Community Organizing and Community Building for Health and Welfare

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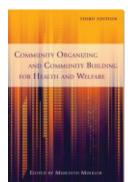
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Ethical Issues in Community Organizing and Capacity Building

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Fields such as public health and social work may be described as "an inescapably moral enterprise[s]," concerned as they are with determining what we as societies and communities ought to do to pursue the public's health and well-being (Petrini 2010; Dunn 1983). These, and related social change professions are governed by codes of ethics (for example, see National Association of Social Workers (2008) and the Coalition of National Health Education Organizations (2010) that serve as primarily prescriptive guidelines for appropriate conduct. Central to these codes are core values—social justice, empowerment, participation, wellness, self-determination, dignity, and respect.

Ethical dilemmas arise when these values come into conflict while solutions are sought to a given problem or an intervention is implemented (Harrington and Dolgoff 2008). Recognizing and resolving these dilemmas is an essential skill for practitioners, including community organizers, health educators, and capacity builders. And while there are numerous frameworks for ethical decision making, this process boils down to three essential elements: the means, the circumstances, and the ends being sought (Childress 2007). In this chapter, we present some common ethical dilemmas in community practice.

Community organizer Saul Alinsky asserted that "the ends justify the means," essentially putting a higher value on what is accomplished than on how it is accomplished (Alinsky 1972; see also chapter 4). This approach, however, presents ethical questions and also risks downplaying core values. With respect to the means, we argue that community determination and participation are critical. The active involvement of people, beginning with what they define as the needs and goals, results in communal ownership of the initiative, the development of competencies, and reduced vulnerability to outside manipulation. Because community involvement and capacity building are primary objectives, this "means" also distinguishes true community organizing from other approaches, such as consultation and outside expert–driven planning. The significant

emphasis in organizing on fostering community determination may at first suggest that the health or social work professional as organizer does not need to engage in extensive ethical reflection; after all, many of the processes in which he or she is already involved make increased freedom of choice for the community a central goal. Yet despite these lofty goals and guiding principles, the practice of community organization is, in reality, one of the most ethically problematic arenas in which health educators, social workers, urban planners, and other practitioners function.

A primary reason why community organization is fraught with ethical challenges has to do with the *circumstances* that inform the effort. Circumstances are essentially the political, economic, cultural, and social contexts of an organizing campaign or intervention. These circumstances can include the reasons that community mobilization is necessary in the first place. They also can refer to obstacles with which a community must contend in order to be successful. It is possible (even probable) that circumstances will conflict with one another, thus generating ethical conflicts. Social factors, such as strong community networks, that might support an organizing effort can be undermined by economic realities that result in competition for scarce resources. For example, two community-based organizations representing communities of color with shared interests (e.g., environmental justice or violence prevention) may find themselves in competition for the same source of funding. It is incumbent upon the practitioner to, first, be able to identify circumstances relevant to the community organizing campaign or initiative and, second, work with community members so that they develop analytical skills in understanding and responding to relevant circumstances.

All too often we find ourselves searching for answers to the ethical challenges we face in the hopes that by doing so, we can move ahead with plans and programs designed to help achieve an initiative's goals. But a resolution of these dilemmas may be less important than a continuing commitment to the process of articulating them, as well as the values and assumptions that inform our practice. In the interest of real community participation and empowerment, how do we facilitate dialogue rather than direct it? How do we tease apart our own agenda from that of the community? And what happens when there are multiple, and often conflicting, community agendas? These are just a few of the questions we face, and whether and how we think about them will have critical implications for our work.

This chapter explores six areas in which health educators, social workers, and other practitioners frequently experience tough ethical dilemmas in relation to the community organizing and community building aspects of their roles. These areas are (1) the eliciting of real, rather than symbolic, participation; (2) the challenges of conflicting priorities; (3) the dilemmas posed by funding sources and regulatory organizations; (4) the perils of cultural conflict, including challenging the -*isms* (racism, sexism, etc.); (5) the unanticipated consequences of organizing; and (6) the matter of whose "common good" is being addressed through the

organizing effort. Case examples are used to illustrate factors that contribute to, as well as possible resolution strategies for, community ethical dilemmas.

Community Participation: Real or Symbolic?

Community participation has historically has been recognized as a central value in public health, social work, education, urban and regional planning, and other areas that emphasize, in part, organizing and capacity building (Corburn 2009; Green and Kreuter 1990; Reisch 2010a; Wallerstein 2006). In the 1970s, calls for "maximum feasible participation" coincided with the birth of the neighborhood health center movement (DeBuono et al. 2007). As noted in chapter 3, community or public participation, together with the concept of empowerment, emerged as the "defining feature" of both the health promotion movement (Robertson and Minkler 1994) and community capacity-building efforts in fields including public health, social work, community psychology, and urban and regional planning (Wallerstein 2006; Corburn 2009; Reisch 2010a, 2010b). Within such arenas, as McCloskey and her colleagues (2011, 13) note, "meaningful community participation extends beyond physical involvement to include generation of ideas, contribution to decision making, and sharing of responsibility."

Despite the increased rhetoric of participation, however, acting on calls for high-level community involvement has proved difficult indeed. As Gail Siler-Wells (1989) pointed out more than two decades ago, "Behind the euphemisms of participation and empowerment lay the realities of power, control and ownership" (142). And even as we attempt to blur hierarchical distinctions by talking in the health field, for example, about health care "providers" and "consumers" and calling for partnerships between health professionals and communities, these power imbalances remain (Minkler 1994).

In an early attempt to bring clarity to these issues of control and ownership, health planner Sherry Arnstein (1969) developed a "ladder of participation." The bottom rungs of the ladder were two forms of "nonparticipation"—therapy and manipulation. In the middle were several "degrees of tokenism"—placation, consultation, and informing—through which community members were heard and might have a voice but did not necessarily have their input heeded. Finally, the top rungs of the ladder were three degrees of "citizen power"—partnership, delegated power, and true citizen power. More recently, Morgan and Lifshay (2006; see also appendix 4) developed a "ladder of community participation" specifically related to local health departments and the communities they serve. Although acknowledging that in some circumstances, such as a sudden epidemic or other health emergency, the health department must "call the shots" on its own, the authors note that even in such circumstances, outcomes are more likely to be effective if these top-down directives are built on a high degree of authentic prior partnership and trust between the health department and the community (see appendix 4).

Yet authentic community participation and determination is easier said than done, and this gap between ideal and real is where ethical dilemmas reside. Although much contemporary practice in fields like health promotion uses the rhetoric of high-level community participation, it in fact tends to operate at the lower rungs of the participation ladder, as professionals "attempt to get people in the community to take ownership of a professionally defined health agenda" (Roberston and Minkler 1994). As R. Labonte (1990) cautioned over forty years ago, such an approach "raises the specter of using community resources primarily as free or cheaper forms of service delivery in which community participation is tokenistic at best and co-opted at worst" (7).

In other instances, the community's input may be sought and then discounted, further reinforcing unequal power relationships between practitioners and communities. The experience of some community advisory boards provides a good case in point. When taken seriously by professionals, community advisory boards (CABS) or committees can make a real difference in the ways in which health educators and other practitioners approach community-based programs and initiatives. As true partners in decision making, such boards can provide valuable input on community needs and strengths, the likely effectiveness of alternative organizing strategies, and the cultural nuances and sensitivities that need to be respected and addressed.

Increasingly, however, CABS are established in response to a funding mandate or similar inducement rather than out of a sincere concern for eliciting and acting on community input. In such instances, community boards often perceive that they are expected to serve as rubber-stamp mechanisms for decisions that the health professionals have already made.

Finally, even programs committed to community participation through advisory boards and the like may occasionally find themselves ignoring input that conflicts with predetermined projects and plans—sometimes at considerable cost. An unfortunate example of this occurred in what is in many respects a national model for effective health promotion on multiple levels—the California Tobacco Control Program (CTCP). We use this example to underscore that even the best programs can slip into paternalistic ways of doing things on occasion, with negative results.

The CTCP was created when a successful ballot initiative in 1992 put a twenty-five-cent tax on cigarettes and allocated a quarter of the money generated to anti-tobacco health education and advocacy. The program has been extremely successful and has been largely credited with the fact that the state's decline in cigarette smoking during the 1990s was three times the national average (California Tobacco Control Program 2010).

Part of the CTPC's early activity involved supporting groups such as the African American Tobacco Control Education Network (AATCEN), which addressed the heavy targeting of cigarette advertising to people of color and helped to mount a culturally sensitive counter advertising campaign. When professionals at the

CTCP first designed a proposed billboard aimed at the African American community, they showed it to the AATCEN's Advisory Group for its feedback. The billboard depicted a young African American man smoking a cigarette under the caption "Eric Jones just put a contract out on his family for $2.65. Secondhand smoke kills." Advisory Group members perceived the proposed ad as extremely racist, and they strongly urged that it not be used. Rather than heed the group's concerns, however, the CTCP did run the ad and received the same kind of negative reaction from community members.

The story behind that billboard is a sad and poignant reminder that it is not enough to "talk the talk" of community competence and community participation. We must indeed be willing to "walk the walk"—in this case, letting an advisory board composed of African American community members teach the rest of us how to avoid further stigmatizing of their community in the name of health promotion (Minkler 1994).

It is easy to see how only paying lip service to the concept of community participation can lead to a healthy suspicion on the part of communities and community groups regarding the agenda of the community organizer. Without a strong commitment to real community participation, we risk undermining our future efforts and dissipating the often fragile trust that communities invest in us. The credibility of the community organizer can be easily undermined when community group members sense that their participation is only symbolic, thus leading the community to question the commitment of the organizer and others to the community's real issues. Recognition of the importance of self-determination for communities, coupled with commitment to the concept of true partnership, must serve as guiding principles for ensuring meaningful community participation.

A useful tool in applying these guiding principles is offered by community organizers Herbert Rubin and Irene Rubin (1992, 77) in the form of the "DARE" criteria of empowerment:

Who *D*etermines the goals of the project?

Who *A*cts to achieve them?

Who *R*eceives the benefits of the actions?

Who *E*valuates the actions?

The more often we can answer these questions by responding, "The community," the more likely our partnerships and community organizing efforts are to be contributing to real community empowerment and high-level participation.

Conflicting Priorities

For health educators, social workers, and other professionals who find themselves simultaneously responsible to a health or social service agency employer, to the

communities being served by that agency, and to the funding sources supporting the particular project or program, a frequent dilemma faced is one of conflicting priorities. This is particularly so when the practitioner is charged with facilitating consumer participation in the agency and acting as an advocate for the community. From an agency perspective, for example, our role may be seen as helping people choose from a narrow range of options that fit within the organization or funder's predetermined goals. When agency agendas fail to correspond to the needs and desires of the community, the health educator or social worker faces difficult ethical dilemmas involving the degree to which she or he will feel comfortable complying with agency expectations and directives.

Two ethical precepts that lie at the heart of community organizing and community building—self-determination and justice—are helpful for thinking about and addressing such dilemmas. Both reflect an inherent faith in people's ability to accurately assess their strengths and needs and their right to act upon these insights in setting goals and determining strategies for achieving them.

In the language of health education and social work, these ethical precepts are reflected in Dorothy Nyswander's (1956) early admonition to "start where the people are." Yet this may be easier said then done. When an HIV/AIDS prevention program has as its goal the promotion of safer sex, in part through mobilization of a community around the prevention of HIV and other sexually transmitted infections, and when the community in question is more concerned about drug abuse or violence, should the health professional put on the back burner, for the time being, the agency's formal agenda and truly start where the people are? Within the bounds of certain limiting conditions to be discussed later, our response to this question is affirmative, since in choosing to start where the people are, the practitioner asserts a commitment to the principles of self-determination and liberty and the rights of individuals and communities to affirm and act on their own values.

Yet there is a practical rationale for starting where the people are as well. When this ethical principle has been followed, when trust in the community has been demonstrated, and when the immediate concerns of people have received primary attention, the organizer's original concerns frequently then are seen by the community's members as having relevance for their lives. Through careful listening, and the asking of thoughtful, probing questions, the organizer may learn how the issue she or he is concerned about is perceived by the local community, what the community's primary issues are, and whether bridges or links can be found between these seemingly disparate agendas.

An early experience of the Asian Pacific Environmental Network (APEN), based in Richmond, California, is illustrative. APEN (www.APEN.org) wanted to organize the local Laotian refugee community around the high levels of toxins to which it was being exposed through the estimated 350 industrial facilities in their county, including a large Chevron Oil refinery. Contamination of the fish on which many refugees were dependent for their livelihood, as well as the ground

in which they grew crops, were among the topics around which APEN hoped to organize (APEN 2002). Upon meeting and dialoging with the refugees, however, APEN staff learned that this community had far more pressing concerns, such as how to grow better vegetables to support their families. APEN's organizing agenda was consequently put aside while the organizers addressed the community's concerns, including the provision of tips on vegetable gardening. This show of genuine attention to the community's agenda increased APEN's credibility among the refugees, who then became interested in what APEN had to share about toxic exposures. Several refugees began mapping toxic waste sites in their community and in other ways setting the stage for organizing around environmental hazards in their neighborhood. The Laotian Organizing Project (LOP) began slowly in 1995 under the APEN umbrella, often taking "baby steps," such as getting residents to each bring five neighbors or friends to a meeting (Buckley and Walters 2005). After a major refinery spill in 1999, followed by two additional leaks, LOP began a campaign to demand that the county department of health services and the board of supervisors establish a multilanguage phone alert system so that Laotians and others with little or no English proficiency would get timely information on how to "shelter in place," and so on, when such problems occurred (Sze 2004). Their success in getting this system adopted by the county, their effective monitoring, and their subsequent work in environmental justice attracted national attention (Buckley and Walters 2005). Yet had the APEN organizers not initially been willing to begin with the refugees' priority—growing better crops—this impressive work on a shared organizing agenda would likely not have come to fruition.

Although we have focused thus far on the problem of conflicting priorities between "the community" and a practitioner's agency, tensions around conflicting priorities may also surface when there are multiple communities or community factions with different and often competing agendas. A community committed to AIDS prevention, for example, may be deeply torn over an effort to organize around getting a needle exchange program. A mixed-use residential community near the proposed site of a new "big box" store, such as Wal-Mart or Home Depot, may be divided between those residents wishing to organize against this perceived threat to local businesses and certain increase in traffic, and those who see the store as a source of needed employment. The social worker or other professional's efforts to organize in situations like this may generate more conflict and confrontation than consensus among community members (see chapter 11). In such instances, the importance of questioning whether to intervene, and if so on what level and with what ethical precepts, takes on added importance.

Dilemmas Posed by Funding Sources, Rules, and Regulations

Restrictions imposed on community-based organizations by funders and other key stakeholders are among the most frequently mentioned sources of ethical conflict (Hyde 2010). Practitioners report that the type of, and access to, programs

and activities can be severely limited by the rules of a resource provider or state regulatory agency. Organizers and other community-based practitioners must continually assess whether to engage in compliance at the risk of accessibility and innovation.

Particularly in times of several economic constraints, the realities of funding availability, and the nature and source of funding for organizing projects can severely limit the extent to which the principle of starting where the people are can be put into practice. Declining availability of both government and foundation funding, for example, sometimes has resulted in community-based organizations' and community coalitions' considering or accepting financial support from sources they may not previously have countenanced—sources that sometimes have invisible strings attached. Where a funding source may pose a direct real or perceived conflict of interest for an organization, such problems may intensify.

One of the best-known examples of this dilemma arose over twenty years ago when Mothers Against Drunk Driving (MADD) first accepted a sizable donation from Anheuser-Busch, the nation's largest beer manufacturer. Widely identified as "one of the most successful public health grassroots citizen advocacy organizations in the United States in the past century" (Fell and Voas 2006, 195), MADD is credited with substantially contributing to the dramatic drop in in alcohol-related traffic fatalities from thirty thousand at the time of its founding (1980) to under seventeen thousand in 2004 (Fell and Voas 2006). Yet when the organization accepted the beer company's $180,000 donation (making Anheuser-Busch its second-largest contributor), MADD's increasingly close affiliation with the alcohol industry was widely viewed as having compromised the organization's ability to take a strong stand on the liquor industry's role in the nation's alcohol problem (Marshall and Oleson 1994). In defense of MADD, Dejong and Russell (1995) pointed up the organization's leadership role in pushing for a national minimum drinking age and other policy changes opposed by the alcohol industry. Yet as these analysts also point out, MADD did not significantly strengthen its position on alcohol advertising until some years later—after it had cut its ties to an industry that, it belatedly concluded, "was truly not interested in solving problems due to the misuse of alcohol," despite its propaganda to the contrary (234).

Even when money comes without apparent strings, conflicts between an agency or group's values and those of a potential financial sponsor may raise difficult ethical questions. AIDS prevention organizations around the country, for example, have been offered substantial financial support from alcohol and tobacco companies to help underwrite AIDS walks, media campaigns, and other events. For health professionals aware of the harmful effects of tobacco and heavy drinking, and of the elevated rates of substance abuse in many marginalized communities, accepting such donations may seem morally and ethically untenable. Yet the community-based organizations or groups with which they work may either feel no conflict or agree with Saul Alinsky (1972) that in organizing, the ends

(in this case, getting support for a needed community event or campaign) justify the means.

To help avoid situations like these, some public health and social work professionals have begun working with "alternative sponsorship projects," which link health and social programs and organizing efforts with alternative corporate or other sources of financial assistance, in the process dealing a public relations blow to alcohol and tobacco companies. Still other organizers have helped community coalitions and programs to decide whether to accept funding from a controversial source by applying what has been called the "the publicity test of ethics." This simple test involves having a group ask itself whether its reputation or integrity would be damaged if the source of funding for a particular project became known.

Such strategies are important, but in a time of major fiscal retrenchment in health and social services and declining support for a whole host of worthy organizing endeavors, they do not begin to solve the problem of severe funding constraints. When the need is great, where should the line be drawn? And when community participation and empowerment are a value, who draws the line? In meetings with community members about a financial offer of assistance from a source that may pose ethical implications, practitioners not infrequently are confronted with the reaction "We need the money—go for it!" Are we truly promoting community participation and empowerment if we disregard the community's desire to accept needed resources from a source we may consider problematic? Or will the community's long-run agenda be undermined if taking the money may at some point put constraints on decision making, priority setting, or program direction? If what we are after is promotion of the common good, how do we accomplish this in a climate of declining public funding and the concurrent pull of likely support from potentially problematic sources? These are but a few of the kinds of questions health educators and other social change professionals need to ask themselves in relation to the funding of programs and organizing efforts with which they are associated.

Where government or philanthropic funding has been received for a public health or social welfare project accenting community participation, additional funding-related dilemmas also may arise. The community's priorities may shift over time, for example, or members' interest may wane before project completion. Does the health or social work professional in this instance urge the community group to continue working on what is now a low priority in order to fulfill a funding mandate? Does she or he propose returning the remaining money to the funders? Or does she or he approach the funding source about accepting the community's change in direction and continuing to provide overall project support, despite the group's failure to complete the efforts originally emphasized?

This challenge was faced by the Tenderloin Senior Organizing Project (TSOP) a nonprofit that for sixteen years fostered community building and organizing among low-income elderly residents of single-room-occupancy hotels in San Francisco (Minkler 2005). TSOP was committed to "starting where the people are"

and addressed only those issues (e.g., violence prevention and improved healthy food access) identified by the residents themselves, while also working to increase individual and community capacity and empowerment. In one instance, the mostly female residents of several TSOP hotels wanted to begin a multipronged nutrition program, including creating on-site minimarkets, a "no-cook cookbook" for residents who were not allowed to cook in their rooms, and participation in a food bank. The TSOP nutrition project, funded by a three-year grant from a local foundation, worked well in the first eighteen months, but after that, residents' interest began to wane as they became excited about other priorities. After talking with the residents, project staff approached the foundation about renegotiating the terms of the original grant. They thus were able to establish a new funding agreement, through which TSOP residents would complete those aspects of the project in which they remained interested (e.g., the cookbook), while scaling back on others, and continuing to engage in the leadership and capacity building aspects of the work that went beyond any particular content area (Minkler 2005).

Writing grants that emphasize community capacity-building outcomes and processes as a key part of the project being undertaken, and working with funders if shifts in the areas of concern to participants do arise, are important (albeit not foolproof) means of helping ensure continuity of funding while still honoring community priorities. As Paul Tough (2008) has pointed out with respect to the internationally acclaimed Harlem Children's Zone in New York (www.hcz.org), processes need to be put in place with funders and other supporters that foster better alignment with potentially changing community priorities, as long as more bedrock concerns with community capacity building, leadership, and participation are maintained.

Still another set of ethical challenges may arise for community organizers working with nonprofit organizations in the United States that have tax-exempt 501(c)3 (nonprofit) status, and therefore are limited in the amount of lobbying activity in which they may engage.[1] Briefly, *lobbying* refers to direct or indirect (administrative support) activities that influence legislative efforts (i.e., bills, resolutions, and acts) by Congress, a state legislature, local council, or similar governing body. Educational activities intended to inform, but not advocate for a given side, are not considered lobbying efforts. Although nonprofits can legally engage in a certain amount of lobbying, some funders become uncomfortable when *any* advocacy on behalf of a particular legislative measure is undertaken by a 501(c)3 organization they support.

A recent example may be found in the California Senior Leaders Alliance (CSLA), a grassroots organizations of diverse older volunteer organizers and activists that grew out of a foundation-funded program honoring and training outstanding older volunteers in the state (www.calseniorleaders.org). After seven years of successful operation, the parent program ran into difficulty when its members (most of whom are from underserved communities) wanted to move from educating the public and policymakers about new legislation benefiting

low-income elders to actually advocating for a particular bill in the state capitol. Although the group's funder was sympathetic, it did not feel it could support such activity, and when a newspaper cover story highlighted the work of the senior leaders at the state capitol as "advocates" for a particular bill, the group had to cease such work until alternative funding could be found. By raising individual donations for unrestricted use, and seeking an additional grant from a second foundation that *was* willing and able to support such advocacy more directly, the CSLA was able to maintain its original funding while moving, with its new funding base, into advocacy arenas not previously sanctioned. For professionals working with either a 501(c)3 or a 501(c)4 agency (which permits somewhat greater, albeit still limited degrees of freedom with respect to lobbying), it is critical to know and respect the constraints posed by particular funding sources, and to work with community groups on better understanding what is and is not permitted by particular funders and other agency affiliations.

Cultural Conflicts and the *-Isms*

It is not uncommon for professionals engaged in community organizing and capacity building to be culturally different from community members or constituent groups. Further, communities themselves are increasingly diverse. Consequently, opportunities for cultural misunderstandings and for real or perceived racism, sexism, homophobia, or other problems between the practitioner and the community, and within communities, are unfortunately plentiful. It is essential that the practitioner be willing to deal openly with cross-cultural misunderstandings by employing the critical organizing and capacity building skills of listening and dialoguing, participatory planning, and self-reflection (see chapters 4 and 8). Moreover, the practitioner must often juggle the cultural norms and values of a given community with broader ethical values grounded in egalitarianism or justice (DeFilippis et al. 2010; see chapter 6).

Many cultural misunderstandings result from well-intentioned, though either naive or incompetent, actions by the organizer that unfortunately can lead to mistrust or ill will. For example, an outside organizer who attempted to show cultural sensitivity by ordering "Asian food" for a community meeting whose attendees were largely Korean, Chinese, Thai, Laotian, and Filipino faced an angry reaction from some when the meal turned out to consist solely of Chinese cuisine. Although the matter may seem minor, some group members thought that the organizer's food choice reflected the larger society's disrespectful tendency to lump together all Asians (and Asian Pacific Islanders). In this instance, the organizer took the important step of acknowledging her mistake and asking the group to decide on the food for subsequent meetings. In response, some offered to contribute their own favorite dishes, while others identified good and inexpensive restaurants serving their native cuisine; the next meeting included a plethora of diverse ethnic treats. Since the four most important words in community

organizing may well be "*refreshments will be served*," taking care to involve communities in this way, and respecting community food preferences, is not an extraneous detail. Our handling of such situations can demonstrate cultural humility, if we approach them with a humble attitude characterized by acknowledgement of our own biases and ignorance, an openness to others' cultural reality, and a sincere desire to listen and to learn (Tervalon and Murray-Garcia 1998; Chávez et al. 2010; Reed et al., in press; see appendix 3).

The practitioner may also need to address intragroup cultural conflicts; communities rarely are free of the *-isms*. Discriminatory or culturally offensive statements and actions can emerge at any time in a community campaign, and the practitioner will need to exhibit dexterity in both respecting the community's opinions or customs while also creating a space for that community's education or development. For one of this chapter's authors (Hyde), a fairly routine community meeting was made difficult when the group's leader began to make homophobic comments. Not wanting to confront the leader publicly, the practitioner chose to have a private, one-on-one conversation with this individual after the meeting in order to explain how hurtful those comments were. Because these two women already had developed a solid working relationship, they were able to have an honest discussion and reach an agreement on how to proceed, which included the leader not offering her personal opinions that were so upsetting. Even though the practitioner lost an initial opportunity to address this with the group, the leader appreciated not being called out publicly in front of her members. Maintaining that relationship proved important in enabling the outside practitioner to return to the group at a later date for a workshop on how to deal with various *-isms*, including homophobic remarks. In this case, building trust was given priority over immediately addressing discriminatory comments, though they were examined within an educational (and safe) context.

With an increasingly contentious public political discourse, a practitioner may also need to assist a community or constituency group in dealing with hate speech directed their way. An organizer needs to be adept at guiding community members toward ethical practices (especially when the initial tendency might be to return vitriol with more of the same), while also acknowledging the hurtful experience. Practitioners who work with low-income people often contend with mean-spirited stereotypes (such as laziness, leeching off the system) directed toward that group; stereotypes that typically are laden with classist, racist, or sexist meaning. Helping a group developed an empowered and dignified sense of self is a tremendous gift to share with marginalized people.

Finally, and as discussed in chapter 8, dealing with cultural conflict and the *-isms* cannot be fully or effectively done in communities unless agency staff and practitioners are also willing and able to deal with their own *-isms*. In Alameda County, California, the former health department director required that the entire agency staff attend two- to three-hour monthly meetings dealing with racism and related issues. Internal changes in the health department and its staff's attitudes,

beliefs, and behaviors were seen as equally important as fostering change in the neighborhoods served by the organization (Iton 2006; see chapter 8). Tools like McIntosh's (1989) classic "White Privilege" checklist, and Undoing Racism workshops, may be useful as well in helping professionals confront their own *-isms* and cultivate the cultural humility (Tervalon and Murray-Garcia 1998) necessary for effective and culturally sensitive practice (see also appendix 3). Such work is far from easy, however. As Wallerstein (1999, 49) points out, even practitioners like herself with long ties to a more marginalized community may be unaware of the "power of authority" represented by their own multiple power bases—and how failure to adequately own and address these may sabotage relationships. As this public health leader further notes, to facilitate true community empowerment and genuine partnerships, "we need to understand our personal biographies of race, education or social status, or gender and other identities" and how they in turn inform our community partnerships (49).

Unanticipated Consequences

The guiding principles of fostering self-determination and meaningful participation can go a long way toward helping to avoid many of the problems that can plague the community organizing process. Yet even when these principles are followed, organizing efforts may result in outcomes or by-products that were unanticipated and that may have negative consequences. Two examples are illustrative, one in the area of injury prevention campaigns and the second in the training of community health workers to enhance their skills in areas such as leadership and community organizing.

Many recent prevention and health promotion campaigns have done an excellent job of involving youth, people of color, LGBT (lesbian, gay, bisexual, and transgender) groups, and other traditionally neglected communities in the design and pretesting of programs and materials aimed at better reaching these populations. At the same time, however, health promotion and community organizing efforts often inadvertently reproduce and transmit problematic aspects of the dominant culture.

A poignant early example of this is found in the work of Caroline Wang (1992), who identifies the stigmatization of people with disabilities that is often communicated through well-meaning injury prevention campaigns. One in a series of billboards, for example, featured a teenager in a wheelchair with the caption "If you think fourth period English is endless, try sitting in a wheelchair for the rest of your life!" Another, with the caption "One for the road," showed a man on crutches with his leg partially amputated. As Wang points out, the implicit message in such ads is "Don't let this happen to you!" Although well intended, these messages reinforce already powerful negative prejudices in our society against people with disabilities. At a time when the disabled were organizing to assert their rights and break down negative societal stereotypes, such campaigns

were particularly demoralizing. In the words of one person with a disability on viewing the injury prevention ads, "I feel like I should be preventing myself!" (Wang 1992).

In our attempts to avoid negative and unanticipated consequences like this one, the principle of high-level community involvement—and in this case, the reaching out to an overlooked community (people with disabilities)—can stand us in good stead. Such an approach is illustrated in the close coordination between two strong advocacy and organizing groups based in the San Francisco Bay Area—the World Institute on Disability (WID) and the Trauma Foundation. Although the latter's raison d'être is injury prevention, its president, Andrew McGuire, formerly served as chair of the board of WID, and he and other foundation staff have remained strong advocates for the recognition and treatment of disabled people as full participants in American society.

In some instances, of course, the very nature of the processes involved in community organizing can have negative unanticipated consequences. The training of "health promoters" or community health workers in both low-resource and postindustrialized nations provides a case in point. From a health education and a community organizing standpoint, such activities makes eminent sense, for they typically identify and build on the strengths of natural helpers in a community and address issues of homophily (e.g., that people often learn best and prefer to receive services from people who are "like themselves" in terms of race, social class, etc.). Many excellent models for community health worker training, moreover, put a heavy accent on empowerment (Eng et al. 2009), often employing methods such as Paulo Freire's (1968, 1973) "education for critical consciousness" (see chapter 4).

Yet as Freire (1968) himself has cautioned, leadership training can alienate the community members who are involved, making them strangers in their own communities. Once they have been trained and, in a sense, "indoctrinated" into the culture of the public health or social welfare organization or department, community health workers may find it difficult to relate to or interact with their peers as they had previously. In one recent case, an environmental health coalition in a Latino community found that the impressive local women it hired and trained as *promotoras* (lay health workers and organizers) were being called *chismosas*, or "gossips," by older women in the community, and even sometimes by husbands suspicious of their wives' new roles (Minkler et al. 2010). Is it the training they receive that gives them a new vocabulary and consequently a different way of addressing identified problems? Is it the fact that they feel some unstated pressure to "fit in" to the agency that hired them, where most people are professionally trained and where the culture of the office environment is different from the culture of the community or neighborhood? Or is it that once someone who is identified as a community leader tries to mobilize a community around an issue—even one acknowledged as being of local importance—she or he is distrusted as being "on the other side"? How should we proceed when we are committed to

involving indigenous community workers in the process of education and organizing, yet are aware that such efforts may serve to alienate these individuals from their communities and serve to limit their credibility in the community? In the case of the environmental health coalition highlighted above, the coalition head, a white male, began by going out for beer with the local men to dispel suspicion about their wives and partners' involvement as *promotoras*. Additional outreach to other community members, and the establishment of a tutoring and training program for children, not only dissipated initial suspicion of the *promotoras*, but also resulted in heavy community turnout at city council meetings and other venues, in turn contributing to the policy changes that were achieved (Minkler et al. 2010).

Still another unanticipated consequence of training community members as health workers, group leaders, and organizers is that they may use the skills they have acquired to manipulate other members of the community. However, numerous examples from North America and around the world of effective lay health worker programs and leadership training activities on the local level suggest that this strategy is, on balance, a critical one for improving health and welfare contributing to individual and community empowerment (Eng et al. 2009; Schulz et al. 2001; Wallerstein 2006). The task for health educators, social workers, and other professionals then remains one of determining how best to help participants acquire the tools they need for effective leadership and organizing, while at the same time communicating the responsibilities this new training imposes, as well as some of the difficulties and challenges they may need to anticipate.

Thoughts on the Common Good

Acknowledging and confronting the ethical dilemmas discussed above may help enhance community capacity building and ultimately greater empowerment of community groups. When we start where the people are, we make every attempt to be responsive to the needs, concerns, and agendas of a particular community, thereby affirming a commitment to self-determination and liberty, as well as promoting the rights of individuals to act on their own values. The question remains—Do we have an ultimate end in our efforts of promoting and preserving the common good of the communities with which we work? And if so, whose common good is being addressed, and who is determining what constitutes the common good? Finally, should we also be concerned with notions of common good that transcend local communities?

Alinsky (1972) long argued that a cardinal rule in effective community organizing is to appeal to self-interest: people will not organize unless they see what's in it for them. However, particularly in a country such as the United States, which is characterized by a heavy accent on rugged individualism, stressing only self-interest may feed into an already impoverished notion of the common good. As

Lester Thurow (1996) pointed out twenty-five years ago, the dominant American ideologies—capitalism and democracy—"have no 'common good,' no common goals toward which everyone is collectively working. Both stress the individual and not the group. . . . Neither imposes an obligation to worry about the welfare of the other. . . . In both, individual freedom dominates community obligations" (159).

In part because of the individual focus of these dominant ideologies, the very debate over public or common good in the United States has been badly constrained. In Larry Churchill's (1987) words, our notions of justice are based on "a moral heritage in which answers to the question 'what is good?' and 'what is right?' are lodged definitively in a powerful image of the individual as the only meaningful level of moral analysis" (21). Churchill went on to argue that "a more realistic sense of community is one in which there are shared perceptions of the value of individual lives and a social commitment to protect them all equitably" (101).

The lack of a more genuine sense of community and of a well-developed notion of the common good may be particularly troubling for health educators, social workers, and other social change professionals for whom a strong sense of social justice often lies at the base of their personal and professional values (see chapter 1). As suggested earlier, moreover, although an appeal to self-interest may be pragmatic in helping to mobilize a community for the achievement of its self-interested goals, there are dangers in this limited approach. Key among these is the fact that a local community group may fail to see or reflect on the connection between its goals and concerns and the broader need for social justice in a democratic society (DeFilippis et al. 2010; Labonte 2009; see chapter 6). Consequently, even though a focus on self-interest may be necessary from an organizing perspective, we would argue that it is too narrow to be sufficient.

We would, however, advocate against an overly simplistic utilitarian notion of the common good that focuses solely on achieving the greatest good for the greatest number. For the latter may not truly reflect the ends that those engaged in community organizing are attempting to realize. Instead, we may want to look toward a definition of common or collective good that both speaks to local organizing efforts and includes a broader vision of society.

The beginning of the twenty-first century has been a time of renewed moral reflection in fields like public health and social work. In a seminal contribution, Wallack and Lawrence (2005) note that although values consonant with public health and social work, such as "equity, compassion and social responsibility," have historically played a key role in organizing around social problems, "most Americans do not articulate these values nearly as easily as they use the language of individualism" (568). As these theorists go on to note, developing what Robert Bellah and his colleagues (1996) call "America's second language'—"the language of interconnection, is critical because once the moral focus is broadened, the definition of and response to public health problems"—and we would add, to problems in social work, education and other arenas—can grow as well (570).

Practitioners who engage in organizing and other community-based work must engage in this discussion, reflection, and debate both to understand the issues and to bring their perspectives to a dialogue that will be critical to the future of communities, community organizing, and community participation. Through such discussions, we can help demonstrate how community organizing can serve as a bridge to thinking more deeply about the collective good not only of this or that community but also of the broader society.

Conclusion

Throughout this chapter, we have been asking hard questions that go to the core of our practice as community organizers. As health educators, social workers, and other social change professionals, we often operate on the implicit assumption that our interventions are ethically justifiable, since they are derived from community-identified needs. Yet the principles of starting where the people are and working closely with communities to translate their goals into reality, while critical to ethically sound practice, do not exempt us from the need to engage in frequent, thoughtful, ethical reflection. All too often, such reflection on the ethical issues in community organizing has been an afterthought, occurring as a result of unanticipated dilemmas and ethical issues. By making such reflection and dialogue instead an early and continuing part of our organizing efforts, we as professionals can enhance our ability to ensure that the actions we take in working with communities meet the criteria of ethically sound practice.

Although we have tried to address a number of specific ethical dilemmas in this chapter, many others cannot be anticipated, given the ever-changing contexts in which we work. We must commit ourselves to articulating the dilemmas we face in our practice as community organizers, with special attention to recognizing the contradictions with which we must cope and understanding where our responsibilities lie.

It is critical, moreover, for us to be able to identify and articulate not only the ethical dilemmas we face but also the underlying values that drive our work. How do we communicate the importance of the values of community participation and empowerment when we find ourselves in ethically challenging situations? When conflicting priorities present us with the task of meeting different needs and different (and sometimes conflicting) agendas, how do we make explicit the values that can help ensure that we do "the right thing"? When our agencies or funders propose what is really only symbolic or lip service community participation and capacity building, how do we formulate effective values-based arguments to reinforce the importance of not only bringing community members to the table but also hearing their concerns and ensuring that their input is heavily reflected in the final product? Finally, what role can we play in helping community groups reflect on their own values as a means of grappling with difficult dilemmas over issue selection or whether to accept funding from a potentially

ethically problematic source? And what role can we play in helping communities to explore the connections between their perceptions of their own common good and a broader vision of society?

Although we cannot anticipate the possible consequences of all our actions, we can anticipate that some consequences of our community organizing efforts will be different from what was expected. We must remind ourselves to expect the unexpected and to recognize that in the process we are likely to find ourselves in ethically challenging situations that require discussion, dialogue, and difficult choices.

NOTE

1. According to the Internal Revenue Service, nonprofit organizations may select one of two methods to determine excessive lobbying activity: (1) the Substantial Part Test, in which disproportionate organizational activities (direct and indirect) concern lobbying or (2) the Expenditure Test, in which the organization (depending on size) cannot exceed $1 million dollars direct (i.e., staff time lobbying) and indirect (i.e., secretarial support) expenditures (http://www.irs.gov/charities/index.html). It is the responsibility of the organization to maintain necessary records that demonstrate that the lobbying activities remain within appropriate limits (for more information, see http://www .irs.gov/charities/article/0,,id=163392,00.html).

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