

Chapter 9

Community-Based Political Interventions



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Introduction

Community control is key for interventions to address local health concerns (World Health Organization, 1986). For this authority to be established, community participation is necessary. Underlying this element is an appreciation of a community's ability to contribute knowledge and skills to the planning and implementation of health initiatives (Israel, Checkoway, Schulz, & Zimmerman, 1994). Community-based projects thus take into consideration the capacities of individuals to communicate their intimate understandings of their well-being, grasp medical information, learn preventative measures, and implement primary care techniques (e.g., Rahman et al., 2019; Smallwood et al., 2015).

There are many examples of community-based training and capacity building efforts in community-based health initiatives. Typically, they aim to increase popular knowledge of medical issues, improve health-care delivery, and strengthen the research skills of individuals, organizations, and communities (Cueva, Cueva, Revels, & Dignan, 2018; Ruiz et al., 2012; Saad-Harfouche et al., 2011). What is often lacking in these endeavors is a focus on their institutional contexts and how they may prevent self-determination and local control.

This chapter addresses this gap by applying a community-based framework to examine structures that shape community health projects and their links with local participation. Special attention is given to the political dimension of traditional and community-based health organizations. The purpose is to illustrate how institutional facets may either undermine or support communities in taking charge of their health.

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This analysis is important for identifying and demystifying oppressive structures in community health initiatives, as well as crucial for recognizing how institutions may be designed to reinforce a community's authority over its health.

At the outset of this chapter, the theoretical framework that guides the present analysis is described. Next, institutional barriers to community participation are explained, followed by a discussion of structures that support a community's control over its well-being. The last section concludes by stressing the importance of community-based theory for creating conditions that encourage communities to direct their own health progress.

Analytical Framework

A community-based lens reveals transformative possibilities for organizations and projects to become aligned with the aspirations of communities. In health contexts, using a community-based framework can bring into view aspects that obstruct a community's ability to make decisions about its well-being. Furthermore, applying this perspective can expose prospects for local participation, which is at the heart of community-based health initiatives (World Health Organization, 1986).

Central to community-based philosophy (Murphy, 2014) is its rejection of realism and dualism (Delanty, 1997). What is particularly problematic with realism is its assumption that there is a domain independent from individuals where principles and values reside, and these elements regulate human behavior and promote social order (Durkheim, 1974). Along these lines, the realities of a community are considered in structural terms (Parsons, 1951) and understood to be separate from its members (Delanty, 1997).

In this view, structures are believed to be objective and, given their universal and absolute basis for action, have a powerful influence over individuals (Durkheim, 1974). Realism may be at play in medical situations when, for example, nurses follow their rounding schedules and protocols for providing care, even when they see that they have a negative effect on the patient experience. These job-related conditions may appear to be solidified and not within the nurses' power to change (Berger & Luckmann, 1966), and so they continue their service as if they were unable to make adjustments in their schedules and tasks.

With regard to dualism, community-based philosophy takes issue with the assumption that value-free information exists in a realm outside persons (Murphy, 2014). The notion that the mind is separate from the body informs the belief that personal perspectives are invalid, due to their subjective nature (Bordo, 1987). Accordingly, objectivity is promoted as the gold standard. Dualism therefore grounds the positivist approach that suggests that only individuals with scientific training have the ability to grasp unbiased knowledge. The reason is that science entails following systematic procedures that remove prejudices and partialities (Delanty, 1997).

When health-care organizations operate according to dualism, efforts to humanize interventions are undermined from the start. Take empathy training in medical schools, for example. Teaching medical students to show empathy toward their patients is challenged by the dualistic biomedical model that physicians are expected to follow. This issue causes tension when diagnosing a medical condition and developing an understanding of a patient's life experience with illness (Pedersen, 2010).

Adherence to dualism results in two general issues that prevent institutions from truly supporting communities in the realization of their health goals. The first is the weakening of the belief in community agency through affirmations of the realist illusion that the social world is detached from individuals (Bourdieu, 1990). For example, organizational problems are seen as natural and, therefore, beyond human control. Communities may thus consider themselves to be incapable of creating change. The second issue is the marginalization of local knowledge through assertions that cling to ways of knowing that disregard individual and interpersonal understandings grounded in daily life experiences (Fals Borda, 1988).

Unlike dualism, a community-based view emphasizes social constructionism and participation (Murphy, 2014). The core idea is that communities co-create their social worlds and critical consciousness of their worlds through dialogue (Freire, 1970). Therefore, community members are not subjected simply to impinging social forces, such as norms, that shape their experiences. Nor are they ever severed from what is known. Rather, they construct their realities and knowledge and linguistically give meaning to them in an interpersonal and cooperative manner (Merleau-Ponty, 1968; Wittgenstein, 1958).

A participatory vision of health care positions the community at the center of interventions (World Health Organization, 1986). All guiding ideas, forms of organizing, and decisions emanate from the group and stem from the negotiated interpretations of its members (Minkler & Wallerstein, 2012). Despite the technical knowledge that medical experts may be able to offer, these persons do not dominate the scene. While their insights may be eventually deemed to be important by the community for an initiative, the indigenous knowledge (Fals Borda, 1988) co-generated by community members through intersubjective communication (Gadamer, 1975) is what establishes communal plans and actions.

Power in community-based projects is thus shared between all community members (Minkler & Wallerstein, 2012), including medical professionals committed to the group's health. Because all individuals are inextricably linked to knowledge, identifying and making sense of symptoms, as well as interpreting lived experiences of illnesses, are accomplished through face-to-face dialogue (Buber, 1970). In this way, community members are empowered and viewed as having the capacity to contribute significantly to processes intended to improve their health outcomes in forms other than merely checking boxes in a health history form or following a doctor's order. In a community-based sense, such actions are always up for discussion between all groups potentially affected by the decisions being made.

The next section applies this analytical framework to assess institutional facets of traditional organizations and projects. Determinations are made with respect to how they may inhibit community participation. Particular attention is given to elements that are typically taken-for-granted, but are, nevertheless, critical for recognizing necessary structural changes, if a project is to become community-based.

Institutional Barriers to Community Participation

Norms that Constrain Community Participation

Institutions are imbued with social norms that consist of expectations that guide the actions of group members. In the Western philosophical tradition that supports traditional health organizations, norms fall under the category of “social facts” (Durkheim, 1982/2013, p. 29). Durkheim (1982/2013) explains that social facts should be regarded as “things” (p. 29) that are disconnected from individuals. Accordingly, norms are believed to hold an objective status with an imposing influence that motivates people to behave in uniform ways and, thus, stabilizes an organization by producing social order.

When formally institutionalized in medical settings, norms become written rules and policies for practitioner conduct (Borkowski, 2015). Most health-care organizations, for example, have established procedures that range from proper practices for attending to patients to processes for executing successfully a community health needs assessment. When these official norms are broken, the result is often reprimand, if not punishment.

Informal norms, on the other hand, are the implicitly, shared understood standards for behaving and interacting (Durkheim, 1982/2013). For instance, Barnato, Tate, Rodriguez, Zickmund, and Arnold (2012) observed critical care physicians accept passively the instructions of specialists. They considered this submissiveness to be attributed to the general understanding of informal norms that allude to appropriate ways to respond to individuals with greater decision-making power.

From a community-based perspective, norms in and of themselves are not problematic. After all, they are significant cultural elements that can facilitate interactions and the co-generation of popular knowledge (Geertz, 1973). In endeavors intended to be community-based, however, norms that constrain community participation are the concern. Such norms likely originate from the dualistic view that assumes a division between communities and their knowledge bases and, therefore, do not give credence to the principles and ethics that are determined by community members. This issue typically plays out in a health context where there is a preoccupation with information that is value-neutral and when outlooks on treatments and healing are expected to be unbiased and free from emotion.

These objective data and views are believed typically to be acquired through the use of the scientific method that involves the implementation of standardized proce-

dures and rules (Delanty, 1997). The emphasis is on applying the language of science to verify truths and confirm logical beliefs about empirical data (Sankey, 2000). In the ordinary medical environment, solely physicians and other health experts are thought to be capable of obtaining factual and, therefore, useful information because of their high-level technical education and scientific literacy. Consequently, the participation of regular community members would be judged to be a distraction to making and evaluating observations, based on the notion that these rules-based approaches for rationalization require specialized knowledge and sound methodological techniques of which average citizens are not aware.

In conventional health-care organizations, actions guided by norms that elevate professional perspectives over local insight restrict community contributions and participation on a regular basis in simple, yet important, ways. For example, patients are often made to feel more like a number than an individual. Their stories about their experiences of sickness are seldom given adequate time and attention by physicians, because of scheduling policies and the subjective nature of patient experiences (Rhodes, McFarland, Finch, & Johnson, 2001).

In sum, there is a need to recognize the issue with the traditional understanding of norms. When they are considered to be an external force, beyond the power of individuals, and seemingly natural (Durkheim, 1982/2013), there leaves little hope for realigning health organizations with a humanistic orientation. Planners informed by a community-based viewpoint do not buy into the function of norms as controlling a community. Rather, they presume that interpretation mediates understandings of norms (Barthes, 1987) and appreciate the ability of individuals to engage one another in the creation and maintenance of local arrangements (Berger & Luckmann, 1966) that encourage behaviors consistent with a community's ideals.

Schemes that Sideline Community Members

Traditional health-care organizations typically strive to be effective by operating in accordance with Fayol's (1949) management principles. They include the establishment of order and a hierarchy of positions. Individuals are expected to employ their technical skills and carry out specialized tasks, while following administrative rules and codes of conduct. These bureaucratic elements support a top-down chain of command. Power is thus centralized at the top ranks (Weber, 1978).

This imagery is consistent with the realist framework that presumes reality is controlled by an elevated base where social norms and power exist (Durkheim, 1982/2013). Organizations constructed according to this assumption are likely led by persons with high qualifications, extensive training, and substantial proficiency, who are believed to be capable of offering unbiased and fair assessments geared toward increasing productivity. Accordingly, the expectation of low-status organizational members is that they obey directives and complete their duties without thinking critically about them.

At this point, the concept of roles is in need of consideration. Realists view roles as being interdependent parts of a social system. The functioning of the system is reliant on the execution of the responsibilities assigned to each role. When roles are not fulfilled, the connections between them weaken and, as a result, the system becomes unbalanced and may even fail. The purpose of social norms is then to guide role behaviors with the aim of ensuring order, and the system is set up in a way to discourage anyone from doing more or less than what their role requires (Parsons, 1951).

To illustrate, the organization of health departments is depicted commonly in the shape of a pyramid. The commissioner is often at the peak. This supervisory role is supported by a board committee that is full of medical professionals who advise on policy matters, provide guidance on programs and services, and handle the budget. Below this group is the administrative staff with managerial responsibilities, followed by the providers, who implement the services. What is evident in this case is not only the hierarchy but also the interdependence of roles. For example, the service providers count on the board to oversee responsibly the department's finances, otherwise there would be a reduction of services. At the same time, their position restricts them from implementing consequences if the higher-ups mismanage the organization. In the event that any role goes unfilled, there is bound to be instability, at least temporarily, because there is a low likelihood of anyone stepping seamlessly into another role.

These schemes are not consistent with a community-based orientation, because they impede community members from holding meaningful organizational positions and taking on leadership roles. Moreover, they exclude local persons from taking part in decision-making processes that concern their lives. A case in point is when a panel of researchers meet to discuss a virus that is spreading through a region and consider options to combat the epidemic without any community members present. In this example, the opinions of various professionals are taken into account and the pros and cons of different approaches to fight the outbreak are debated without the perspectives of the community.

The essence of community-based endeavors is community members and, without their direction, projects run the risk of being insensitive to a group's needs (Minkler & Wallerstein, 2012). Writing on his community-based efforts in Colombia, Fals Borda (1979) noted that "when the actual level of consciousness of the situation encountered (that of the members of the basic communities) was taken into account as a starting point for action..., political errors caused by excessive activism or ignorance were avoided" (p. 50). His work exemplifies how community-based projects are rooted in communal ideas and understandings, rather than in colonizing and imperialist assertions that dehumanize community members and relegate them to the periphery of their own realities.

Even seemingly minor symbols in traditional health-care intuitions should be reconsidered such as the sliding window in waiting rooms and online patient portals used for disseminating test results. These features may be interpreted as barriers between individuals and their care. Technology, in fact, is often assumed to be a tool to enhance neutrality, which is part of the positivist tradition (Delanty, 1997) and may impede local participation.

Routines that Restrain Community Action

Greenwood, Oliver, Sahlin, and Suddaby (2008) define a routine as a “more-or-less taken-for-granted repetitive social behavior that is underpinned by normative systems and cognitive understandings that give meaning to social exchange and thus enable self-reproducing social order” (pp. 4–5). In organizations, these context-specific behavioral patterns facilitate the coordination of individuals and transfer of information with minimal mental effort (Becker, 2004). Furthermore, institutionalized recurrent actions are believed to create organizational stability (Howard-Grenville, Rerup, Langley, & Tsoukas, 2016).

Essentially, this common view of routines relies on realism. Bourdieu (1990) explains that what allows behaviors to become repetitive over time and, eventually, institutions, is the dependence on seemingly autonomous structures for guidance. Individuals therefore perform routines as if they were merely mindless, passive actors. Because human agency is distinct from structure, the maintenance of the status quo is almost guaranteed.

Routines are commonplace in health-care settings (O’leary & Mhaolrúnaigh, 2012). To a large extent, patients can predict accurately how their appointments in a health clinic will come to pass. From check in to check out, routines are enacted continuously. Any deviation from expected patterns of behaviors is likely to be viewed as problematic, suspicious, or awkward. For example, a patient would probably feel uneasy if prescribed medicine before being examined thoroughly.

From a community-based standpoint, routines in health-care projects are not inherently troubling. Rather, they become concerning when they are reinforced by dualism and, thus, believed to be unalterable. Additionally, this understanding overlooks the abilities of individuals to innovate and create new practices (Howard-Grenville et al., 2016). In health-care institutions, dehumanizing routines are bound to undermine the self-determination of persons. This issue becomes evident when health professionals are so worried about upholding rules that they continue to follow them even while their actions undermine their ability to reach organizational goals (Merton, 1939).

In a public health survey, for instance, interviewers are expected to administer the questionnaire in the same way with each respondent. Because the principle of objectivity underpins this process, entertaining the perspectives of participants will only sidetrack researchers and taint the results. Therefore, what is not usually built into this standardized information gathering routine are opportunities for respondents to explain their health experiences in detail.

A community-based approach, however, would not view such a break from the routine as a distraction. In fact, this action would be common practice. Because knowledge is mediated by language (Lyotard, 1984), dialogue with survey participants is considered necessary for obtaining insight into local realities. Such engagement allows the interviewer access to the community’s biography (Berger & Luckmann, 1966), which is composed of the interlinked meanings that individuals

attach to their group's culture, history, and prospects for their collective future. Given the emphasis on anti-dualism in community-based philosophy (Murphy, 2014), accessing and correctly interpreting a community's biography should be standard in community-based projects.

Institutions that Support Community Authority

The rest of this chapter explores how community-based institutions foster local participation. Of primary focus are values, formations, and communication that center communities in health interventions. In contrast to a dualistic view that considers these institutional elements as autonomous and controlling (Durkheim, 1982/2013), a community-based perspective facilitates an understanding of these features as always interpretive and socially constructed (Berger & Luckmann, 1966). This theoretical shift is necessary to create institutional contexts that support social action and sustain community momentum.

Values that Promote a Community's Vision

Interventions that are community-based adhere to local values (Fals Borda, 1988). Therefore, community-based planners should learn the residents' ideals and ethics, as well as the meanings that they give to them. Only then may a planner begin to grasp a community's logic and contribute meaningfully to the design of project goals. Nonetheless, in a truly community-based initiative, a group's health aims are always determined by its members and are founded on their understandings of what objectives may be possible to meet. This process integrates the unique standpoints of community members by respecting their personal perspectives, interpretations of their collective experiences, and the lessons that they have learned from their everyday lives (Hancock & Minkler, 2012).

Traditional medical professionals and health practitioners, who rely on positivist procedures for project development, tend not to operate with this appreciation. These persons typically enter a community with the belief that their objective knowledge is what may serve the group best. For example, public health consultants may propose drafts of policies for medical clinics without engaging their communities of practitioners and patients together in dialogue about their health-care service experiences. In these cases, there is little reason to engage a community in the creation of health plans, because neutral information derived from the generalizable results of scientific research is what is considered important. Accordingly, conventional approaches involve the imposition of values that hold in high regard technology and strategies for obtaining unbiased data.

What a community-based lens brings into view is how social norms, including morals and customs, are established through "joint action" (Blumer, 1969, p. 17).

Moreover, behavioral patterns are believed to spring from arrangements of social action (Blumer, 1969). The implication for the development of community-based organizations is that institutional rules and expectations that are commonly thought to be outside the control of individuals, in actuality, may be created from local interpretations. Structures, therefore, may be grounded in the agreed upon meanings that group members give to their realities and, in turn, may be designed to be consistent with a community's vision.

From a community-based perspective, what is important to note is that traditional understandings of institutions are problematic, particularly with respect to who and what guides a project. When a medical organization is the result of local, interpersonal creations (Berger & Luckmann, 1966), the aspirations of a community to be free of environmental health hazards and disease may be articulated in ways that promote group "buy-in" (Woods, 2013) and, thus, allows for community participation to be the centerpiece of a project (Fals Borda, 1988).

In short, values that are generated by communities provide the appropriate guidance for their activities (Berger & Luckmann, 1966). Significantly, a community-based approach encourages communities to use their power to socially construct institutions that support local involvement. At the same time, this orientation takes into account the meanings that individuals give to these institutions, so that they may be (re)shaped in ways that promote local leadership.

Formations that Foster Community Leadership

Community members are the main leaders of community-based projects (Sandmann & Vandenberg, 1995). Without their guidance, interventions are not likely to be effective. Institutions with a community-based focus thus need a type of organization that espouses local control. Traditional organizations, with their top-down hierarchy, do not usually support this objective. Decision-making power is centralized and enacted by upper-level administrators and executives (Weber, 1978), who are often far removed from direct patient care, settings with barriers to health care, and the challenging realities of residents. This condition tends to marginalize communities in health initiatives and undermines their capabilities to lead.

A horizontal structure, however, intends to eradicate dominating relationships, encourage local participation, and allow for potentially any community member to step up, albeit temporarily, to contribute their skills to a project (Ramnarayan, 2011a). Local residents, for example, provide guidance on the activities of neighborhood health centers and ensure grassroots planning and supervision (Cooper et al., 2016). When power is decentralized (Ramnarayan, 2011a), communities have the opportunity to oversee their health development and take ownership of initiatives that are supposed to benefit them. Moreover, there is a collective commitment to the belief that shared decision-making is in the group's best interest (Locke, 2003) and an appreciation of the stock of local resources that can be drawn from for community improvement purposes (Ramnarayan, 2011b).

Because the ability to lead is not considered to be an inherent quality, persons are seen as capable of learning new skills and training others (Van Wart, 2003). Along these lines, all community members, not only individuals with a high-level proficiency and advanced education, are thought to have the capacity to take on responsibilities in planning and implementation processes (Raelin, 2003). In community-based organizations, even timid individuals who are not considered usually to make good leaders may feel encouraged to offer their voices and talents, rather than go ignored or wait to be asked by an authority figure for their opinion or to assist in an initiative.

Community health workers are a prime example of everyday people engaged in leadership positions (Cooper et al., 2016). These individuals may have low literacy skills and little experience in the health field, but what makes them ideal community leaders is that they have considerable familiarity with a locale, earned respect from their neighbors, and a strong desire to serve others. Their local knowledge may help to create an interpretive frame for identifying community issues and conceptualizing possible interventions (Fals Borda, 1988), while their solid social relationships and dedication to their community may be important unifying factors in a project. Indeed, community health workers have been found to be successful in implementing health services around the world and are valued by many health associations (Cooper et al., 2016; Kim, Farmer, & Porter, 2013; Rahman et al., 2019).

To be clear, health researchers, clinical practitioners, and other medical specialists may hold, at some point, important leadership positions during an initiative. However, they are not conferred high status in projects based on their academic background and medical expertise (Raelin, 2003). In fact, the egalitarian foundation of community-based projects provides an orientation that aims to empower everyone involved and facilitate democratic organization for constructing community knowledge and programs.

Communication that Creates Community Knowledge and Cohesion

Communication is a crucial aspect of participatory processes and community building initiatives (Walter & Hyde, 2012). Writings on practices for open and strategic communication abound in the body of literature on community health interventions. The emphasis is usually on developing technical skills, such as active listening, for effective communication (Li et al., 2018; Tran et al., 2004) and, therefore, considers communication in merely instrumental terms (Mumby, 1997). Clearly, these practical competencies are important, but community-based health promotion recognizes the need to consider health concerns using a discursive understanding of communication in conjunction with social constructionist views of community and culture (Ford & Yep, 2011).

Regarding communication as constitutive calls for engagement with how communities linguistically interpret health and illness and their experiences of these issues (Mokros & Deetz, 1996; Mumby, 1997). This anti-dualist orientation calls for dialogue that is rooted in reflexivity and focused on achieving shared understanding (Cunliffe & Easterby-Smith, 2004). Reflexivity involves the suspension of judgment (Buber, 1970) and the examination of personal assumptions and parameters of perspective. By becoming aware of one's stance and its limits with reference to a particular cultural frame, the foundation is formed for engaging the viewpoints of others (Gadamer, 1975). The challenge, then, becomes arriving at mutual comprehension, which requires grasping the realities of community members. This aim may be achieved through entering into open, reciprocal relationships and recognizing others as fully human (Buber, 1970).

When community members are committed to dialogue, they may discursively build prejudice-free, democratic spaces that allow all community members to express their ideas and challenge one another's views in what Habermas (1984) calls, "the ideal speech situation" (p. 25). In health contexts, a community-based approach involves linguistically contesting and undermining privileged perspectives on disease and medical concerns, so that ideas that are typically marginalized have a chance to be considered fully (Mokros & Deetz, 1996; Mumby, 1997). Accordingly, diversity of thought and the existence of different knowledge bases are not feared, because community members have the ability to understand divergent logics and can agree to disagree (Habermas, 1996). Any differences in statuses among the group are not given any meanings that could influence the marginalization of voices, advance authoritarian views, or result in manipulated consensus. What does rise are the ideas and arguments that stem from authentic communal agreement (Habermas, 1984), which provides the basis for a cohesive effort.

For illustrative purposes, a medical researcher who merely indicates that children need a healthier diet, based on where their measurements fall on a growth chart, may be viewed as futile information when their households lack food for days at a time. In such cases, the children's experiences of hunger would likely be more telling of the kinds of interventions needed than height and weight statistics. That is not to say that empirical and seemingly unbiased data should be disregarded completely. Rather, they should be generated and interpreted using a community's knowledge and logic.

No matter how critical and straightforward information may appear to be to a community's well-being, such as the contamination of a local water source or simple hand washing methods for preventing sickness, health professionals should understand that their knowledge needs to be conveyed in a way that is consistent with a community's worldview. In order to do so, they will need to engage in culturally sensitive ways and comprehend the community's modes of thinking (Airhihenbuwa, 1995).

Conclusion

This chapter explored the political side of health interventions by applying a community-based perspective. Using this lens revealed problems with placing confidence in the ability of traditional health organizations to address the well-being of communities. These institutions tend to be sustained through taken-for-granted assumptions about the organizational power of structures to encourage conformity and bring about order. Their abstractness conveys the image that they are beyond human influence, which leaves individuals and communities subject to domination (Berger & Luckmann, 1966). The “natural attitude” (Husserl, 1913/2014, p. 48) is to accept institutions as they exist. As a result, ineffective, and even irrelevant, organizations and interventions may persist (Berger & Luckmann, 1966).

A shift from dualism, however, reveals that organizations are a social product. Institutional transformation is thus predicated on justifications that are grounded in human action (Berger & Luckmann, 1966). This understanding should evoke a sense of optimism about community-based health initiatives. Community members can (re)construct norms to facilitate their participation in health projects and promote dialogue about their well-being. They can also make organizational arrangements that allow them to take on leadership responsibilities and make locally informed decisions about their group’s future health. Of course, all of these activities are political. Yet, when a community-based approach is employed, the possibility is opened for the “people’s power” (Fals Borda, 1988) to prevail.

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