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Community Development Corporations and Public Participation: Lessons from a Case Study in the Arkansas Delta

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In this paper, I focus on the role of community development corporations (CDCs) in fostering public participation in the local political process. Using survey and interview data gathered from CDCs operating in the Mississippi Delta region of Arkansas, I show that the CDC is an important intermediary between the citizens and the local political arena. While, according to this study's findings, the CDCs' long-term goal is to develop a lasting sense of efficacy among CDC participants, leading to direct political participation by citizens, the nature of CDC funding does not fully support these efforts. As a result, these critical activities remain at the fringes of their official mission. By focusing on short-term outcomes rather than long-term development process, the money spent to improve the CDC constituency's capacity appears to miss its target. The results of the current study 1) shed light on the disconnect between the needs of CDCs and the objectives of funding agencies; and 2) help community practitioners interested in community development to better understand challenges related to engaging citizens in local issues and facilitating citizen participation in ways that enhance collective efficacy in poor communities.

Keywords: *citizen participation, community development corporations, efficacy, community development, collective efficacy, poor communities*

Community-based development organizations (CBDOs) play an important role in economic and community development efforts across the United States (Vidal, 1992). The primary CBDO responsible for identifying and addressing several important community development needs of people in poverty (e.g., access to affordable housing, credit counseling, social services) is the nonprofit community development corporation (CDC) (Silverman, 2001; Green & Haines, 2002; Steinbach, 2003).

According to Steinbach (2003), the community development corporation has become the primary mechanism responsible for development efforts in distressed communities. Created in the 1960s with the goal of giving voice and representation to people and communities left behind, these grassroots organizations stress, among other things, responsive and representative local action, partnerships among public and private sectors, and flexibility (Steinbach, 2003). (For a fuller description and history of the CDC, see Stoutland (1999) and Steinbach (2003).) In theory and in practice, CDCs have become the vehicle by which self-help efforts are attempted in rural areas (Stoecker, 1996). Given their role, the CDC's ability to place relevant issues before local decision-making bodies is essential.

Most practitioners and researchers agree that citizen involvement is necessary to generating true representative and responsive community and economic development policies (Sullivan, 2004; Daley & Marsiglia, 2001; Gaunt, 1998; Rothman, 1979). Understanding how to increase citizens' access to local government is critical to assuring that issues faced by its most fragile constituency are in fact addressed. Equally important is to examine the nature of public participation in CDCs, as such participation can occur at different levels, ranging from informational and review, to interactive (Gaunt, 1998). By encouraging different levels of citizen participation, the CDCs create different opportunities for capacity building, hence, citizen participation in the local political process.

Yet, despite the important role CDCs play in local capacity building, on the one hand, and facilitating public participation

in local government, on the other, there has been a dearth of studies assessing the level of participation they encourage or their organizational efficacy. Moreover, little is known regarding the extent to which the CDCs balance the need to empower their citizen base with fulfilling project objectives as determined through external funding entities.

In this article, I draw on my study of CDCs operating in several Arkansas Delta communities to explore the following issues: (1) With regard to current efforts and future directions, what level of participation (information sharing, review, and/or interaction) is the public involved in?; (2) How does a CDC effectively participate in the local political process?; and (3) How can (and should) a CDC promote citizen involvement and to what result? (Those states included in the Mississippi Delta Region are: Mississippi, Louisiana, Kentucky, Tennessee, Missouri, Illinois, and Arkansas. See *The Delta Vision, Delta Voices: Mississippi Delta Beyond 2000* available at <http://ntl.bts.gov/data/DeltaVision-Voices.PDF>.)

Defining Public Participation

Public participation in its most elementary form is defined through and by collective action. Local participation can be described as “empowering people to mobilize their own capacities, be social actors rather than passive subjects, manage the resources, make decisions, and control the activities that affect their lives” (World Wildlife Foundation, 1993, p. 13). While ranging in levels from minimal to intensive, public participation, and its effectiveness, depend upon the relationship between the public and the institutions of governance and service delivery.

In its purest form, democracy demands a level of public participation in all governmental decision making. Whether through elected officials in Washington, D.C. or at the city council meetings, public policies arise from information sharing, discussion, alternative development, and evaluation (Gaunt, 1998). Of course, levels of public involvement in policy making vary across various governmental and non-governmental bodies. For instance, in Gaunt’s (1998) study, and later in Sullivan’s (2004), participation is presented in three varying

degrees or types beginning with the least participatory level, as shown in Table 1.

Table 1: Types of Public Participation*

Type of Participation	Definition/Characteristics
Informational	The public receives information regarding impending meetings or projects and is provided with the information regarding the amount of resources allocated to each.
Review	The public receives information and is asked to comment on project specifics.
Interactive	Stakeholders participate in joint analysis, leading to action, formation of new local groups or strengthening of existing ones; stakeholders take control over local decisions, giving them both an incentive in maintaining structures or practices and an investment in the outcomes.

*Definitions come from Gaunt (1998) and Sullivan (2004).

The informational participation type functions as an information dissemination point only. However, Sullivan (2004) posits that it may lead to increased citizen input later. That is, as information is shared and citizen input encouraged, each interaction should result in increasing levels of input.

Under the second participation type, review, the citizens voice their concerns, interests, and opinions regarding project specifics and community needs. With the diversity of commentary, much of the input may be different from the ideas of project developers and government interests (Daley & Marsiglia, 2004). Still, this level does not concede any share in project decisions nor require project developers or government officials to consider citizen input.

While the two previous types treat citizens as consumers, the third and final participation type assumes that the community's well-being depends, to a large extent, on its ability to participate in decision-making processes and defining needed

resources and services. Given the CDC's goal of giving voice and representation to its constituency, as well as engaging in the long-term capacity building, the interactive participation type would be optimal in order to meet this goal as well as encourage civic participation.

Public Participation and the CDC

In his influential work, Green (2003) examined how civic participation and organizational networking activities of local governments influenced the success of economic development efforts in several non-metropolitan areas in the United States. Green (2003) found that the organizational networks of local governments consistently influence economic development (measured as job growth) while public participation (number of participants and average attendance at public, economic development meetings) had little to no effect. Green (2003) attributed this influence to increased levels of information and resources available in the organizational networks and posits that these "findings do refute the claim that public participation *per se* will improve economic development efforts" (p. 13).

Green's (2003) findings should not be construed to suggest that public participation is wholly ineffectual. Rather they lend support for the social capital argument that civic participation in the form of broader social ties and organizational networks may have a much more influential role in development efforts than participation *per se*. In fact, numerous studies of public participation and successful development efforts note how social capital is generated in self-help housing projects (Kellogg, 2001), tourism industry development (Beaulieu, 2002), and downtown revitalization efforts (Glasser & Yavuz, 2003). Besides public participation, the commonality among these particular development efforts is the work of non-profit community-based organizations. Glasser and Yavuz (2003) hold that, ideally, community members find their voice through their government and institutions, including CDCs.

Most researchers and practitioners agree that, without public participation, development projects will tend to focus almost exclusively on growth as determined by business

leaders' interests without more than a backward glance at the remaining public and any mention of equality in distribution of resources (Sharp & Flora, 1999; Gittel & Vidal, 1998; Gaventa, 1982). However, knowledge is limited regarding the public's levels of participation in truly impoverished areas. Also, while Gaunt's (1998) typology stresses the importance of interactive participation, he seems to conceptualize it more in terms of an outcome than a process, glossing over the process of capacity building as necessary for this level of participation to occur. In the present study, I attempt to fill the gap regarding empirical knowledge of the levels of participation. In doing so, I build on Gaunt's (1998) typology, with the main difference being that I conceptualize the interactive participation as a process. First, I discuss the methodology of my study.

Methodology

My analysis is based on several data sources. First, I conducted a survey of CDCs operating in the Arkansas Delta. Because "starts and stops" are a common feature of the CDC model (Stoecker, 1997), one of the challenges to collecting information was finding a comprehensive list of CDCs. To ensure that I reached as many as possible, I consulted several published lists of CDCs operating in the study area. In the late summer and early fall of 2003, I distributed a survey to nineteen CDCs. The survey was composed of seven questions regarding organizational composition, programs, and public participation levels. I mailed a replacement survey (and phoned or faxed several others) two weeks later to those not responding to the first mailing. Out of the nineteen surveys sent out, nine completed surveys were returned by CDC directors. However, it is not clear what the actual response rate was, as eight of the remaining mailed surveys were returned unopened and upon further inquiry, their operations and essentially, their existence remains unknown.

Second, between the fall of 2003 and continuing through spring 2004, I conducted interviews with directors of three CDCs. I chose these CDCs based on both their geographic locations and resource limitations. Specifically, the three CDCs serve residents in the five southern-most Delta counties

bordering the Mississippi River. As such, these counties contain the most impoverished areas of Arkansas. Interview questions were designed to allow a descriptive analysis of the following: organizational history, structure, operations, socio-economic factors relative to CDC director, staff, and target area, factors enhancing or impeding organizational projects and programs, factors encouraging or discouraging public participation in grassroots projects, the role the CDC director, staff, and public play in the local governmental decision-making process as well as the level of public participation in CDC membership and projects.

Finally, I also collected relevant meeting notes or minutes (i.e., CDC, city council, planning commission) as well as CDC organizational documentation (i.e., mission, project descriptions, newsletters, and strategic plans). All of these documents provided insight into the process of, and participants in, community development efforts.

For the purpose at hand, I narrowly define “public” or “citizen” to refer to those area residents receiving services from the CDC and other area providers. Participation includes both direct (e.g., local governmental meeting attendance either in an individual capacity or as a CDC member) and indirect (CDC board member, employee or volunteer or attendance at CDC meetings and activities) components.

The Study Area, Target Population, and CDCs

The Arkansas Delta Region

Located along the flood plains of the Mississippi River, the Delta region geographically encompasses portions of seven states¹ including Arkansas. The flat lands and rich soils characterizing this region have produced times of boom and bust, depending on the cycles of agricultural production. As compared to the rest of the United States, where African-Americans account for 12% of the total population, the heart of the Mississippi Delta, composed of Arkansas, Louisiana, and Mississippi, has a relatively high proportion of African-Americans, comprising 20%, 34% and 47% of the populations of these states respectively. This region also remains one of the most rural and impoverished areas in the United States,

experiencing unprecedented population losses, while maintaining one of the widest economic gaps between the very poor and the very rich (Lyson, 1988; Gray 1992; Summers, 1995; US Census 2000; HAC, 2002). Accordingly, many in this region remain dependent upon grassroots activities and non-profit organizations for a variety of their needs.

Target Population

Of those receiving CDC services, the typical family includes a single African-American mother bringing home an annual income of \$8,399. The official unemployment rate in her community (population of 19,214) is just under 18 percent and the number of individuals living below the poverty level is slightly higher than 40 percent. These socio-economic conditions are fairly representative of other Arkansas Delta communities (US Census Bureau, 2000). From one director interviewed, we get a picture of life in her largely African-American, Arkansas Delta community:

We don't have a choice in schools. Many don't get a high school diploma and those that do, can't fill out a *Sonic* [restaurant] application. We don't have a choice in jobs. You know we lost that uniform [clothing manufacturing] plant and the 45 jobs that went with it. There's no severance package, no health insurance, no childcare package in these jobs but they jobs and we need them. People don't understand what it's like here. In the Delta, you got educated farmers or uneducated, unemployed people; there are no in-betweens. Those who could get out have gone; the rest of us are just trying to do the most with what we got.

To place the aforementioned quote in its proper context it is important to consider that with a largely absent middle class, many rural areas in the deep South are commonly referred to as two-class societies, with one class of large corporate farms and plantations, and another class comprised of a large poor black population (Smith, 1969; Cobb, 1992; Dill & Williams, 1992; Hyland & Timberlake, 1993; Duncan, 1996, 1999). Similar to other communities in the region (Wilkinson, 1988; Duncan, 1996, 1999), the highly stratified communities in the Arkansas

Delta and their economies have long been dependent upon a single industry with the elite socially and physically segregated from the poor. In this type of social structure, the poor are isolated from "...contacts to obtain legitimate work, and cannot relate to potential role models in other classes because they are segregated from them ... and they do not gain the cultural skills necessary to participate successfully in the economy and civil society" (Duncan, 1996, p. 114).

CDC Characteristics

In this section, I summarize the study CDCs from both survey and interview data. These CDCs primarily provide housing services to a rural, low-income, predominately African-American, female constituency and have African-American female directors with some post-secondary education (social sciences or business). These CDCs also provide such capacity-building services as credit counseling, homeownership counseling, GED classes, parental training classes, and job training. Importantly, more than 50% of these vital services are not funded by CDC funds.

Despite the devolution of community development responsibilities to the state level, the federal government remains a primary funding source for these institutions. Specifically, a majority of the study organizations are funded by grants through such federal agencies as U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture. Given the unstable nature of federal funds, most organizations expressed a need for developing programs (e.g., property management) which will generate funding sufficient to keep the organization in operation. One CDC has developed such a profitable network of transitional and permanent housing program that a separate organization now manages it. In general, the remaining funding comes from multiple private sources, including nation-wide foundations, such as Ford Foundation and Kellogg Foundation, as well as local philanthropic organizations, such as the Don W. Reynolds Foundation, the Arkansas Community Foundation, and the Winthrop Rockefeller Foundation. These foundations have various agendas with different emphases including improving race relations, child care options, and educational

opportunities.

The overall budgets of the study CDCs range from \$80,000 to \$390,000. In terms of expenditures, most of the available funding is earmarked to support the day-to-day operations of the CDCs, including staff salaries and specific programs. Importantly, given the ubiquitous budget cuts, the CDCs experienced a great degree of instability with regard to their ability to support their staff. In fact, an ever-decreasing CDC staff is always a concern among all, but one of the CDC directors: “[w]e end up doing a lot of different jobs because we [have no] money to hire qualified staff (Interview transcript).” In this context, the unpredictability of securing a certain level of basic financial resources has an effect on the CDCs long-term ability to engage in capacity-building. And, as I discuss later, one of the main venues of capacity building in these impoverished communities is through employment opportunities in the CDC.

With the exception of one CDC, which has been in place for 22 years and has more than 20 staff members, these CDCs have been in operation for a relatively short period of time (one to seven years) and are very lean in staff members (two to seven). In addition, most of these CDCs have recently suffered staffing cuts as a result of drastic budget declines. In this context, all directors expressed the need for increased staffing levels necessary to, among other things, maintain fiscal responsibilities as well as seek out additional grant sources.

While one of the study organizations is led by a white-woman, the remaining CDCs are led by African-American women. Also, 89% of staff members are African-American women. Yet, only about 25% of the board of director seats are held by African-American women, with all of the study CDCs having a largely African-American male board of directors. For the most part, these CDCs maintain good or productive relationships with their largely white male government representatives (relative to CDC activities, these representatives would be the mayor, city council and planning commission members). Finally, the staff (and in most cases, the director as well) are all members of the public receiving CDC services.

Findings and Lessons Learned

The CDCs and Public Participation

Overall, findings from the surveys and interviews indicate that the public participates in CDC operations and meetings, but not in local government meetings. Examples of CDC activities in which the public participates are: project and program development; daycare; internet training and access; and general office work. Generally, this participation involves attendance at the monthly CDC meetings where lunch (or breakfast) is served, and project and programs (on-going and/or potential) are discussed. According to all respondents, the public participation in these monthly meetings does not go beyond the public receiving information regarding impending projects and being provided with the information regarding the amount of resources allocated to each. Using Gaunt's (1998) typology, participation in these meetings is limited to the informational level. According to all respondents, this outcome is not due to the fact that the public is not being asked for input into policy making. Instead, as one of the directors I interviewed suggested, it appears that the lack of a more involved participation can be explained by citizens feeling intimidated to provide feedback in front of the largely white local authorities in the "formal" setting of a public meeting. In fact, one study director states that the most productive constituency input (review level of participation) occurs in one of the more informal community settings:

You go to the grocery store, and you know, they see you in your sweats, in your tennis shoes and you become one of them and that's when they open up and talk to you. My best conversations happen there...everything from church, bills, and school to our programs and board members. They will talk to you about anything, maybe even come up to the office, but not without the initial conversation. Yeah, we cover a lot of ground in the grocery store.

As for project or program development, all directors state that a typical meeting would involve a member of the staff describing the area of need, proposing several project or program

ideas, disclosing the funding available or needed, and requesting feedback or input from the attendees. Placing this within the context of Gaunt's (1998) typology, study CDC directors promote the informational and review levels, but rarely experience public participation at the optimal level—the interactive. According to one director interviewed, one or two members of the public “always have something to say, and sometimes it may even be helpful. But we’re always trying to get more people involved in our decisions, especially the young ones. We need someone to care about the CDC after we’re gone.” It is apparent from this quote that public participation is also important to the CDC’s survival by increasing its assets.

According to both my surveys and interviews, without exception, citizens are involved in local government meetings and activities only indirectly through the CDC directors or other representatives. Examples of such local government meetings include city council and planning commission meetings with each occurring monthly. With one exception, all directors responded that they worked well with local government officials and that they regularly attended both city council and planning commission meetings. (One director stated that local government officials were “hurdles” to her most recent housing project. When asked to elaborate, the director responded that her organization was not alone in its problems with the mayor and city council regarding decisions relative to collaborative projects.)

However, CDC directors also stated that their project development relies more on decisions of federal and private funding sources than those of the local government or community. One interviewed director stated, “I have a great relationship with the city council and the mayor—he is the main reason we are here—but we are a community organization and we answer to people out in the community and the funders. The mayor *has* a house.” Echoing the comments of other directors, she stated that, in addition to meeting the funding source agendas, CDC programs are designed to foster citizen participation in CDC activities and the local economy as a way to encourage and model civic engagement in local government activities—another goal typically beyond the short-term objectives of funding sources.

This level of citizen engagement takes time, patience and possibly, a new, more realistic view of development efforts relative to funding options. That is, according to the surveys and interviews, CDC funding opportunities are typically tied to short-term, quantitative and economics-related project outcomes such as housing starts or increased employment opportunities. Although these project outcomes are obviously important, there are two important issues that need to be considered. First, the funding agencies' outcome measurements attached to specific grants must be attuned to the unique character of impoverished communities these grants serve. Second, and related to the first point, is the recognition that the long-term, qualitative aspects of the work that CDCs are involved in need funding as well.

Specifically, all interviewed directors stated that appropriate funding decisions—and by extension, the very survival of their organizations—depend upon two interrelated issues: (1) an accurate understanding of the Delta condition and (2) a long-term vision in the creation of remedial development policy alternatives. One director stated that her CDC efforts would become more effective with an increased understanding of:

[o]ur Delta history and the fact that poverty [and its effects] didn't happen overnight and it won't disappear overnight. We have to get the [federal] government, our funders, and our own community to understand that development takes time and that a small change here will make a big difference down the road. Educating our community is important 'cause these people are not only the ones we take care of, they are us [CDC employees]. And because of the conditions here and our history, we sometimes have to start from scratch with things like credit counseling, teaching the value of owning your own home, building your education and skills training. We are talking about people coming from multiple generations of poverty and government assistance...they don't know anything else...all of this takes money, skills, and patience. It's hard to get people to understand that.

Despite the general lack of funding for the aforementioned capacity-building activities, each CDC continues to provide these services as “spillover effects.” [Stoutland (1999), defines spillover effects as those that “occur when one program (or a combination of programs) is carried out in such a way that beneficial effects that are not the program’s primary goal occur as a result” (p. 227).] Given that the CDC’s constituency is the pool from which these CDCs arise (and vice versa), the continuation of these services is critical.

More than spillover effects, these capacity-building programs would not only continue to bring the public into the CDC organization, but also could result in Gaunt’s (1998) interactive participation level—the optimal participation—in local government activities, and the local and state economy. Such programs also go a long way towards “mending fences”:

You know we don’t have jobs here. But we are the number two employer here behind the school district. We get people from the community to work here. But before we can put them on a project, we usually have to build them up. Remember most of these people lived on government assistance their whole life and they don’t need to talk to government people here and that probably suits most people just fine. But that’s not fine with us. We can’t produce the project numbers we need to keep our funding until we build our people up. Once we build the person up, they work here in our organization. Then you see their shoulders raise a little, they maybe even show up at a city meeting, maybe even bring someone with them. That is even better, cause then it’s not just me talking [laughter]. With every little job done, no matter how big or small, you watch the person change and you know it will have an impact later on for everyone to see. It just makes good sense. Don’t we as a community have a better chance at prospering if everybody’s working?

What this quote articulates is that, while housing programs, daycare programs, and youth activities may contribute to capacity building efforts, they are possible only after foundational or basic skills training has occurred. That is, given the socio-economic context in which these CDCs operate, the beginning layer of capacity-building efforts have to be quite basic,

meaning they should include the most fundamental skills, such as parenting skills and budget planning. These initial capacity building efforts allow local community members to acquire new skills and a corresponding confidence in their ability to make decisions and acquire additional skills and access related to housing, employment, health care just to name a few. In addition, as part of a more holistic approach, the CDCs directors emphasize how crucial it is that their organizations can continually support their staff, creating a pool of informed community members, activists, and future leaders—long term or sustained civic engagement.

The reality that funders almost exclusively support short-term economic rather than the long-term, capacity-building efforts described in this study is not news to scholars or practitioners (e.g., Stoutland, 1999; Silverman, 2001; Steinbach, 2003). However, the reasoning behind this funding trend seems misguided to the CDC directors. In fact, implicit in the remarks of the three directors interviewed is the belief that an increase in capacity would be equal to a dramatic increase in organizational performance. The three interviewed CDCs have plans much larger than their budgets. And every organization (surveyed and interviewed) is all too familiar with the quandary involved in the need to produce programmatic results for continued financial support despite varying capacity levels and budget cuts. Although these organizations are effectively providing affordable housing in their communities, one can only imagine the additional output—to say nothing of the issue of organizational sustainability—which would be generated from these capacity-building endeavors.

Lessons Learned: How does a CDC encourage participation in its activities?

My study indicates that the public as well as the CDC employees participate in CDC projects. The public receives CDC services, attends CDC meetings, and interacts with the directors. For example, all of the CDC directors interviewed stated that their organizations provide the only internet access points available to the public. In addition, daycare facilities, credit counseling and GED classes, all rarities in this region, are provided and utilized by the CDCs and their constituencies. Because the study CDCs are located and operate in very small

communities, interactions between CDC staff and the public they serve can occur at the local post office, bank, or grocery store. One director stated that her best project ideas come from her conversations with several community members at a local store: "...people will talk your ear off at the *Dollar General* and won't say a word at our meetings. Mostly, I think they come for the food and maybe to check on what we're doing."

In the study CDCs, public participation opportunities occur as the result of a conscious and persistent effort on the part of CDC directors to encourage it. First, the CDCs identify small projects where they can demonstrate success to each community. That is, by creating projects that yield significant and immediate results, the CDC gains the necessary level of legitimacy to facilitate public interest and participation (e.g., credit counseling, GED classes, and tax workshops). Second, in recognition of several barriers to public participation, the CDCs attempt to overcome these barriers by providing information regarding upcoming meetings, transportation, and child-care options. Third, the CDCs use a combination of public hearings, open door policy, and community training with clearly stated outcomes so that each CDC is seen as accomplishing something tangible. For example, after announcing a free tax workshop designed to help community members prepare and file their taxes (at a city council meeting and later at its monthly meeting), the CDC provided transportation, childcare and food in addition to the technical expertise necessary to perform this yearly task.

The CDC directors involved in this study (surveyed and interviewed) agree that the CDC's influence would be greatly increased by informed public participation and a more realistic, long-term vision regarding project outcomes. Specifically, public participation within the CDC appears to be at the informational and review levels, the consumer-oriented levels as opposed to the interactive, or decision making-oriented level. That is, while the funders support, or are willing to support, several short-term projects mentioned above (e.g. housing starts), the most fundamental and basic efforts (e.g., budgeting skills) that actually enable the capacity- and trust-building efforts necessary to increase public participation are not typically supported by funders. Directors agree that the CDC's

mission, thus its public's well-being, depends upon its ability to create participation in decision-making processes and defining needed resources and services. So the question becomes: What is needed to move public participation in the study communities to the interactive level?

The most common interview response was the dire need for more foundations to support both the basic programs that enable the capacity-building efforts as well as the long-term capacity-building efforts. Through this support, more people and organizations would realize the importance of these efforts and understand that by increasing the capacity, we increase the dialogue and potential for uncovering needs and potential solutions.

Another interview response, directly related to the first, is the need to develop process-oriented measurements for capacity-building efforts. Foundations have traditionally focused almost exclusively on economic development defined in terms of increasing the economic assets and/or wealth in communities. One reason for this is because these types of development are easily visible and easy to measure (e.g. three houses, two businesses, and two organizations). Missing from this calculus are the capacity levels (both individual and community) necessary to support these economic development activities. All of the interviewed directors took me through a similar scenario. For example, when one person gets a GED (human capacity building), completes a credit counseling class (human capacity building), an internet training class (human capacity building), a homeownership counseling class (human/economic capacity building), purchases a home (economic development and economic capacity), and begins attending public hearings dealing with the proposed developments in area surrounding his/her property (civic capacity), this process counts only "one" house (economic development) and, in some cases, it also counts as a tax payer (economic development). According to interview responses, what funding agencies are typically not interested in are the other aspects of what has occurred here, including (1) the stages of capacity-building that led to the tangible economic outcomes; and (2) the possible non-economic by-products of the process, such as the addition of a new more educated, and civically engaged, community citizen. From the

data, it appears that there are foundational capacity building efforts and long-term results not currently included in most funding agency priorities. By changing from an *outcome* to *process*-based measurements, all levels of capacity building efforts (initial, traditional, and long-term) will be included in the development calculus.

The hardest part about this adjustment may be that in addition to requiring the implementation of new measurements it should also involve a requisite change to a long-term vision and commitment. Based on my study, it appears that only with a long-term support and commitment to the development process, public participation in the organization, as well as the local political process, is likely to increase. This is so, because, regardless of the type, development is a process as opposed to a strategy, program, or outcome. As a process, development, whether community or economic, involves social skills, participation, goals, energy, momentum, power, people, and organizations to accomplish both the process and the desired outcomes.

This study's findings also have implications for Gaunt's conceptualization of the participation levels. As I noted earlier, it appears that Gaunt's (1998) interactive level of participation is conceptualized more as an outcome than a process. Yet, as this study suggests, interactive participation should be conceptualized as both the process and the outcome of capacity-building. That is, we need to recognize the importance of the capacity-building process to creating the interactive-participation as an outcome, as well as the importance of interactive-participation process for capacity-building efforts.

Lessons Learned: How does a CDC, operating in disadvantaged communities, participate in the local political process?

It is important for citizens to participate in local political processes, but the long-term disadvantaged rarely do more than gain information and often, they do not even do that (Rubin, 2000; Gittell & Vidal, 1998; Stoecker, 1997; Gaventa, 1982). Based on the study data (both surveys and interviews), the CDC's constituency does not participate in the local political process, except through the CDC. At the same time, however, its participation in the CDC occurs mostly at the

informational and, sometimes, the review participatory levels. Thus, in impoverished communities, the CDCs often participate on behalf of their constituencies, but their constituencies do not participate in joint analyses of the issues, or in forming new programs needed to meet the local needs.

From the perspective of the interviewed CDC directors, developing true citizens of their communities requires four steps: (1) The CDC participates in the local political process on behalf of their constituencies; (2) Citizens participate in CDC activities, which builds individual capacity; (3) CDCs build community capacity via its programs, which often time involve citizens as messengers and the target audience, and (4) Capacity building eventually leads to increased participation in local politics.

What appears to be missing in the accounts of all (surveyed and interviewed) of the CDC directors is the recognition that if members of the constituency do not participate in the CDCs at the interactional level, how can one expect the same people to participate at that level in the local government? Given this, the findings of my study suggest that what may be needed is a two-step process.

First, the CDCs must be able to create context-specific strategies to promote interactive level of citizen participation in its own activities. Importantly, given the information received from the (surveyed and interviewed) CDC directors involved in this study, this cannot be accomplished by the CDCs themselves; it also requires a change in the accounting practices of funding agencies. As I suggested earlier, this would require the funding agencies to create different approach to measuring both the intermediate stages as well as the overall outcomes of grant activities. Second, to accomplish their true mission, the CDCs must be able to assure that the capacities their constituents have developed in the context of their involvement in CDCs get translated into their direct, and, ideally, interactive participation in the broader political arena.

But, as I emphasized throughout, the CDC's power (thus its voice) comes from its funding. As a result of having access to external funding, the CDC becomes an important player in its own right in the local economy and therefore, the local political arena. For example, one of the CDCs I interviewed is

the largest source of jobs in its county. This situation creates a critical contradiction wherein the CDC is at the same time trying to serve the needs of their community-based constituency and meet the goals of its funding contracts, which are narrow and focused. This conflict can have an impact on citizen participation levels if the CDC is viewed as serving external funding agendas outside of the community. On the other hand, if the funding agencies are not convinced that the CDC's constituency needs are aligned with their funding priorities, they may withdraw the funding, ending CDC operations, and by extension, public participation levels will cease. Accordingly, the CDC directors must perform a careful balancing act in order to meet community needs through the organization's projects and programs, while addressing the requirements of external agents.

As I have discussed previously, from the perspective of the funding agency, progress is typically measured by short-term, easily visible, economic indicators—for example, new housing starts within a two-year period. Yet, if members of disadvantaged communities are ever to participate directly in the political arena, then capacity building must involve developing their sense of individual efficacy – first by getting jobs and maintaining them, then by owning homes and not losing them, and ultimately, perhaps over generations, by developing the self concept of a community citizen. That is, in order for a particular disadvantaged community to participate in the local government process (working with governmental agencies and officials to access resources), the community members must first be empowered to understand and define their needs. This is a necessary first step before the interactive participation level can be achieved and institutionalized. All study directors believe in the importance of the interactive participatory level, and continue to provide social development projects and programs, despite the fact that they are never fully funded.

How can funders increase the impact of their dollars? Without exception, the study CDC directors (survey and interview responses) stated that an increase in funding for social development activities would equal a substantial increase in public participation and therefore, feasible project development and outcomes. In essence, funders need to broaden their

agendas and commitment such that they support (1) broadly defined basic capacity-building, process-oriented projects; and, at the same time, (2) engage in long-term development efforts necessary in areas like the Arkansas Delta.

For example, in order to achieve the optimal interactive participation level, a funder could make sure that a CDC receives funding for a community based project or program that includes and rewards the community members for participation in all stages. This means that the community members would be involved in, and reimbursed for, analyzing problems, defining needs, developing strategies to address these needs, and implementing these strategies. Importantly, it would also mean being sensitive that, in certain communities, in addition to a monetary reward, the community members would have to be provided with other necessities as they relate to public meeting attendance: childcare, transportation, and translation services. From this perspective, the goal is to achieve the interactive participation level such that *communities* control their assets, whether through non-profit and/or government organizations and agencies, to the extent feasible.

Lessons Learned: How can (and how should) a CDC promote public involvement and to what result?

Research suggests that if a bureaucracy is broadly representative of the public it serves, then it is more likely to make decisions that benefit that public (Thieleman & Stewart 1996). Moreover, researchers have shown that minority access to positions in the bureaucracy results in policies beneficial to that minority constituency (Seldon et al., 1998; Meier, 1993; Hinderer, 1993a; 1993b; Meier & Stewart, 1991). And, according to the CDCs' mission statements, they must retain ties to the community they serve. This objective is accomplished through both the CDC membership and programs each offers. Thus, as my study suggests, capacity building and public participation are critical to CDCs survival. In this context, the question emerges as to whether a CDC can be financially and technically supported while effectively retaining the ties to the population it represents.

According to my findings as well as other similar research (Silverman, 2001; Thelman & Stewart, 1996; Vidal, 1992), to

be effective, the CDC must build its human resources within its organization through both in-house and outside training. Importantly, all directors interviewed agree that providing this training is difficult as it is both time consuming and usually falls outside the priorities of most funding sources. Despite this, these CDCs continue to provide these services in order to build individual and organizational capacity. The CDCs see themselves as not repairing the Delta condition of market failure and private disinvestment, but rather, as part of a long-term strategy to remake their communities. By providing many years of a variety of services, the CDC directors believe that they can show that their communities have changed for the better.

Finally, based on my findings (survey and interview data), it appears that when CDCs operate in impoverished communities, especially those characterized by a polarized racial-structure, they may benefit from capitalizing on the informal interactions occurring between the CDC directors and staff and community members. This insight may be of central importance to practitioners interested in community-development issues who are looking for alternative ways to engage citizens in local issues by effectively facilitating citizen input into the policy-making process.

Towards An Alternative Approach to Performance Measurement

My findings show that CDC directors, both those surveyed and interviewed, unanimously believe that funding priorities are based on short-term, easily-visible project outcomes almost to the exclusion of the process involved. Specifically, all directors stated that although project outcomes are necessary to maintain public interest and participation in CDC activities, the process (techniques used to gather public input and produce project/programmatic outcomes) must be meaningful, that is must be sensitive to the social context in which these CDCs operate. In addition, identifying and measuring programmatic effects is troublesome and the subject of much disagreement. When both process and success are to be measured, in addition to using economic criteria (typically measuring

short-term generation of tangible economic assets), a set of measures assessing the social dimensions of the process, how the input is sought and how it is most likely to occur, and the social outcomes of CDC activities is also needed. Also, given the importance of capacity building to increasing the levels of participation, it is crucial to assess the different processes of capacity building, such as involving the stakeholders in the day-to-day operation of CDCs as their staff or through program participation, at both individual and organizational (CDC) levels as well as their outcomes.

In his study of Appalachian poor, Gaventa (1996) describes the disconnect between traditional, quantifiable measures and the level and range of activities that the CDCs engage in as follows:

Community-based initiatives increasingly emphasize development within, using local knowledge and capacity, in comprehensive fashion. On the other hand, traditional evaluation approaches, often based on models of positivist research, emphasize the necessity of external judgment, based on 'objective' standards and measures, usually conducted by experts schooled in narrow disciplines, not comprehensive approaches (p. 62).

This disconnect also exists in poor Arkansas communities, exacerbating the dilemma inherent in trying to address, through development programs, the systemic problems in Delta communities—a declining manufacturing sector, racial separation, escalating poverty levels, and declining populations. These problems, which are for the most part beyond the control of the citizens, fall on the shoulders of the CDC, the primary organization providing many necessary social services.

My findings suggest that a more realistic version of CDC effectiveness would include a mix of traditional (e.g., housing production numbers, GED diplomas, employment) and non-traditional outcomes including the following:

- level of public participation in CDC activities
- comparison of CDC staffing and project outcomes throughout the length of the grant/funds

- community impacts ranging from increasing public participation in the political arena, child care quality and options available to residents, housing rehabilitation and decreases in criminal activity to removal of debris, planting of flowers and trees, and any other impacts which result in an increase in community assets through public engagement
- increase in social services and activities available to community members.

In addition, the CDC's overall effectiveness must be judged in the context of the city and community in which it operates as well as its political capital. To allocate funds based on standardized, quantifiable measures, regardless of the context in which the program operates, is economically unsound.

Through public participation efforts, CDCs typically represent (and advocate on behalf of) community members in the political arena. That is, CDCs must present community needs/issues such that they ascend to the appropriate political agenda (can be acted upon), lobby for potential remedial policy alternatives and support, and negotiate for funding and/or political support for CDC activities. Given the capacity-building efforts that are both necessary and on-going, this is the preferred protocol or process. Although the CDC directors stated that the primary stakeholders in their day-to-day operations are the CDC funding sources rather than government officials, each recognizes the importance of political support and participation and that these must be leveraged to increase funding.

Finally, a long-term organizational goal of all study CDCs is to increase citizen access to, and interaction within, the political process and arena. Although the CDCs have already created a model, even if imperfect, of civic involvement, the implementation of this model beyond CDCs is not easy task. Still, such civic engagement is essential in order to address the needs of Arkansas Delta communities. Many analysts (e.g., Glasser & Yavuz 2003; Gittel & Vidal, 1998; Gray, 1998) have pointed out the need for broad-based change in the social structure of disadvantaged communities, but this cannot be both the beginning and the ending of the analysis. The question remains as to *how* to bring about this change. From the study findings, we see

that any meaningful change in communities characterized by long-term poverty and inequality must begin with incremental development of the people themselves. The best—perhaps only—organizations which can accomplish this end are the community development corporations, but given the realities of their funding, their efforts remain at the fringes of their official mission. And by focusing on short- rather than long-term goals, the money spent to improve the CDC constituency falls short of its full potential.

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