Empowering community

In 2009, the Red Cross started implementing a community-based health program for marginalized regions in Lebanon. While designed to privilege equal community participation and local knowledge, community-based programs sometimes end

Lamia Moghnieh is a PhD candidate in social work and anthropology at the University of Michigan, Ann Arbor. Her dissertation thesis focuses on humanitarian and communal representations and interventions of violence during «war» and «peace» in Lebanon.

IN 2009, THE INTERNATIONAL Red Cross proposed a new humanitarian program for the Lebanese Red Cross society: Community-Based Health and First Aid (CBHFA), to be implemented for underprivileged communities in Lebanon. Having experienced massive political and social upheavals, in the form of a 15-year civil war, Israeli invasion, occupation and intermittent outbursts of internal political violence, Lebanon represented an exemplary site for CBHFA, designed as a preventive program against conflicts. More recently, the war in Lebanon in 2006 resulted in at least 1,109 deaths, 4,399 injuries and the displacement of an estimated one million individuals.¹

Community-based programs have become a universal trend in humanitarian relief organizations due to their attractive premises of community empowerment and cost-effectiveness.² They emerged as a response to global health projects that neglect embodied social experiences of health; community-based

programs privilege local knowledge of the community being served, and demand its active and equal participation at each step in the design and implementation.³ Unlike other global projects that advocate standardized implementation, community-based programs are meant to have local flavor and cultural embeddedness.⁴

In an apparent paradox, however, the premises of equal participation and of privileged local knowledge behind these programs sometimes end up disempowering the same marginalized communities they aim to empower, thereby reifying the same global principles of health, participation and community which it aims to localize.⁵ This article aims to unravel the techniques and processes behind this double bind of community-based programs, as it unfolds in encounters and negotiations between Red Cross social workers and Lebanese communities around CBHFA. It is also a critique of humanitarian intervention in societies in

at the Lebanese margins

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conflict and the type of humanitarian civic subject community-based programs produced at the margins of the state.⁶

My argument grows out of anthropological field research conducted on Lebanese Red Cross workers in the Bekaa area in Lebanon during the summer of 2009 and 2010. I worked with social workers in the Lebanese Red Cross as they started implementing CBHFA. Throughout my research, I followed the Red Cross workers as they tried to recruit, organize and train communities in Hermel, a marginalized rural region in the eastern side of Lebanon. I participated in a three-day workshop held by the Red Cross Federation and the Lebanese Red Cross to train the social workers on the premises and goals of CBHFA.

I relied on an ethnographic method of participant observation, which can best be described as «a close engagement with the everyday life-worlds of people» in particular settings.⁷ My participant observation mainly consisted of taking notes during meetings,

while attempting to engage as a social worker in the field itself. By following social workers as they are introduced to CBHFA and start to implement it in Lebanon, my research turned into a multi-sited ethnography of a community-based program as it traveled, in meetings and interactions between social workers and Lebanese community members.⁸ While the analysis and context of this article are heavily informed by all the research conducted around CBHFA, I take as a main case study one particular meeting held between the Red Cross workers and the community leaders in Hermel, in order to better trace and unravel specific forms of contradictions embedded within CBHFA, and community-based programs in general.

Empirical debates

Empirical debates around community-based programs center on their empirical efficiency in preventing and promoting health across settings and populations.⁹ The modest impact

that these programs achieved¹⁰ have pushed for a more in-depth investigation on the kind and level of community participation taking place, revealing certain limitations like male dominance and the lack of participation of underprivileged social groups.¹¹ Moreover, a great deal of work has been done in anthropology and social work about implementing global programs in local sites, and intervention. To name a few, Lakoff's work on the striking absence of bipolar disorder in Argentina and the different forms of epistemic resistance that global biomedical psychiatry face in local sites;¹² Atlani and Rousseau's attention to cultural specificity of suffering and violence in the refugee experience and its incompatibility with trauma-related interventions;¹³ Fassin and Pondolfi's work on the production of expert knowledge through intervention and the impact of the discursive and operative strategies of intervention on subjects' lived experiences of violence and conflict.¹⁴ However, few studies have addressed the role of local professionals in implementing global programs,¹⁵ or have attempted to ethnographically explore how principles of equal participation and local knowledge behind community-based programs actually unfold and manifest in practice.

Social workers as social agents of change might teach us a great deal about how global projects actually operate in the everyday locations and practices of the state.¹⁶ Social workers and other health professionals have not been taken seriously by social scientists as worthy of research.¹⁷ Social workers have also become professional subjects who are both from and beyond the community, who hold a specific kind of «global» knowledge about the community they live in. Many of the Red Cross workers involved in CBHFA were young single

women recruited from the community in which the program was to be implemented. Throughout our many drives around Lebanon, a lot of them spoke about the difficulties they had fitting in with their community. Many had problems being in a relationship or finding a husband from the community who could understand the nature of their job and would be as educated on issues like health and social justice. Their professional subjectivity placed them in a position of authority and privilege that not so many single, low-income Lebanese young women acquire very easily.

This article explores the practical manifestations of two main principles of CBHFA, and community-based programs in general, as they unfold in encounters between Red Cross workers and community leaders in Lebanon: 1) an equal and active community participation and 2) the incorporation of local communal knowledge into the program. The first section unveils the contradiction embedded in the premise of community participation, which requires and produces a new form of self-governance and discipline for Lebanese marginalized communities. The second section examines the tension between expert global knowledge and local practical knowledge, and the irreconcilable differences between them.

The paradox

The Red Cross is an international humanitarian organization with a long-standing reputation for encouraging community-based programs across the world.¹⁸ Since 2005, the Red Cross Federation launched CBHFA in 15 post-conflict societies as a program that stresses the importance of community learning through action. The slogan of the program was *learning by doing*, emphasizing the role of experiential and communal knowledge.

CBHFA was meant to be a cost-effective program that could be designed, assessed, and implemented by and for the community, to improve health and first aid awareness and prevent an outbreak of disease following conflicts. The program was able to accommodate a wide scope of issues to include disease prevention, health promotion, first

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aid, disaster preparedness and response, in order to meet the community's needs at large.¹⁹ It heavily relied on volunteering and ownership to ensure sustainability and long-term influence.

In Lebanon, one of the first steps social workers took to start CBHFA was to introduce it to community leaders, or *makhatir*,²⁰ in Hermel, a region in Eastern Lebanon, and ask for their active participation and permission to access the community to recruit volunteers.²¹ The difficulty in transportation between villages, the dearth of resources and significant poverty level in this region made it «an ideal place» to start CBHFA. Hermel also had a long-standing Red Cross center that is well known and visited by Hermel inhabitants.

Two weeks after the parliamentary elections in the summer of 2009, I traveled to the Red Cross clinic in Hermel with the director of sociomedical services, Sana, to attend the first meeting between Red Cross social workers and *makhatir*. This meeting represents one of the local practices of participation and collaboration between different groups in Lebanon that come together with different

sociopolitical agendas but share a common final goal: the development of the community.²² Out of fifteen invited *makhatir*, only four showed up. Community leaders' lack of participation in Red Cross meetings is not surprising to the social workers working at the Red Cross center. *Makhatir*'s main community work focuses on macro-politics, like campaigning for parliamentary elections, which had just ended, and forming sociopolitical networks and relationships with leaders in the region. Mobilizing the community to vote for political representatives brings promises of aid, development and political power to a region that has been historically marginalized by the Lebanese state.

The Red Cross center in Hermel has an established reputation and «has been there since before the civil war». It functions as a clinic for «dispensary of medications», occasionally hosting lectures and health awareness workshops. This time however, Sana was asking for a new type of participation, one that called for community's active «will»:

The Hermel center is a developmental center and does not work if people, including the leaders, don't participate in its activities, so you can see and judge what works and what does not work.

Action and commitment from community leaders were required for this program, and not just passive consent and permission to implement an already-established program. This type of participation was not easily received by *makhatir*, who quickly responded with a long exposé of what they have done for «the community», especially during parliamentary elections, mentioning the shortcomings of the Lebanese state towards

this marginalized region. Makhatir's real community work seems to be as fillers of political and economic gaps produced by the state, not as active participants in health programs that should have been provided by the state.

The debate on community-based participation quickly became defined in terms of responsibility, governance and blame. Through its participation in designing and implementing CBHFA, all community members were asked to demonstrate responsibility and self-governance over their own situation. They were asked to redefine, discipline and conceptualize their own socioeconomic

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conditions, behaviors and suffering into categorical needs, think of ways to satisfy them, and use available resources to ameliorate their overall situation, rather than relying on state and non-state institutions. Participation in CBHFA required a new form of governance that calls for self-discipline and self-achievement on the level of the individual, not the state.²³ It also calls for a specific kind of governmentality that enforces a form of civic participation that does not challenge the state's shortcomings but reinforces them by making the community solely responsible for them.²⁴

However, by relocating the responsibility of governance from the state to community members themselves, social workers were asking Hermel residents to surrender their only existing political power, their

marginality, something that makhatir quickly understood and challenged. Located at the margins of the Lebanese state, Hermel's residents lobby for their rights for aid, development and political power from this marginal location, which makes them visible as «vulnerable» and underprivileged subjects. This historical marginality is a political identity that serves to demand for rights and resources.

Moreover, CBHFA assumed equality in participation among community members without taking into consideration the already existing forms of sociopolitical relationships in Lebanese society. The mode of Lebanese participation in macro-politics and society heavily relies on an intricate web of socio-sectarian connections, social status, gender and family relationships. For a marginalized community, a *mokhtar*, an elected parliament member and a sectarian leader all constitute *backing* for communal rights and needs. The marginalized community in return *backs* the leaders by participating and voting for them in elections. This relationship dictates a specific form of political and communal participation that is fundamental for ensuring basic needs and rights, medication, food, money and jobs. While Lebanese marginalized communities also rely on non-governmental aid and funding, this aid has to go through the same political channels in order to arrive at the community.²⁵ This form of participation defines the marginalized community's relationship with the state and its institutions.

By displacing the state's responsibilities onto the community through disciplined and active participation, CBHFA is simultaneously reinforcing the marginalized position of communities it represents, and taking away from them their ability to speak to the state form this position and the long-standing right

Hermel.

to receive aid from the state. This paradox of participation²⁶ emerged during the meeting between Red Cross workers and community leaders, where community-based participation, meant to empower a marginalized community, ended up allocating the role of development and need-satisfaction to community members themselves, thereby reinforcing the failure and inability of the state to care for its citizens.

Local knowledge, global health

After the meeting with makhatir, social workers had scheduled a meeting with community groups to discuss and introduce the program. Women from different age groups sat in a Hermel public high school classroom and listened to Sana and the social worker from Hermel, Mariam, talk about

CBHFA. «What can you provide for us?» asked one of the women. Mariam rushed to explain that the Red Cross did not want to do a project that the community did not want. «Are you interested in health education for example?» Everyone answered positively. «And first aid?» Yes. The director tried to turn these passive affirmations into *real* ones by asking them why they needed first aid. «So that we know what to do when we are sick». The group was mainly silent, trying to figure out what the right answers to the social workers' questions were.

After the meeting with the women's group, the Red Cross federation representative, Farah, held a debriefing meeting to discuss the future steps for CBHFA. Farah provided her own vision of the program and suggested reducing the number of participating villages to three, which will increase the level of impact and

create more visibility and appeal for other villages. What followed was a discussion of the Hermel community's needs. Social workers suggested summer clubs for children and training groups on how to recycle their own garbage. Miriam contributed her own expertise as a senior social worker from Hermel:

This region [Hermel] is «kham» [crude and untamed], whatever you do here is good and will have a positive impact (...) but the problem is that they [community members] cannot express themselves [cannot express their own needs].

As a region at the margins of the state, Hermel was represented as a wild and untamed land, where subjects will visibly be impacted upon by any kind of intervention. This marginality however, is a double-edged sword, since Hermel communities are not yet disciplined and aware enough to express their own needs the way CBHFA expects and demands.

The second premise of community-based programs is the ability to incorporate and privilege communal knowledge, through *learning by doing*, over global understandings of health and needs. However, the narrative above clearly shows the difficulties social workers find in unearthing and revealing local needs that can be expressible and commensurable enough to measure impact, a crucial indicator for funding and for the sustainability of any program. While CBHFA wants the community to define their own needs, the program can only recognize measurable and quantifiable ones; needs that are articulated and evoked in compatible ways with both CBHFA and Red Cross principles of neutrality and independence. This is why the staff agreed in the debriefing meeting on recruiting volunteers in the community to

coach them on Red Cross and community-based principles, in order for these recruits to *find their needs*.

In the meeting with makhatir, social workers also relied on an evidence-based PowerPoint presentation to reveal what they knew about the conditions in Hermel. They presented a needs-assessment study conducted in 20 villages around Hermel to extract the «needs» of the community. According to the administered survey, the community members expressed the following needs: a stable clinic, first aid education, medications for chronic illness, awareness and educational campaigns, literacy workshops, entertainment camps for the children, vaccines, and learning in foreign languages.

Community members were expected to identify their own needs through categorical surveys. Concepts and ideas like «awareness campaign», «health» or «education workshop» were not explained to community leaders nor negotiated with community members who supposedly expressed those needs. These concepts remain global and did not require a local communal definition. This unequal distribution of knowledge was not contested by makhatir, but seemed rather expected. The scientific production of health-related knowledge seems to be a knowledge expertise solely confined to social workers and not the community. Making this knowledge about health «scientific» excluded community leaders from a «complete active participation» or *learning by doing* principle.

The social workers' ability to exclude community members from certain conversations and decisions because of their knowledge expertise and the productive power of needs-based surveys resonate with everyday micro-level experiences in, and encounters of, power-knowledge.²⁷ The production of

scientific knowledge around CBHFA is linked to forms of power and authority that themselves decide, define and limit the problems that need solving and questions that need answering.²⁸ In this sense, power produces knowledge and they both become implicative of each other, shaping, creating and distributing everyday experiences, practices and identities.²⁹

The exclusionary power of knowledge was also apparent in the Red Cross director's definition of the community leaders' main role as holding the true and more sophisticated knowledge of what people and the community in general *really* need:

people might not know the needs of the village and this is where your role comes in, especially in regions where there is a lot of deprivation. [You tell us] What are the needs?

This hierarchy of needs and knowledge production reflects and reifies the social hierarchical status among community members and it contradicts the community-based programs' premises of equal participation and knowledge production.

While CBHFA calls for the privileging of local knowledge, it also requires an expert form of knowledge production from the community itself: knowledge of how to fill and complete surveys, how to articulate and talk about one's behavior, emotions and dreams in terms of categorical needs, how to demand and ask for things, how to choose, imagine oneself as part of a community that is outside of one's immediate family and surroundings and, most importantly, knowledge in terms of empirical and scientific knowledge.

By becoming both scientists and practitioners, by juggling both global demands for a scientific approach to create a «good impact» and encouraging community-based

participation and knowledge, Lebanese social workers were unable to implement *learning by doing*. Stuck between requirements of expert global knowledge and CBHFA's requirement of local communal knowledge, the social workers selectively approved or omitted certain parts of the program in order to fulfill both requirements, but always keeping global expert knowledge privileged.³⁰ Social workers found themselves in a situation in which they had to choose «between incompatible alternatives»,³¹ thereby reifying the same global premises of participation, health and community that the community-based programs try to localize.³²

But what kind of needs will community members actually be able to articulate through a needs-based survey within this expert model of knowledge and community-based participation? During the debriefing meeting, the Red Cross federation representative asked the social workers to negotiate needs with the community, especially needs like having a stable clinic in their village or a playground for the children. Since the Red Cross cannot afford

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to do these things, the needs should be at a simpler and more immediate level, something «they will be able to do on their own».

The call for the reformulation of community needs into a more executable, commensurable and affordable plan of action, as well as strategizing over which activity is more effective and brings more visible outcomes, contradicts CBHFA's call for community

participation at each step of the process. It also reinforces the state's lack of involvement in these regions, by allowing the community to demand small things rather than a playground or a clinic. The *same strategy* was also visible in the meeting with makhatir, when one of the latter asked for medication, services for the handicapped and a stable clinic, in response to Mona's question about the kind of needs they expect to find in the community. Mona replied by relocating the satisfaction of *these* needs to the state:

all these can be obtained through the mobile clinic. The role of the volunteer will be to ensure a kind of statistical census for these cases in the villages, as well as for the chronic diseases in each village. Then the mobile clinic will deliver medication to the village. The volunteer will also train people in how to deal with health, diseases and high temperature. This will compensate for the absence of a doctor and of a stable clinic. We need more steps to get to this, to get to one common and right level of awareness. We can then decrease the need for a stable clinic, and the need to build a clinic in each village is a program for the state and we all know the state.

Conclusion

Community-based programs claim to privilege community participation and local forms of knowledge over global scientific ones.³³ However, in marginalized regions, community-based participation ruptured the survival politics of relief and aid that defined the relationship between Hermel communities, the state and non-state institutions. Also, local knowledge of health and needswere always subverted by, and reformulated to fit into, a growing form of scientific and humanitarian professionalization and standardization of cost-effective interventions.

Social workers are becoming more and more

responsible for mediating these interventions as part of global humanitarian policy and intervention.³⁴ In recent years, global humanitarian organizations have depended more on private funding from states and aid donors and have been forced to produce more evidence-based data to support the efficiency of their programs in order to acquire funding.³⁵ These tasks of evaluation are falling on the shoulders of local social workers, along with the responsibility for implementing the actual humanitarian program. The workshop held to train the Red Cross workers on CBHFA contained not only an overview of the principles and purposes of the program, but also research skills like data collection, survey administration and analysis that the social workers were already quite familiar with. All these skills force scientific categories of health onto local knowledge produced from *learning by doing*. Eventually, the conditions of possibility for communal knowledge and needs become bounded by the same expert knowledge that community-based programs are attempting to localize.

Funding for the CBHFA was suspended a couple of years after it started as a program in 2009. The Lebanese social workers, however, found the community-based skills and knowledge they were trained in valuable for their work. They adopted it as an approach to marginalized communities whenever it was deemed useful and compatible. They rely on it today in their work with Syrian refugees in the Akkar region in northern Lebanon.

As this article shows, the double bind of community-based programs lies in the inability of the social workers to implement the premises on which these programs are based, and to give them «a local flavor», which ends up disempowering the marginalized community they serve. This article is

furthermore a contribution to broader empirical debates about the modest impact that community-based programs have achieved by recording how the premises of participation and knowledge behind CBHFA take form in practice in marginalized communities.

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