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# Community Based Interventions, Definitions and Types

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**Introduction**

Traditionally the world's poor, making up most of the global population, have suffered a greater prevalence of malnutrition and hunger, higher infant mortality rates, shorter life spans and other poor health indicators, illiteracy and other educational deficiencies, greater employment problems, higher crime rates, and the intergenerational continuity of these problems, than has been the case among the non-poor. In trying to improve the quality of life for the poor, planners and policy makers of human service delivery have in the past three decades, moved increasingly away from "top down" (government only) program planning and implementation to strategies of increased input from the organizations, leaders, and citizenry of the communities targeted by their policies and programs. Yet these "community based" interventions (CBIs) also rarely achieved the goals and objectives desired by those planning, implementing, and sponsoring these projects.

We suggest in this paper that part of the problem is the evasive problem of defining and effectively operationalizing what we mean by the concepts of "community" and "community based." With regards to community, Hawe (1994) talks about three different concepts of community that are found in CBIs. First she says is "the most common notion of community found in health promotion is the most simple…..community as `lots and lots of people' or community as population" (p.220). She says such ideas of community interventions is " propelled by the concern to reach as many people as possible and make the best use of scarce program resources." (*ibid*). A second approach to community in health promotion she says is

> "borne out of the first, [and] could be described as community as `giant reinforcement schedule' or community as setting, with aspects of that setting being used as levers to support and maintain individual change. In this approach, organizations, groups and key individuals in the community are valued because of their capacity to translate the health messages of the campain into the local culture. " (*ibid)*

The third approach to community, says Hawe, "could be termed community as `ecosystem with capacity to work towards solutions to its own community identified problems or community as social system. Here the job of the health promotion intervention is to harness and enhance the natural problem-solving and helping process in the community. " (p.201). Here Hawe is defining community as a geographic/ demographic cluster, and in the second or third type, as a unit for addressing a health or social problem. This type of conceptualization of community is that of community as a **"unit of solution."** In all three of her models of community, community is viewed as a geographic, demographic, or social entity. The individual is placed within the concept of a social unity, whether it is the wider geographic unit, various social units such as local organizations, institutions, support networks, and key individuals.

Hatch and his colleagues, on the other other hand, suggests that those involved in community interventions should also be aware of another concept of community, one that

is more of a psychological context, that is influenced by a variety of social factors. As they comment:

> "…it is important to keep in mind, what we mean by `community…. [for example]…the `black community' as a unit of identity for black Americans not the same as geographic/demographic clusters in which the majority of the people are black. Places demarcated by natural or psychological boundaries serve as a common core of commercial and human service organizations, churches, and schools, and, where the population is all black or predominantly black, are called black communities. However, community can be defined ' also by shared interests, common fate, social and political history, and cultural affinity. Blacks share a bond to the history, ethos, and institutions that form the heart and soul of the identity known as the black community. Even though black communities are by no means homogeneous geographically, the experience of being black in America has produced sentiments and experiences that have molded a sense of peoplehood.' A sense of peoplehood, formal or informal ties to religious and social organizations, and family conceptually define the black community for the majority of African Americans. Researchers seeking community models must consider both the geographic boundaries to the black community and the sense of cultural identity that also unites it. These black communities may be poor, working class, middle class, upper class, or of mixed socioeconomic status. Their social organization ranges form organized and stable to disorganized and transient. Styles of leadership, patterns of social organization, and internal coherence will vary in accordance with past and present events and traditions within the community and in the broader society." (Hatch et al 1993: 28).
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> The same can be said for members of various ethnic groups in the U.S.

Hatch and his colleagues are making a distinction between the concept of community as a geographic/demographic cluster, and community **as a unit of identity.** With regards to the latter, they are also discussing how units of identity may differ as a consequence of a variety of social and economic factors, as well as the personal life course.

Then there is the concept of **community *based* interventions**. In my work as a community health anthropologist, I have seen seven different types of programs that have referred to themselves as community based. I have categorized these programs in the following way:

(1) TYPE I Programs in which individuals or groups/organizations indigenous to the community to be served by a program (target community) initiate, without any external (to that community) support;

(2) TYPE II Programs in which individuals or community groups/ organizations indigenous to the community initiate, and recruit external, technical (expertise) support;

(3) TYPE III Programs in which individuals or community based organizations (CBOs) pursue external fiscal support or funding;

(4) TYPE IV Programs in which individuals or CBOs indigenous to the target community initiate and recruit external technical and fiscal support;

(5) TYPE V Programs which are initiated by external *change agencies* (public or private organization, university, a corporation, a foundation or some other philanthropic group, and so on) within a target community, but does it without any input from individual residents or organizations of that community, except as program recipients;

(6) TYPE VI Programs which are planned and initiated by external change agencies, and community members are eventually invited to participate on community advisory committees, or as lower level project staff such as "community outreach workers", or as volunteers; and

(7) TYPE VII Programs which are *planned* and implemented as an *equitable* partnership by CBOs and an external change agent or technical organization.

As one can see from the last 6 types of CBIs, there are collaborations between community based groups and persons from outside of the community. These collaborations have been stopped In the three decades that I have worked in the planning, implementation, and evaluation of such programs, one major problem became increasingly apparent: *the consistent lack of CBIs having all of the components necessary to maximum program success.* Over the last thirty years I have come to see the program components necessary for maximum success as the following:

(1) conceptual *strength* and *comprehensiveness of design*;

(2) *rigorous* discipline in implementation;

(3) the potential for *socio-cultural "effectiveness"* (a generic concept used to capture what have became know among CBI professionals as *cultural sensitivity*, *relevancy*, *appropriateness*, or *competence*, and the capacity for program components to be *integrated* into the routine *socio-cultural contexts*, *processes*, and *meaning systems* of the community targeted so as to assure sustainability and diffusion); and

(4) *process oriented* in implementation and evaluation.

By the end of the 1980s, the recognition of the need for such necessary attributes in the success of CBIs led both public and private sponsors of such programs to encourage partnership development between technical experts (researchers, scientists, and other highly trained professionals) and community based organizations (CBOs) and activists. The technical experts would bring the first two of these necessary factors

(conceptual strength, comprehensiveness of design, and rigorous discipline in implementation and evaluation). The CBOs and the community activists would provide the socio-cultural effectiveness and comprehensiveness of program implementation so as to not only achieve the proposed or desired goals of health or social change, but also strengthen the potential for the *sustainability* (endurance) and *diffusion* (spread within a population beyond those who were first introduced to the program) of the achieved change.

However from working with numerous CBIs over the past three decades I have observed a number of problems with attempts at program partnership. First is a lack of standardization with regards to what is meant by an *expert-community partnership*. In fact over the years I have witnessed a variety of programs with a range of different partnership structures, but that were all referred to by their respective staff as being "community based." I have come to the conclusion that we need to better understand these differences, as I have also come to see how partnership structure can affect the level of success that a program might have in achieving its proposed goals and objectives. In the remainder of this chapter I will present a categorization of the different types of CBIs that I have observed, in terms of their partnership structure, and discuss the implications of these differences for achieving their proposed goals and objectives.

**Types of Partnerships, Their Strengths and Limitations**

TYPE I CBIs are the most "pure" community based (without external influence) programs, and will hereafter sometimes be referred to as *pure* CBI. Being completely initiated by community residents, many of whom do not have the training of scientists, Type I programs often have the greatest potential for sociocultural effectiveness as they tend to operate within the natural sociocultural dynamics of the community. At the same time however, they are quite frequently conceptually weak and undisciplined in terms of:

(1) being poorly planned;

(2) having an unclear or overly ambitious statement of goals and objectives;

(3) exhibiting a lack of clarity as to the strategies and time necessary for achieving goals and objectives;

(4) showing an inability to stay focused during the implementation of the project and losing sight of their goals and objectives; and/or

(5) displaying an absence of an evaluation plan to clearly show what has been achieved.

The accomplishments gained and lessons learned by those carrying out pure CBIs frequently remain parochial because there usually are few written accounts of their experiences which can be disseminated broadly.

TYPE II CBIs frequently operate with the same weaknesses as the first category, as the external technicians are not usually given the power or influence by the controlling CBO to overcome the weaknesses in the paradigm of the pure CBI. Indeed, technicians hired by CBOs often find that they have little influence in the decisions made regarding the implementation of the project, but that frequently their motives or methods are questioned or simply ignored. In certain cases, external technicians, particularly researchers and program evaluators are simply not trusted by the CBOs or community members.

The weakness of TYPE I and TYPE II programs are primarily a function of the fact that the community members who initiate these programs usually do not have the training nor great familiarity with the methods and knowledge base that a technician might bring to a CBI; or their experiences with external technicians have been negative. They often cite cases of technicians who maintain a sense of elitism while working with community groups; past researchers who exploit the community and leave; or technicians, media personnel and others who contribute to negative public images of the community.

Most CBOs however have increasingly found it difficult to achieve the goals and objectives of community improvement programs without external fiscal support. However, the sponsors of these TYPE III programs have also increasingly required that external technicians, particularly program evaluators be hired, thus creating TYPE IV programs. Frequently such technicians are selected by the sponsor or the CBO because they bring with them a scientific paradigm which promises to overcome the CBI's weaknesses of inadequate conceptualization, unclear, overly ambitious, or immeasurable goals and objectives, a lack of discipline regarding process, and an unclear evaluation design.

The broad based belief in scientific paradigms, particularly in publicly funded programs, contributes to a domination of TYPE V programs, those initiated by external change agencies who can demonstrate their capabilities regarding the tenets of this paradigm, and who may then attempt to pursue such programs without any input from individual residents or organizations of that community, except as program recipients. The increasing call for community participation or involvement during the past several decades has led to the popularity of TYPE VI programs, those initiated by external change agencies who at some point invite community members to participate as community advisory committee members, or staff members or volunteers who serve as community "outreach" workers, and so on.

While the domination in the planning, implementation, and evaluation of CBIs by the scientific paradigm found in TYPE V and VI programs overcome the weaknesses of TYPE I through IV programs, they often exclude the strength of the pure CBIs: *socio-cultural effectiveness and process*. This occurs because the modus operandi of the contemporary scientific paradigm is the testing of theoretical models, or a small number of a priori stated hypotheses or objectives in experimental or quasi-experimental research designs. Such paradigms often exclude socio-cultural holism, relevancy, and normal

community processes, primarily because such concerns would introduce into the mix too many variables over which those utilizing the scientific paradigm would have no control. Investigative control is one of the primary tenets of traditional notions of science. Moreover, the scientific process may have little "meaning" in terms of the target community's concerns. As such, they have little chance of improving the community's well being, or to sustain whatever success is achieved, once the project ends. Even their often proposed contribution to the creation of policy which would more effectively serve communities or populations similar to their target community is infrequently achieved because of their lack of socio-cultural effectiveness. (I will discuss the problem of the domination of scientific constructs in the implementation of CBIs in more detail in Chapter 3).

Undoubtedly, the ideal CBIs would be those of category VII, those designed and implemented by an equitable partnership between community and external technical and fiscal agencies. However, most attempts at such an endeavor have still been dominated by either the experiential or the contemporary scientific paradigms. Public sponsors remain oriented towards the scientific paradigms and they tend to dominate at the expense of CBOs and other community efforts oriented toward service. Thus in most government sponsored intervention programs where states, counties, and municipalities targeted for prevention and intervention monies, there is a requirement for partnership development with planning committees made up of various community stake holders, including local policy organizations, local health care delivery or human service organizations, relevant CBOs, and sometimes, so-called community residents. But here again, for example in the case of AIDS and Ryan White monies, formal health care organizations that can supply the best scientific paradigm (and track records and facilities for) care will most often get the large bulk of the money; while CBOs attempting to provide neighborhood based care complain of getting little support. More often than not, community based groups and individuals are "partners" of very little, if any, decision making powers regarding program design and implementation. They are simply added on to fill the requirements necessary to achieve the funding.

The other side of this coin, in my experience, when community based organizations are targeted as the primary grantee, they are asked to establish partnerships to achieve very ambitious goals and objectives, but with much more severe fiscal and time constraints than are placed on organizations with more scientific or technical expertise. Their programs are more likely funded as exploratory or developmental, primarily because they are not informed by a recognizable scientific or technical paradigm. And then again, as stated earlier, because CBOs frequently do not have staff trained in these paradigms, they often times are not successful in achieving the needed funding for their projects; and when they do succeed in achieving such funding, it usually is a consequence of having proposed overly ambitious goals and objectives.

I will end this chapter with a summary of a project that I worked on almost two decades ago that will be referred to again in other chapters. I am sharing a brief summary of it here because I thought this program had the greatest potential for an effective partnership in terms of achieving community based planned change, of any that I have

ever experienced. In 1981, I was asked by a large foundation to evaluate a CBI that was being carried out in a major metropolitan area. While the conceptual idea of this program originated with an outside agency, and was also being implemented in a number of rural communities throughout the South, community organizers worked hard to get large turnouts at community meetings to introduce the project and recruit volunteers to establish a *Community Organizing Structure*. This community organizing structure would continue to develop and operate, recruiting community wide participation and to support another structure made up solely of community members, its *Community Problem Solving Structure*.

The Community Organizing Structure was oriented towards developing neighborhood level cells across the lower income neighborhoods of an entire city or county, with representation from each residential unit (in the traditional sense of Jeffersonian democracy). As such, problems were brought forward from the neighborhoods to be addressed at monthly meetings of community wide assemblies--to which all residents of the community were invited. The community wide problem solving structures were made up of committees of community residents with each specific committee charged with addressing a specific problem (i.e., housing, education, health, employment, etc.). The change agency staff included community organizers who developed the community organizing structure, and were available as a technical assistance unit to help committees respond to specific problems.

This program was conceptually the strongest and therefore potentially the most effective community development model that I had experienced over the thirty five years that I have worked in this area. However, the program and its potential effectiveness were severely crippled by a limited resource base. Fund raising was primarily done by the program's founder, who did not have the research credentials to take advantage of a broad range of potential funding sources. Limited funds meant limited staff, and monies for staff training, as well as for other program needs. At the same time, programs that had been initiated in dozens of rural counties, and the program director's commitment to continued expansion throughout the South, resulted in tremendous over extension, and a strain on the effort that he was funded to address in the larger city. Moreover, the director's staff had limited skills beyond community organizing, including the scientific ones which could help to maintain existing funding and secure additional fiscal support.

These limitations led to community and staff disaffection, and the rejection of the program director by both parties, as staff was not getting paid and the community began to see the director not as someone who was helping them solve their problems, but simply as someone who got his kicks from telling them how to do things. This eventually led to broad attrition by the staff, the loss of the one funding source that the project had, and eventually the end of the external agency's presence in the community before it could begin to achieve any of its long term goals and objectives. Even though the community tried to carry on its own, without longer input from the change agency for both project conceptualization and implementation, and as a source of problem solving resources and technical assistance, the program died shortly after the change agency's departure.

## References Cited

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