Chapter 2
A Community-Based Organization

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Introduction

Becoming community-based is not easy, although this idea has become quite de rigueur nowadays (Murphy, 2014). But most often, this maneuver is treated as logistical. Service agencies, for example, are placed in communities, while local persons are selected to sit on their governing boards. Although these steps are important, they deal mostly with technical matters. The aim of these and similar tactics is to bring services and any accompanying research closer to communities. Nonetheless, these changes overlook a significant factor in the process of becoming community-based.

There is no doubt that this shift in orientation requires that very pragmatic issues be addressed. Along with referral links, supervision, and treatment options, the location of a service center is important and should not be brushed aside. But with this focus on practical matters, the philosophy behind community-based work is regularly downplayed or missed. However, knowledge of this philosophy, and how to implement the related ideas, is crucial to successfully making this change.

The principle at the core of community-based interventions is participation (Fals Borda, 1988). The basic idea is that all persons create their respective realities in concert with others; no-one is an atom that acts alone. Broadly speaking, community-based philosophy is an off-shoot of constructionism (Gergen, 1999). Social facts and norms, accordingly, are not viewed to be objective but framed by communities in one way or another. The result is that communities consist of interpretive worlds that must be entered, if service or research is to have relevance (Gadamer, 1996). Local knowledge and control, therefore, are the cornerstones of community-based practice.

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In philosophical terms, community-based work is anti-Cartesian, or non-dualistic (Bordo, 1987). Traditional planning, on the other hand, is dualistic, with a differentiation made regularly between subjectivity and objectivity. But within this typology, emphasis is placed on objectivity, since subjectivity is considered to be an unreliable source of information. The desire to enact "evidence-based" medicine is an example of this trend (Howick, 2011). The use of rigorous methodology, for example, is presumed to promote appropriate service delivery through the discovery of data divorced from the errors introduced by interpretation. Given this bias, communities participate minimally in planning activities, since they are situated and biased.

The elevation of local knowledge in importance reflects this anti-dualistic stance. Consistent with the outlook that persons are constructing knowledge, including so-called medical facts, the resulting body of information should guide all clinical interventions and research. In this sense, local knowledge matters, along with local control of any community project. With persons actively shaping their communities, and thereby specifying preferences and promoting select perspectives, these changes are entirely logical.

What is important is that community-based projects or interventions begin with an epistemological shift. Accordingly, the status of knowledge should be reviewed, along with the identity of evidence. Discussions should be initiated about local knowledge and how this information should be used, and why local guidance is imperative. For the most part, however, service planning and delivery does not begin in this manner. In short, philosophy does not play a foundational role.

This new philosophy, nonetheless, has not been applied to an important area, that is, the development of organizations that are expected to deliver health care and other services in a community-based manner (Lune, 2010). Most important to remember at this juncture, considering anti-dualism, is that communities should no longer be treated merely as places. Health-care facilities, additionally, should not be viewed as anchors that hold these locations together. This imagery obscures the existential or constructionist character of these organizations and their surroundings.

Contradicting a standard portrayal, a community-based organization is not a linchpin in communities that disseminates health services. What is omitted from this depiction is the participation that creates both organizations and communities, and in the end joins them together. A perspective on organizations must be unveiled that is compatible with this thesis, or health facilities will not become community-based. To use a pertinent term proposed by Philip Selznick (1948) some time ago, a community-based organization must have a proper "character." Specifically, a move must be made away from the realism that sustains the traditional rendition of organizations and toward a position that values human agency.

Realism Is Problematic

In the traditional description, organizations are expected to bring about stability and order. To accomplish this aim, they are provided with a unique status in the context of realism. Predicated on dualism, organizations are assumed to be autonomous;

they are touted to represent closed systems (Scott, 2002). With this stature, they are divorced from daily contingencies and can impose control. The survival of social order, in fact, depends on the lasting impact of this institutional effect.

A façade must be provided, in other words, that creates the illusion of organizational invulnerability. To have gravitas, organizations must appear to be substantial and transcend the uncertainties of everyday life. Rules, for example, must have universal legitimacy and should not favor a particular group or seem to be applied willy-nilly. Order will falter unless a sense of universality is cultivated and unbiased authority is maintained.

So, how is this image created? Usually, organizations are described by using structural metaphors (Perrow, 1979). In this way, their functioning and lines of authority are reinforced. A quick glance at an organizational chart in most healthcare facilities reveals the logic and chain of command that is operative. Most often, this imagery is hierarchical, with precise paths of interaction specified between departments. With such a depiction, the message is conveyed clearly that such an organization has a purpose and operates according to reliable principles.

Following such a realistic portrayal, persons are expected to adjust to organizational requirements (Fromm, 1959). Certain parameters are illustrated that should not be violated. For example, an organization is accorded fixed boundaries, an exact division of labor, and purposeful norms. Accordingly, all those who enter should know their place, the tasks they are supposed to perform, and the network of authority. These expectations are thus clear, without ambiguity, so that an organization operates smoothly.

Obviously, discipline can be enforced with this strategy, but other problems begin to arise. The desired autonomy, for example, begins to separate organizations from their communities. Specifically, organizational identity is sustained by focusing on their unique traits and capacities. In the case of health care, these organizations are thought to have specific functions that preserve a community. What they are expected to accomplish should not be confounded by the intrusion of demands associated with other organizations. Blurred boundaries can only cause problems—the meaning of health care cannot be institutionalized effectively if contested. The equilibrium of a community would be disrupted by such a mistake.

This realism also has impact on the internal operation of an organization (Burrell & Morgan, 1979). Due to the rigid division of labor, jobs are narrowly designed, while the range of persons who can perform specific roles is restricted. The result is the gradual professionalization of care delivery, with an accompanying hierarchy of knowledge (Freidson, 1970). As might be expected, emphasis is placed on professional medical education and the associated knowledge base.

As long as organizations are conceptualized in these ways, they will never become community-based. Indeed, their identities are secured by remaining autonomous. Becoming thoroughly integrated into a community would only cause confusion brought about by conflicting interpretations and demands. When couched in realism, a reliable organization must rise above this cacophony. For example, even choosing the name of a hospital may be problematic, with respect to identifying who is welcome and the tasks performed (Wu, 2011). A fuzzy identity is not helpful.

A proper sense of autonomy must be promoted to guarantee that a clear label or brand is presented.

The division of labor that is usually prescribed, however, militates against any significant change. The professionalization of most tasks means that local knowledge tends to be sidelined, along with the participation of everyday persons in meaningful ways in health-care organizations. So-called laypersons are thus consigned to the periphery of service delivery and, most likely, merely asked periodically for input that has little impact.

The standard realism must be abandoned before health-care organizations can become close to a community. New imagery is necessary that is less imposing and exclusionary. Organizational integrity must be preserved, but while incorporating local knowledge and control. In other words, a mode of organization must be proposed that is reliable, in the absence of the typical institutional effect brought about by realism.

Realism Is Not Needed

The general aim in community-based work is to make an organization concrete—accessible and reliable—without reification. Important to remember is that a community is not a place but comprised of various interpretive worlds (Dussel, 2008). Consistent with the principle of participation, a community should not be viewed as an object. What this discovery means is that a community must be engaged but not merely through contact with an organization. But rather, a form of entanglement must be achieved that is not possible with objects.

New imagery is needed that defies the bounded and structural character of traditional organizations. The purpose, however, is not to deconstruct organizations and transform them into an array of periodically interlocked activities. Although Karl Weick's (1976) position on sense-making, and loose-coupling, at first glance looks to be compatible with a community-based philosophy, such a conclusion would be premature. Simply calling for flexibility is not enough. Instead, and truly significant, persons must be able to construct and preserve an organization through their agency. Through their participation, they must be able to create an organization that has longevity and embodies the goals of a community.

As should be noted, dualism is overcome in a community-based model. There are no insiders or outsiders, but only those who unite, as an organization, to promote health care. Any job design that results, for example, is an outgrowth of the interaction that takes place during this process. The resulting organization is not merely loosely coupled but real and demanding, but only because of the agreements of the participants. In this regard, some critics argue that such organizations are held together by trust (Luhmann, 2017). But the glue that is present is not this vague. What unites these organizations is the solidarity that is engendered through the day-to-day activities of solving problems and achieving goals. In this portrayal, an organization is self-created.

Rosabeth Moss Kanter (1983), for example, was once on the verge of proposing this perspective on organizations. In the so-called matrix organization, persons are allegedly capable of writing their own jobs, while authority is dispersed. With this proposal, she wanted to unleash the entrepreneurial spirit of persons. Viewing the members of organizations as entrepreneurs was common during the 1980s, when she advanced this imagery.

But life in the matrix was never this creative. Those who proposed self-managed organizations, on the other hand, certainly had this outlook in mind (Rothschild & Whitt, 1986). In effect, a community-based model borrows from this orientation, whereby average persons are given the latitude to invent and control organizations. From this perspective, their exclusion in the past was not due to a lack of desire or talent but prejudices based on political and other reasons.

There are no organizational *a prioris* in a community-based strategy. The focus is on skill development and the dissemination of information, so that an organization never becomes autonomous and issues demands. Adaptation should thus be eclipsed by invention and self-direction, as an organization is dissolved into a community. True community-based organizations are not simply flexible but a product of their member's desires and actions. Rather than obtrusive, such organizations disappear into a community.

In reality, community-based organizations represent not only a change in the image of an organization but the nature of social relationships. Much more is advanced, in other words, than technical changes. In some ways, these new organizations embody a cultural revolution, a novel and shared vision of valid personal behavior, acting together, and creating knowledge and order.

A Few Practical Concerns

Traditional organizations are semi-permeable, with limited access granted to communities. Community-based organizations, on the other hand, are much more than permeable, although local access is greatly increased. And while access is important, a self-managed organization does more and encourages the exercise of a community's agency (Rothschild & Whitt, 1986). But going beyond access, the point is to promote total transparency through local control.

A community-based organization invites more than input; in fact, the term "invite" conveys the wrong impression. In this new framework, an organization is not autonomous, and thus does not generate opportunities for their members. There is no distance between persons and organizations that can lead to conflict with and, possibly, the oppression of their constituents. Rather, this form of organization spreads out laterally like a field (Bourdieu, 1990). There is no separation created by autonomy that is necessary for alienation to occur.

What happens, instead, is that a community-based organization is built from the ground-up, possibly beginning with a local health committee. This base establishes the framework, for example, to identify needs, the required services, and the general

policies to be enacted. The delivery of services, simply put, is established from below. In many respects, the aim is to overcome the influence of the so-called "medical emperors" that have dominated service delivery and give more responsibility to those, in the past, who were merely the recipients of services (Cueto, 2004).

At this juncture, readers may begin to think of stakeholder participation (Stufflebeam, 2001). But community-based participants are different from stakeholders. Stakeholders, for example, are much more generic and, most likely, have little to do with the daily affairs of a community, or any organization that is established. Furthermore, their interests are often very personal, even idiosyncratic, and contravene the common good of a community. Community-based participants are neither strategic political appointments nor interested in receiving notice or praise. These persons work for the community and are attuned to the realities that are at play. In organizational parlance, they are mission driven.

Because of this involvement, a community-based organization is never finalized. The guidance provided by a community is ongoing and not restricted, as is often the case, to the beginning of a project or intermittent consultations with stakeholders. A constant flow of advice is underway, thereby preventing services from drifting away from a community.

Community-based organizations, accordingly, are a lot less professionally oriented than is usually the case. In short, these organizations are guided completely by local personnel. The awareness is promoted that local persons have valuable insights into their problems and the types of services that are appropriate. In other words, local knowledge is at the core of these organizations.

For some time, the attempt has been underway to employ in health agencies the members of the communities that are served (Lefkowitz, 2007). In this way, both patients and practitioners would share some history, thus making service delivery more palatable. But because the traditional conception of the organization was not seriously challenged, professionals often remained in control of interventions. Real effort had to be made to include laypersons (Ward Jr. & Geiger, 2017). But in most cases, a strategic plan was inaugurated to search for local professionals who had the requisite credentials, or to get local persons professionally trained. As a result, services may have been dispensed by local persons, but neighborhood control was seriously compromised.

At the outset of a project, however, professionals may be helpful. The point is not to disparage their skills, but to put them in the hands of local persons (Geiger, 2016). The plan, accordingly, should be to expand the knowledge base of a community, without overshowing local insights. And once locals are exposed to this new knowledge, they can decide how much of this information is relevant, the modifications that should be made, and how quickly implementation should proceed. A community-based strategy does not introduce information and cajole community members into accepting certain ideas and goals, but rather inaugurates a discussion that can advance in any number of directions.

Knowledge, in this sense, is not in the possession of any one group. A knowledge base is simply expanded, so that the most locally relevant decisions can be made. The problem is that such growth, often called capacity building, is undertaken regularly

in a paternalistic manner (Kretzman & McKnight, 1993). That is, processionals descend on a project with a plan that they tout to be progressive and necessary for a problem to be successfully solved. Therefore, adoption is thought to be logical and thus almost foreordained, and any reluctance exhibited by a community is treated as irrational.

Evidence is mounting, in fact, that local persons can carry out many procedures that were formally restricted to the bailiwick of professionals (Behforouz, Farmer, & Mukherjee, 2004; Rifkin, 2009). Many of these activities are quite complex and require training that locals can master. In many ways, local persons are demonstrating abilities, and gaining expertise, that were thought to be beyond their range. But before this knowledge expansion can have significance in communities, a change in orientation must take place. Learning must be the focus of interventions, rather than looking to the usual, professional sources of knowledge. Many biases must be overcome pertaining to who has important knowledge and is capable of entertaining new or complex ideas and mastering new skills.

The resulting organization is non-hierarchical or, in managerial terms, flat (Lune, 2010). But a flat organization is not necessarily community-based; indeed, in managerial circles, flat organizations have been around for time. Typically, the designation flat simply signals that few status distinctions are made, although control of an organization may still remain in a few hands. Local control, accordingly, is not given serious consideration.

Community-based organizations are considered to be flat because jobs are invented, rotated, and leadership is situational (Murphy, 2014). Skills are learned as persons change jobs and encounter new situations. Hence, a loose division of labor is present. As a result of this practice, the knowledge base of everyone is enhanced.

At this juncture, "task shifting" may come to mind (Campbell & Kerry, 2011). This term is used regularly when discussing the dispersion of knowledge in community-based projects. Similar to job rotation, tasks that were monopolized by medical personnel are shifted to others. But in a community-based organization, tasks are shifted to unskilled persons. An entirely new theory of work is adopted, whereby locals are treated as experts, intensely trained, and encouraged to direct an intervention (Greenhalgh, 2009).

For many persons, however, the origin of their jobs remains a mystery. When they enter an organization, a structure already exists and their job assignments are prescribed. A weighty imagery and practice are present that stifles agency. Contrary to this condition, in a self-managed organization jobs are defined by the collectively negotiated goals and put into practice through the interaction that takes place. For this reason, these organizations are described as invented.

Additionally, in community-based organizations, different persons are expected to step in when leadership is needed. Rather than assume that leaders are born, or emerge from one social class of persons, the point is emphasized that leadership rests on expertise and interest. Therefore, one person may lead in a particular situation and another during a different task. In the end, however, skills are disseminated and support offered to the extent that leadership is no longer monopolized.

But especially noteworthy is that local persons write their jobs. In other words, they establish the division of labor. As mentioned earlier, Kanter (1983) broached this idea. This ability, however, is what makes an organization self-managed, a twist that Kanter never took seriously. In a self-managed scenario, a narrative is proposed that specifies the tasks, logic of production or performance, and the mode of evaluation, not to mention the style of authority. This entire process of organizing, therefore, is a collective invention.

As should be noted, the operation of a community-based organization is thoroughly dispersed. But tasks are not merely assigned to persons who were earlier on the periphery. When this is the case, dissemination likely has little to do with local invention and control. Authority may remain hierarchical and impose tasks. True dispersion, in line with a community-based philosophy, indicates that an organization reflects local agency. Governance is thus embedded in local interaction and represents the will of the community that constitutes an organization. As is required of community-based organizations, dualism is overcome and organizational autonomy is averted.

A Move Away from Philosophy

Organizations must change when they strive to become community-based. Particularly important is that they become completely transparent, with information flow unimpaired throughout the process of service delivery. Accordingly, as should be noted in the previous section, an organization and a community become thoroughly integrated when they are community-based.

At this juncture, a few concrete examples are introduced to illustrate this process. Questions are asked that attempt to illustrate how transparency and integration are achieved in community-based health organizations, such as hospitals or community clinics.

1. Is an organization hierarchical or flat? The goal of community-based organizations, of course, is to be as flat as possible. Can policy decisions and accompanying changes be led at any level of the organization? In this way, community sentiment can easily reach leaders, who are not ensconced in the world of administration. The organization, in other words, is not abstract and intimidating.
2. Are departments linked together, other than, perhaps, on the organizational chart? A real linkage should be in place that requires these groups to work together and share information. Rensis Likert (1967) called this a "linking-pin model." Do persons in specific departments collaborate with others, as a regular practice of conducting business? Do they coordinate their needs and efforts? In community-based organizations, departments should be interacting, for example, as they track clients when they receive services and move through an organization. In this way, a client's record is holistic, while the members of an organization gain a broad picture of service delivery.

3. Do local persons sit on departmental committees? Community members, for example, are often invited to be on hospital boards. But participating regularly in how these committees function represents something completely different. In their case, local knowledge is integrated into the everyday operation of an organization, rather than intermittently when a crisis may arise.
4. Is there active involvement with communities? Usually, most community contact is passive—locals may be consulted, for example, when a needs assessment is expected to be conducted. Community outreach is, likewise, passive, with attempts made to locate or contact persons. But the question remains: Do community members work regularly, for example, with clinicians or evaluators? Are they a normal part of these teams?
5. Is training available to local persons? The point is that local skill development is important, along with community participation. For example, learning how to navigate the administration of a hospital, become familiar with clinical nomenclature, and how to introduce significant input and make changes are important skills. Training should thus be extended to all those who are expected to shape an organization.
6. Are clinical practices—hospitals as well as neighborhood clinics—close to communities? Often these providers are spatially in or near to communities, but have the pathways been cleared to treatment? Is local knowledge used to define problems and accessibility, so that stigma is not attached to seeking care, for example, for mental health issues? Making sure that services are in a community must extend beyond logistical considerations. How a health organization interacts with a community should be a local determination.

Conclusion

The bottom line is that the delivery of health services is a group effort. But the nature of this group, or organization, is a key concern in the design of community-based interventions. By traditional standards, community-based organizations implode and dissolve into their respective communities. According to traditionalists, such organizations are insubstantial. But while these organizations may be unobtrusive, they are not flimsy.

An organizing principle certainly exists that is neither natural nor autonomous. A community-based organization is self-generating and represents collectively designed narratives about how health issues should be addressed. A community specifies what problems are important and how remedies should be applied. In fact, how these plans are executed constitutes a health-care organization. In terms of a community-based philosophy, this dispersed locus of organizing is vital.

In community-based work, a particular population becomes the organization. No facet of this process is treated as autonomous; nothing about service delivery is imposed. As a community becomes self-directed, and begins to focus on health

care, an organization emerges that is dedicated to identifying and finding solutions to problems. In this regard, service delivery is thoroughly local.

At the root of this change is philosophy. Specifically important is that organizations must be imagined to exist without support from dualism. Within this new framework, at least initially, institutions may appear to be weak, even flighty. But without dualism, problems can be identified, plans made, and remedial strategies implemented in the absence of the usual formalized guidelines.

For this reason, community-based organizations are substantial but difficult to pin down. The community that invents these organizations knows the rules, has access, and recognizes transgressions, because local knowledge is operative. Outsiders, nonetheless, may declare in frustration that no organization exists, only a hodgepodge of persons and practices. Those who want to become community-based, however, should not fall prey to the stale imagery supplied by realism and settle for rigorous, clearly delineated but irrelevant health-care organizations, out of fear of not having a true organizational presence.

Community-based organizations hold a lot of promise. Health services can be provided in an effective way, thereby improving care. And somewhat related, communities can acquire skills and gain a sense of self-efficacy, so they can become agents of social change (Bandura, 1995). But these changes are not likely to occur unless service organizations are rethought. A new theory of organizing is needed, one that enhances local agency, knowledge, and, in the end, control. In this sense, philosophy is at the core of changing direction and becoming community-based.

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