were engaged in the traditional role of child minding. This reading programme, involving school children, was viewed as an extension of the child-minding role. It was designed to demonstrate new or expanded roles for the elderly through intergenerational helping behaviours; it was also designed to promote literacy among the young. Twice a week, two to four retired teachers and elderly residents read books, taught songs or told traditional stories around an umbrella table outdoors on the library lawn, where children walking home from school could stop by and participate in the activities. Initially, the READ foundation, an organization which promotes reading skills, was an outside resource for the programme.

- **A health education and screening programme.** This programme provided blood glucose testing for diabetes, hypertensive screening, and health education to the elderly township residents. The programme was an opportunity for the township clinic nurses to do independent programme planning and implementation. A screening clinic was held once a month at a hall on the days that the elderly congregated there to receive their monthly pensions. Nurses from the local white health authority assisted with the first clinics and taught the township nurses to do glucometer testing. Thereafter, the township nurses and two elderly volunteers made up the three-to-five-member screening team. The number of elderly residents screened at each of these morning clinics varied from 50 to 170. Personal record cards, a clinic record system, and follow-up of positive findings were initiated.

- **The food gardening programme.** This programme was a response to the inadequate diets of the residents, particularly those who had migrated to the city from rural areas and had foregone traditional eating habits. Previously in rural settings, many respondents had grown vegetables and planted fruit trees for family use. The low-cost, intensive gardening methods of the Food Gardens Foundation (FGF), an organization that teaches effective gardening techniques, were introduced through this project. An FGF staff person came to teach individuals and families how to supplement their diets by planting highly productive vegetable gardens. Local people were then trained to carry on with the programme. These people also initiated garden clubs and an annual garden competition, and took responsibility for stocking and selling garden seeds. The co-ordination that was required to obtain the equipment, supplies and a motivated target group to a site at a designated time was difficult. Considerable follow-up was also required to support the efforts of the gardeners until they could experience the reward of the produce from their gardens. Demonstrations were done at the health clinic and home gardens around the township.

- **A nutrition education programme.** The survey data indicated the nutritional deficits of the sample. The respondents were not necessarily aware of these deficits. It was noteworthy that the respondents did not appear to eat as economically as they could have. This programme gave homemakers needed information about nutritionally-sound, low-cost foods. It involved women of all ages so that the information brought home by a household member of one generation would not be dismissed by a member or members from an older or younger generation. Initially, the expertise came from state dietitians who agreed to come to the township to teach and demonstrate nutrition and food preparation. However this arrangement proved to be an inefficient way to reach the large numbers of people in the township. Government re-organization also changed the roles and responsibilities of these professionals. Sub-

sequently a local person was trained and paid as a community nutrition worker (CNW) to demonstrate food preparation and teach basic nutrition. The training of the CNW was done during a two-week course given by nutritionists at the Medical University of South Africa (MEDUNSA). Thereafter, the CNW came under the supervision of the township clinic nurse-in-charge. The CNW has continued to expand her knowledge base.

Discussion

The experience from this study suggests that appropriate criteria for projects that can develop CIH and self-care skills in communities are that

- they meet a need identified by people of the community;
- the people of the community are willing to take responsibility in developing and maintaining the programmes;
- they impact on the health of individuals in the community;
- they demonstrate self-care principles at the individual, family or community level; and
- they are initiated in a way that can be sustained over time.

A common reaction of leaders and professionals from the community was to place responsibility for inadequate supports and services onto apartheid discrimination, which over the years had beaten down their will to improve things for themselves. They felt that earlier discrimination on racial grounds was a reason why they had stopped trying; or they feared the consequences of trying too hard to change their situation. Such fears were not unfounded in past decades.

Passiveness toward human needs within the community, inexperience with and distrust of people outside their race group or township, and a sense of helplessness about successfully initiating solutions, were significant obstacles to creating a working partnership between people of the community and outside groups or professionals. These obstacles should be explored before initiating large-scale self-care and CIH programmes.

The elderly respondents frequently appeared resigned to whatever situation they had lived with during their lifetimes. This attitude was labelled as apathy by some of the townspeople who were more eager to work for change. A response common among the elderly as well as the broad community was to look to someone to do it for them. This led the researcher to view this as a response to the situation rather than a response of a specific age group. Looking to someone else for solutions had been partially functional in the past, when the business sector or the government had sometimes responded to expressed dissatisfaction by simply putting a solution into place.

A positive response from some groups and individuals was a stated desire and ability to solve problems. The elderly women who walked to the library twice a week to read for the library story hour were enthused about the contribution they could make; they were also determined to help the children of their community. The elderly women who volunteered to assist the nurses at the screening clinics worked hard to help the professionals who were willing to help the elderly residents of the community. The many people who became involved with organizing the garden and nutrition programmes had all seen the need for these programmes; some had unsuccessfully tried to meet that need in the past.

The eight-step process model that was developed and refined in the course of the operationalization of the four programmes helped people who were new to community development to focus on general principles. It also helped to interpret and implement programmes in the context of the local culture and resources. The model served as a guide for township nurses, employees in health-related programmes, and lay members of the community in their efforts to start new supports and services for their community. The schematic model has also been explained in a small illustrated booklet (Hildebrandt & Hildebrandt Watson, 1993).

In the past, the magnitude of the problems and the limited number of health activists often resulted in a situation where people with education or organizational experience could meet only a small percentage of the needs in the community, or they were spread so thinly that it impaired their effectiveness. A lack of knowledge about programme planning and implementation processes had also detracted from the effectiveness of their past efforts. The use of the process model expanded the core of people who could be effective in building the community. It also empowered the participants to move beyond hoping for change to actually creating that change.

The changes made over the two years of this study by a group of involved citizens will not necessarily make a permanent change in the amenities of this community. This research effort placed emphasis on teaching people the process of initiating programmes to meet identified needs. It demonstrated a structured approach that could enable them to act more effectively. If these four programmes end, the people of the township will be better equipped to restart them, or to initiate other programmes that they feel they need more.

Evaluation

CIH is a process that develops over time whereby people increase their control over factors that affect their health status. To accomplish this, emphasis should be placed on the process of involvement as opposed to the immediate and quantitative impact of the process on a particular health problem. Basic evaluation tools were designed with both process and outcome criteria.

The evaluation showed that growth in community involvement and in community self-care was evident in all programmes. The involvement of the health professional from outside the community decreased as the involvement and abilities of the community professionals and lay people increased. This inverse relationship indicates the transfer of expertise and responsibility from the outside professional to the people of the community.

Conclusion

Health projects that involve people in communities should be flexible and open to experiment. Communities are complex networks with patterns of leadership, traditions, values, assets and talents, as well as shortages and inadequacies. To address health, social and quality of life issues, and to impact on community-health problems, it is necessary to understand and respect the role of the broad culture, values and priorities of the community. Programmes are more likely to succeed if they build on an existing local base (WHO Report 809, 1991:12).

Empowering individuals to responsibly participate in their own health care and the health of the community is a key strategy in primary health care. This study shows that effective CIH requires a considerable initial investment in the community. Black communities in South Africa have not enjoyed autonomy, nor have they been responsible for planning in many other areas of their lives. Such an assertive mindset and the necessary skills have not been promoted in

the past and will require learning or relearning if communities are to be successful in mastering effective CIH. Trust should also be developed among the people in a township, and between outside professionals and the township population.

A limitation of the CIH concept is a lack of research data to support the conceptual framework. CIH should be more that a new label on the same activities. The process model, referred to in this article and discussed and analyzed elsewhere (Hildebrandt, 1993a,b), subjects the concept to scientific inquiry and adds to the body of knowledge about CIH, its validity and its overall credibility. Additional research-based process models are needed that can be used to operationalize CIH and to gather supportive data about functional strategies for structuring effective approaches that empower people. It is beyond the scope of this article to further analyze the programmes and the process model that were used to structure the start-up of the research on which this article is based.

Community autonomy and responsibility can be taught and learned. However it should be assumed that this process will take time, effort and resources. The CIH approach holds more promise for success, than have conventional or previous approaches to community health which have also taken considerable time, effort and resources. To achieve this success, health-care providers will have to meet the challenge to change how they practise and manage care. CIH will have to be integrated at the policy level and all subsequent levels of implementation.

Recommendations

It is recommended that future community health-care projects use a structured partnership approach, and evaluate the impact of the project on their community and the outcomes, to develop a database for CIH.

It is recommended that data be collected by fieldworkers who are members of the survey population group. They should be given thorough training and ongoing, direct support by the research team. This approach was shown to enhance the quality of the data collected in the study reported here. The benefits were shown to outweigh the traditional concerns that have been expressed in the past in South Africa about this method.

It is recommended that the process model developed by the author (Hildebrandt, 1993a,b) and briefly described here, be used for retroactive analysis of both successful and failed community-oriented health-care projects. Objective evidence and tools to gather such data are limited. Information derived from such an exercise could be used to address the question of why some projects succeed while others fail. The process model is a tool that could be used to sort out the approaches and dynamics involved in developing and sustaining programmes at the community level. The tool warrants further testing.

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Note

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Special issue on

Intergenerational relations

SAJG is planning a special issue on **intergenerational relations** for its October 1994 number (Volume 3, Number 2). Interested persons are invited to submit suitable manuscripts for consideration for placement in the number.

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