# Original article

# Exploring the effects of government funding on community-based organizations: 'top-down' or 'bottom-up' approaches to health promotion?

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**Abstract:** Community-based organizations hold an increasingly central role in the representation and advocacy of marginalized groups and individuals. In these capacities, such organizations make significant contributions to the areas of health and health services. In particular, they are considered well-positioned to operationalize 'bottom-up' approaches to health promotion. In this article we use a case study to illuminate unforeseen consequences of government funding of community-based organizations involved in health promotion and health service work. Previous research has found that many health promotion practitioners are engaged in a shift *towards* 'bottom-up' approaches to health promotion (1). In contrast, our findings suggest that due to government funding, those best positioned to promote community participation and empowerment may be experiencing a converse shift *away from* 'bottom-up' approaches. (Global Health Promotion, 2009; 16(3): pp. 45–52)

**Key words:** community-based organizations, government funding, health promotion

## Introduction

Community-based organizations hold an increasingly central role in the representation of, and advocacy for, marginalized groups and individuals. For example, community-based organizations represent the interests of individuals in areas such as HIV/AIDS, hepatitis C, unemployment, and migrant issues, to name just a few. Groups such as these play a key role in providing services and support to those marginalized or disadvantaged sections of the population, which governments find difficult to engage (2). In these capacities, community-based organizations are pivotal to 'bottom-up' approaches to health promotion, i.e. they enable public participation in health programme decision-making, and thus promote social justice and equity in health (3, 1).

In recent years, not-for-profit community-based organizations have become known as the third sector – a term that differentiates such organizations, and their unique organizational structures and roles, from government and market sectors (4). In many Western countries, the third sector is increasingly diverse, with a range of informal and formal organizations of varying sizes and capacities (2). In the area of health, many condition-specific organizations now exist alongside organizations with a broader health and welfare-related scope (2).

However, over the last two decades, community-based organizations have undergone substantial changes to their role and position relative to other sectors (5). Prior to the 1980s, third sector organizations were primarily funded through grants schemes and subsidies, and funding was provided as

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block grants (6). As part of policy trends that favour increased collaboration between sectors, the third sector has seen a shift towards contractual, tied funding programmes with government. Such shifts have fundamentally altered the relationships between organizations and governments and, in turn, between organizations and their communities. The development of government contracting of the third sector has, in many instances, significantly changed organizational dynamics and characteristics; tied funding programmes have been seen to draw organizations away from their community groups and change the nature of service delivery (7, 8, 9). As a result, recent changes regarding inter-sectoral collaboration are understood to present a 'widespread challenge both to the way non-profit [community-based] organizations have actually operated and to popular conceptions about how they are supposed to behave' (4: 8). With regard to their role in advancing health and social justice, the shift towards closer ties and partnerships between community-based organizations and governments presents a particular challenge. Although greater service provision (enabled by partnerships) may benefit individuals and communities, the strength of third sector organizations often relies on their close networks with communities. Some suggest that, through incorporation into mainstream structures, partnerships with government can undermine organizations' connections with community groups and thereby their unique contributions (9).

In this article we use a case study of a government-funded community-based organization, engaged in health service delivery and health promotion, to illuminate some of the challenges that these partnerships present for public health and health promotion. We suggest that close partnerships with government, and increased government funding of community-based organizations, have the potential to decrease 'bottom-up' approaches to health promotion, in favour of more conventional 'top-down' approaches.

## Research design

The research was ethnographic in approach, and comprised participant-observation combined with in-depth interviews with a selection of workers at a community-based organization. Drawing on Foucault's work on governmentality and recent anthropological developments in understanding and theorizing 'community' (see, for example 10, 11), we conducted a thematic analysis of the data, including fieldnotes, interview transcripts, and internal organizational documents. Throughout the analysis, themes were explored iteratively with participants. The research was granted approval by a Human Research Ethics Committee.

### Setting

The Oliver Smith Council is a community-based, non-government organization for people affected by hepatitis C. The organization was formed in 1994 and began as a volunteer organization involved in the support and advocacy of people affected by hepatitis C. Since then it has secured government funding for both paid staff positions and for projects. In 2005–7, when the research was undertaken, the organization had 13 employed workers filling seven full-time equivalent positions, and approximately the same-sized pool of volunteers (although volunteer numbers fluctuated). The structure of the organization can be seen in Figure 1, with staff arranged into four core sections.

While initially the Council primarily filled advocacy and support roles, its focus has expanded in recent years. The organization has come to fill a variety of roles: it now contains many of the features of a self-help group and acts as a pressure group to advocate for increased funding and research. It is also a service provider engaged in community empowerment and development work, and uses its expertise to contribute to public debate.

### Participants

#### Participant-observation

We conducted four months of participant-observation at the beginning of the project. During this time, the primary researcher on the project participated in volunteer work attended the Council's social functions and activities, and observed staff and volunteers at the organization on a daily basis. Detailed fieldnotes were kept for later analysis. During this period of observational work we met regularly as a research team to identify, develop and explore themes in an iterative fashion. We later used these themes to construct an interview guide for semi-structured in-depth qualitative interviews.
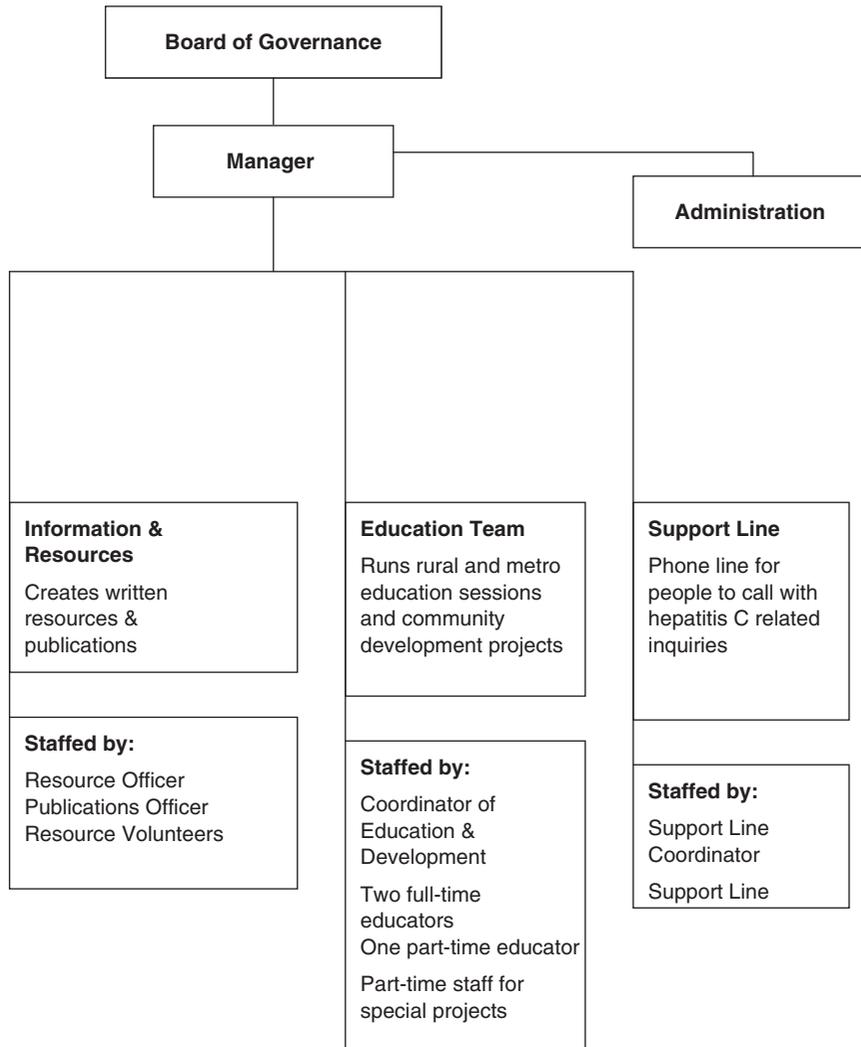
**Figure 1.**   Organizational structure of the Oliver Smith Council for hepatitis C

*Interviews*

After the four-month period of observation, we interviewed a selection of volunteers and staff at the organization. Nine staff and volunteers took part in interviews, which represented approximately half of the workers at the organization. Individuals were selected through a combination of willingness to participate and position. We interviewed at least one staff member from each of the organization's four internal sections, and at least one volunteer from each of the two groups of volunteers. In total, seven staff members were interviewed, drawn from management, Board of Governance, administration, education, support and resources, plus two volunteers. Details of interviewees' involvement in the organization can be found in Table 1. Interviews were transcribed verbatim, analysed thematically and then contrasted with the findings from the observational data.

**Table 1.** Participant involvement

| Worker | Years with the organization | Section | Employed | Volunteer | Previous volunteer |
|---|---|---|---|---|---|
| Sam | >10 | Education | Yes | No | No |
| Frank | >10 | Positive Speaker/ Support Line | Yes | Yes | N/A |
| Cathy | >10 | Support Line | Yes | No | Yes |
| Gail | >10 | Management | Yes | No | No |
| Frankie | 1 | Education | Yes | No | No |
| Tom | >10 | Board | No | No | Yes |
| Ryan | 4 | Resources | No | Yes | N/A |
| Lilly | >10 | Administration | Yes | No | Yes |
| Kate | >10 | Education | Yes | No | Yes |

### Steering group

Staff and volunteers were invited to take part in an ongoing steering group. We convened this group monthly starting at the end of the four-month observation period and continuing until the analysis of results was complete. Five staff members were recruited for the group, consisting of the manager, and members from the organization's Board of Governance, administrative staff, resources and education staff. While no volunteers chose to take part in the group, several of the group members had undertaken volunteer work within the organization prior to obtaining paid positions. In steering group meetings, we explored the findings from the analysis of fieldnotes, data, interview transcripts and documents obtained from the organization in an iterative way. The steering group participants made significant contributions to the analysis and interpretation of findings.

### Theoretical approach

As previously mentioned, the research analysis was informed by Foucault's work on governmentality and recent developments in anthropological understandings of community (10, 11). This meant that emphasis was placed on exploring the relationships between social structures; in this case, the relationships between state and federal governments and third sector organizations. In combining these diverse theories, we sought to understand the impact of governing processes on organizations' understandings of the communities with which they work. It is worth noting that although our analysis was informed by these theories, it was still conducted in

an inductive fashion; themes emerged from the data and were then explored and developed using theoretical insights. A more in-depth theoretical analysis of the findings can be found elsewhere (see 12).

### Findings

Increasing ties between the Oliver Smith Council and government, and subsequent funding arrangements, were accompanied by a significant shift in organizational focus and role. Prior to forming ties with government, the Oliver Smith Council primarily filled support and advocacy roles, often on a 'one-to-one' basis. However, as a result of increased government funding, the organization has broadened its focus; it now engages in prevention work and provides service delivery to a much larger population. In the following quote, Sam, Paul and Tom reflect on this change:

> [People coming to the Council were] people who were generally fairly messed up, who were looking for nurturing and a fairly high level of personal support ... and that's what people used to give them. That kind of fairly intensive, immediate support is not really available anymore because the general idea is to be supportive of a whole range of people at a more moderate level. (Sam)

> Supporting people who were living with hepatitis C—for a long time I thought that should be our only focus, but I realised that an organisation like ours needs to be contributing [more broadly] ... that's also around funding, I think probably that was the bottom line, the state department really

wanted us to be thinking about this. I think that's a bit of a trade off, if we're really here to support people with hep C we should be doing this. (Paul)

There are different schools of thought in the Council. Some people want to concentrate on the most marginalised people in the community, and that's probably a good thing to do, but at the same time in [our state] there are tens of thousands of people with hepatitis C who don't even know they've got it … so perhaps we need to work [with these people too]. (Tom)

The Council's broadening focus is consistent with conventional public health approaches; it now focuses on populations, rather than individuals. Concurrent with this, workers have established 'priority' and 'target' populations:

I think we have invested a lot of energy in people but sometimes it's for the organisation, and for the greater good ... I've realised that in a number of [instances] there was a lot of energy going around ... volunteer stuff. If you look at the bigger picture ... we really needed to make some changes in our work that was much more 'out with the priority population' ... (Sam)

Workers [from other organisations and institutions] are our secondary target group, but we're working more towards them. So there's been a definite shift. Which is about funding as well. It's from a governmental level, it's not one person sitting at the Council saying let's change let's do this, it's the way that things happen. The Council is evolving into something else, a much more political entity ... (Kate)

For the organization and, more broadly, the government and community, this shift in focus might be considered a significant gain; resources and services are further reaching and likely to have a greater impact on health and well-being. As Sam suggests in the following statement, the organization has greatly increased its capacity:

I think [previously] it was probably more [about] people living with [hepatitis C], or affected by hepatitis C ... over the last three years we've been ... trying to target and work more with organisations ... we've increased our focus and capacity.

While this shift has seen significant gains, there have also been associated costs to the organization and for individuals who previously used it for support and advocacy. As workers explain, they no longer offer the type of support they used to.

The shifts associated with establishing a population approach or focus in the organization also raise broader questions regarding the role and position of community-based organizations relative to governments and communities. The unique contributions of many community-based organizations to the health and well-being of both individuals and communities relate to their capacity to engage with, represent and advocate on behalf of particular groups in the community. As the organizations shifted to a population approach, workers became concerned that its networks and relationships with its community groups diminished:

It's not a drop-in environment anymore … we must spend a lot of time and energy getting out to the community. (Gail)

It's not the same place it used to be – it's not as personal as it used to be for people, the volunteers are not as empowered, it's not as empowering for them. I feel like community is being left behind, because that's how it is, the further up the corporate ladder [we go] and the more of peak body stuff we get into, the more bureaucratic we become. It's just a way that things happen, so community get left out. (Kate)

Yes we have the information lines where people can ring, and that's a great service, and we have individuals like myself who go out and do [work], but we're really looking more at working with workers, educating workers, doing everything with workers, rather than working with community ourselves. Which I can see the wisdom behind that, but it sort of leaves community floating a little bit because there's no other body here for them. (Kate)

Furthermore, some staff at the Council question whether the organization's new focus is consistent with the ideological underpinning of a community-based organization. The term 'community-based' denotes a high level of community involvement in, and a degree of community control over, the organization. This can be seen in the following statements made by workers:

A community organisation: ideally community should be in control of that, community should have the input into that. Within practical stuff, the community should be working and be volunteering, everything else. (Kate)

I can see we're going in that direction – working with workers. At the same time I see a need ... I see that there are some people who work here who are very invested in maintaining that grassroots approach, the hands-on approach ... and seeing that as being very important for maintaining the contacts with people in our community. (Frankie)

It's important [to have] people who actually have practical understanding and experience [of hepatitis C], not just things that they've read out of books ... if you only have the theory without the practice, that's really empty, and I don't think the Council is empty. (Cathy)

One of the ... key things to my sense of community ... is ideally people who are working in these organisations and operating these organisations are actually people who belong to the community ... so people directly affected, that would be my ideal. (Gail)

## Discussion

The shifts occurring at the Oliver Smith Council raise two questions for consideration relevant to health systems; firstly, what do these changes tell us about service delivery and community-based organizations in the health sector? And secondly, what do these changes mean for sustaining community integration, or the 'community base', of these organizations? In the remainder of this article we will draw on the experiences of the Oliver Smith Council in order to address these questions.

Laverack and Labonte (1) argue that currently two discourses co-exist in health promotion. Conventional health promotion discourse emphasizes disease prevention through lifestyle management and/or vector control. The second, more radical, discourse is concerned with improving social justice through community empowerment and advocacy. While Laverack and Labonte (1; see also 13) emphasize that while these are not discrete categories and

public health practitioners may incorporate elements of both discourses into their work, they roughly represent 'top-down' and 'bottom-up' approaches to health promotion:

In the first instance, community becomes a venue for health behavior programs. In the second instance, community becomes a locus for organizing efforts to shift broader public and private socioeconomic policies and practices. (14: 5)

Within the quotes from Oliver Smith Council workers we can detect a shift in health promotion discourse. Initially the organization operated within the more radical, 'bottom-up', discourse of increased social justice through community participation, empowerment and advocacy. With an increase in inter-sectoral collaboration and the acquisition of state funding, it appears that this discourse has begun to be abandoned in favour of more conventional health promotion discourse, focusing upon disease prevention and population approaches.

This shift is particularly interesting when we reflect upon how these two discourses are changing in the broader sphere of health promotion. Laverack and Labonte (1) argue that, traditionally, health promoters have operated within the 'top-down' discourse, and have only recently begun to engage in 'bottom-up' community-centred approaches. Somewhat ironically, it seems that as the value of community-centred social justice approaches to health promotion have been recognized, the ability of community-based organizations to engage in these practices has been diminished.

Arguably, the need to locate the organization's practices within a conventional health promotion discourse speaks to a question of legitimacy. In their statements, workers comment that the changes that have taken place relate to government funding, and the types of roles in which the government would like to see the organization engaged. The fact that this search for government legitimacy has resulted in a shift towards 'top-down' approaches suggests that community-centred approaches may be undervalued by governments. Interestingly, this runs counter to the reasoning behind government funding of community-based health service organizations. It is widely accepted that governments fund such organizations because of their ability to engage communities that governments cannot (2).

This observation leads us to the second question raised by the experiences of the Oliver Smith Council: what do these changes mean for sustaining community participation, or the 'community-base', of these organizations? As noted by workers, the shift away from community-centred advocacy work raises questions about what it means to be a community-based organization. Close relationships and networks with communities are an important and defining feature of community-based organizations; their community-centred, 'grass-roots' advocacy work distinguishes them, and the contributions they make, from other types of organization. Just as workers reflect that the shift in the organization's focus leaves community 'floating', so too does it leave the organization 'floating' in terms of its definition and ideological underpinning. Wolch (15) refers to this awkward positioning as becoming part of the 'shadow-state', where service provision offered by community-based organizations is broadened, but autonomous action and community networks become diminished. In third sector research there are broad concerns about the effect of the shadow-state phenomenon on the important social justice functions that community-based organizations fill, including health-related work (see, for example, 16, 17).

## Conclusion

In this article we have used a case study to illuminate some unforeseen consequences of government funding of community-based organizations involved in health promotion and health service work. While we have only examined the experiences of one such organization, the finding that such partnership models can promote 'top-down' approaches to health promotion is significant. State funded community-based organizations are seen as having a pivotal role to play in improving or maintaining the health of individuals and groups due to their close relationships and networks with community groups (3). While the broader profession of health promotion is engaged in a paradigm shift towards 'bottom-up' approaches, this article suggests that those best positioned to promote community participation and empowerment are potentially experiencing a converse shift, away from 'bottom-up' approaches.

The issues, raised by this paper, concerning tensions between bottom-up and top-down approaches to health promotion, raised by this paper, are manifest in current discussions regarding the value base of health promotion (see 18). Bauman et al. (18) and Laverack and Labonte (1) rightly point out that ideally a balance between these two approaches could be struck. However, we suggest that in relation to community-based organizations, the effects of government funding and the search for organizational legitimacy may be prohibitive to finding such a balance.

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