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Repair work in raced welfare capitalism: community health workers in the United States

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ABSTRACT

In modern capitalism, the costs of care and social reproduction are widely externalised to women in households, but also to (women in) community organisations. This article analyses the role of community medicine in the US, and in particular the labour and struggles of community health workers (CHWs). Highlighting the gendered and raced inequalities of US welfare capitalism, I explore how CHWs sustain individuals and communities through three main forms of repair work: Safety net plugging is the often-invisible work of addressing unmet community needs; bridging is the work of intermediating between (punitive) state authorities and oppressed communities; and transforming lived experience is the devalued personal work of turning discrimination into care. Drawing on qualitative fieldwork in the US with a focus on California, my findings stress the laboriousness of caring in a punitive welfare state, and the devaluation of doing so in a 'meritocratic', credentials-centred social order. I argue that CHWs' repair work might be a cost effective 'fix' for the health system, but that their struggle for professional recognition also challenges ingrained, racialised concepts of merit and professionalism. Their struggles connect with broader debates about reparative justice, repair, and labour value in our current socio-ecological crises.

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Introduction

The devaluation of care and social reproductive work is a central feature of contemporary economies, as feminist economists have amply demonstrated (e.g. Fraser 2016, Bhattacharya 2017, Folbre 2018, Mezzadri *et al*. 2022). This scholarly tradition also highlights the welfare state's ambivalent role regarding care and social reproductive work. On the one hand, welfare state services such as childcare or elderly care services reduce (otherwise unpaid) care and social reproductive burdens (Folbre 2018). Yet on the other, welfare regimes have long co-produced gendered and racialised economies: economies where not everybody's work is valued fairly or leads to economic autonomy, and where care and social reproduction are systematically devalued and underprovided (Orloff 2009). The reification of the white heterosexual family as the unit of social reproduction and economic security (Fraser 2016, Cooper 2017), backlash against universalist social policies due to white supremacy (Quadagno 1994), and the stigmatisation, economic exclusion, and social control of Black solo mothers (Gordon 1994) are well-documented traits of liberal welfare regimes and specifically the US welfare state.

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While much of the debate about gendered and racialised welfare regimes focuses on its repercussions for women in families and households (Fraser 2016), the role of collective care and social reproductive work is getting increasing attention too (Hopkins 2017, Banks 2020, The Care Collective 2020, Dowling 2021). Feminists have highlighted the potential of community organising for emancipatory purposes toward a more caring economy (e.g. The Care Collective 2020), but also warn that community volunteers can be exploited as a cheap 'free' resource to subsidise a care-less welfare capitalism (van Dyk 2018), and that volunteer spaces can be socially selective and hierarchical (Dowling 2021, p. 92). This article builds on this work and analyses the care work that communities, and more specifically community health workers (CHWs), perform in US welfare capitalism – its modern capitalist order that includes social welfare policies – at three levels. First, I amplify feminist economic insights that welfare state retrenchment and gaps in services create care burdens at the community level, specifying how this works for community care in the 'safety net'. Second, I suggest that the punitive face of the state generates an additional burden of care that CHWs address as community-based intermediaries between state authorities and oppressed communities. And third, I argue that the professional and 'meritocratic' organisation of the welfare state is maintaining CHWs as a devalued, 'flexible' community resource. Unseeing CHW skills in a credentials-based class and racial order is not only exploitative, but also disempowering because it minimises CHW voices and expertise. Thereby, this article points to professionalism and meritocracy as important determinants of community labour and (dis)empowerment in raced welfare capitalism.

Empirically, I focus on the care work of US community health workers (CHWs), who operate in a part-volunteer, part-remunerated space 'between' the medical system and grassroots communities. With diverse origins in, for example, First Nations health services, Black empowerment, or borderland, homeless and rural health, CHWs serve – and tend to come from – marginalised, 'hard-to-reach' populations. CHWs are mostly female and disproportionately from ethnic minorities. Their activities include health advice and help with accessing healthcare, housing, food, or other social support. I will argue that CHWs' work is both necessary and devalued in a welfare state that falls back on community organisations and CHWs as safety nets of last resort, while constantly othering, disciplining and exploiting racialised, criminalised, and illegalised groups on whose behalf these organisations and CHWs work. Therefore, I understand their work as repair work, by which I mean *care work that sustains individuals and communities under hostile conditions. Repair work is skilful, necessary care work in the face of raced welfare capitalism, but often unseen or taken for granted given its context of normalised inequality*. I emphasise that CHWs' repair work is both laborious and skilful, and thus join efforts to counter racialised (and classist) devaluations of certain people's care work (Raghuram 2019).

Thus, complementary to studies that use the term repair work to analyse the labour of 'maintaining the planet' (Corwin and Gidwani 2021) in the face of environmental destruction, this article centres on welfare capitalism as creating the need for repair. Specifically, I distinguish three dimensions of repair work performed by CHWs. First, *safety net plugging* consists of finding social services or charitable resources for individuals whose basic social needs are not met. Given the rationing and bureaucratisation of services for the poor, safety net plugging means ongoing improvisation on the ground, and ongoing grant writing and financial bricolage in healthcare organisations trying to fund such work. Second, *bridging* is the social repair made necessary by the punitive side of the state. A main role of CHWs is to serve as mediators between oppressed communities and public health departments, hospitals, immigration officials, or law enforcement, and thus to mend histories of medical violence, deportation, and punitive welfarism. Finally, *transforming lived experience* is CHWs' personal repair work that allows them to care for their communities against many odds. CHWs are 'experience-based experts' (Gilkey *et al*. 2011), which can mean that they themselves are survivors of trauma, discrimination, or incarceration, and that they can support others through hard-learned skills of overcoming adverse life experiences. This 'lived experience' is sought-after by

community and medical organisations yet tends to go hand in hand with a lack of formal credentials, placing CHWs in precarious positions at the bottom of professional hierarchies, workplace safety, and pay.

This analysis is informed by both social reproduction theories and theories of care, which significantly overlap but also have different emphases – broadly on necessary work and economic value in the case of social reproduction theories, and on affective dimensions and (however constrained) agency and intentionality in the case of care theories (Williams 2018, Mezzadri *et al*. 2022). Since this article is informed by the reflections, ethos and struggles of CHWs, I understand their activities as critically aware, even though constrained, care work. I specify their care work as *repair work* to stress that it copes, both individually and collectively, with the harms of a discriminatory, often hostile, welfare state.

I will suggest that CHW struggles for recognition, and their search for a professional identity beyond the reigning, elitist medico-professionalism of the US healthcare system, contribute to transformative and reparatory thinking about today's raced welfare capitalism, which is reproduced through racialised and classist professional orders.

In the remainder, I first situate CHW repair work in debates about raced welfare capitalism, community organising, and care work. Next, I introduce the CHW occupation and its struggles in the US, and then describe my sources and methods. I subsequently explicate the dimensions of CHW repair work: safety net plugging, bridging, and transforming lived experience. The conclusion discusses wider implications and transformative visions.

Community-based repair work in raced welfare capitalism

In Fisher and Tronto's classic definition, care work entails 'everything that we do to maintain, continue, and *repair* our "world"' (Fisher and Tronto 1990, p. 40, italics added). In some respects, the need for repair is simply part of the human condition, where health crises or other periods of dependence are part of life. Yet, the 'world' that needs such maintenance and repair is of course not the same for people and carers across time and history.

For many workers, especially in the Global South, the social reproductive labour necessary to survive gendered and racialised exploitation is an 'everyday' experience across formal and informal economies (Mezzadri *et al*. 2022). Other repair needs arise from direct physical harms such as workplace accidents in hazardous occupations when a network of kin must step up to fix their impacts in the absence of adequate insurance (Goldblatt and Rai 2018). In Europe and the US, scholars have traced the many ways in which liberal and neoliberal economic orders offload care work to women in families and minorities in disadvantaged communities (e.g. Fraser 2016, Cooper 2017, Williams 2018, Dowling 2021). Going beyond the realm of care for humans, scholars of technology and the environment explicitly use the term 'repair work' to highlight how accumulation in the Capitalocene rests on the devalued, racialised labour of vulnerable populations remedying pollution and repairing infrastructure, all while sustaining themselves through care (Corwin and Gidwani 2021).

Of special relevance to this article is that repair needs also arise from the workings of welfare states, and specifically the raced welfare capitalism that has emerged in the US. As feminist and postcolonial analyses highlight, the welfare state can be a redistributive means for righting gendered and racialised wrongs (Folbre 2018, Klein 2023). Yet welfare states also rely on feminised and racialised labour (Jenson 1997), and they reproduce racialised and gendered inequalities – in the US, historically, through '[l]abour markets and their associated welfare regimes [that] were racially segregated' (Bhambra and Holmwood 2018, p. 581), and continuously by reinforcing white, patriarchal and heteronormative family models (Gordon 1994, Quadagno 1994, Cooper 2017), as well as by organising economies in ever new ways that coerce (racialised) women to provide devalued care (Glenn 2010). Hence, regardless of where one stands considering debates about 'racial capitalism' and thus the ultimate relationship between race, gender, and class (see Coates 2014, Bhattacharya 2017,

Bhambra and Holmwood, 2018) – and I do not try to resolve this debate in this article – the basic observation that racial, class, and gender inequality are deeply intertwined in postcolonial welfare states and that this impacts economies of care has been underlined through many studies.

While much of this critique is focused on the (racial) politics of the family and household, the community as a strategic site of welfare capitalism is also increasingly debated. Community spaces – such as, for example, non-profit organisations, volunteer, or neighbourhood groups – can potentially be sites of resistance and organising, for example for alternative care economies (The Care Collective 2020; and see Dowling 2021, pp. 98–103). Black feminist writers have pointed out that women's unpaid work in the extended family can be a form of resistance to oppression instead of mere patriarchal exploitation by men (Collins 2000, p. 46). Yet, this potential is constrained by the fact that usually states control social resources and thereby the scope, if not terms of community projects (see already the discussion of state-controlled socialisation of care in Federici 1975, p. 7). US welfare state history illustrates the daunting struggle for community autonomy with the experience of the 1960s War on Poverty. In this endeavour, 'community action programmes' were designed as participatory mechanisms to enhance Black empowerment in sync with the civil rights movement (Quadagno 1994), and community health centres should ensure accessible, community-owned healthcare (Ward and Geiger 2017). Yet, community groups' political influence was soon curtailed by entrenched white supremacy and local systems of political patronage (Quadagno 1994, pp. 48–59), and community health centres' economic autonomy initiatives as attempted, for example, in Mississippi, were blocked by the bureaucracy (Ward and Geiger 2017). Given neoliberalisation, non-profit 'community-based organizations' (CBOs) have become safety nets of last resort, providing critical support to often ethnically defined communities (see subsection *Plugging holes*).

This article supports concerns that community care can function as a subsidy to welfare capitalism through unpaid or underpaid care work (see van Dyk 2018, Dowling 2021). Indeed, as I will discuss in the section *Plugging holes*, CHW activities are strongly shaped by and improvise within the constraints and gaps of the US 'safety net' for the poor, and this need to improvise also means regularly going beyond task descriptions and thus beyond what health organisations or funders might see or remunerate. This observation echoes critiques of community or kinship networks as bearing the cost of social reproduction, especially for oppressed groups (Shah and Lerche 2020). Yet in addition, the work of CHWs also points to two facets of raced welfare capitalism that have not gotten as much attention in debates about care work. The first is the care burden and complex role of community care given the punitive side of the welfare state. US welfare capitalism operates through varied mechanisms of 'punishing the poor' (Wacquant 2009), for example the mass incarceration of people from Black and poor communities (Alexander 2012), or illegalisation – which keeps people deportable, vulnerable, and often without access to social services and healthcare (Kanstroom 2007, Pandey *et al*. 2014). For CHWs, this means that they must be mediators between people who have many reasons to distrust the state, and welfare state agencies trying to reach the poor with their programmes and services. CHWs engage in the repair work of bridging rifts between the welfare state and communities in ongoing activities of translation, social and physical connection and trust building between community members and state authorities.

Second, CHWs operate in the shadow of an ingrained medico-professional dominance of health, and a credentials-centred understanding of 'meritocracy' exploiting and devaluing CHWs. In a health system that is strongly medicalised even though barriers to accessing medical services, as well as broader causes of illness are social, public health leaders celebrate CHWs as a workforce that acts on the 'social determinants of health' (Peretz *et al*. 2020). Indeed, CHWs, who have long mostly worked for CBOs, are increasingly recruited by healthcare organisations (Malcarney *et al*. 2017). Nonetheless, CHWs struggle to find stable employment with decent pay. Their 'lived experience' makes them a resource for health systems trying to 'reach the poor' but places them lowly on credentials-based professional hierarchies. This discrepancy between the social value and the economic value of CHW work is deeply rooted in broader inequalities of racial capitalism, and in the

professional, 'meritocratic' order that sustains inequality in the US economy (see McMillan Cottom 2017). Specifically in the health domain, the racialised and classist process of professionalisation goes back to the early-twentieth century triumph of 'scientific medicine', which restricted access to the profession to well-educated persons (usually white men), at the expense of Black and rural colleges and communities (Brown 1979) and established steep hierarchies between professionals and non-professional health workers (Freidson 1970). The outcome, as medical sociologists and anthropologists have amply shown, is a healthcare system marked by a huge social and power gap between health professionals and the racialised poor, often exacerbated by medics' use of inaccessible medical jargon, and a system-induced medical disregard for patients' social situation (e.g. Holmes 2013). As I will elaborate in the following sections, CHWs are not only there to 'fix' this situation and advocate for their clients before healthcare authorities. Their longstanding struggle to be recognised as a distinct profession and as valuable members of healthcare teams in a world marked by racialised and classist credentialing also shows the way toward a necessary, reparatory rethinking of professionalism.

Community health workers in the US

CHWs are widely associated with developing countries, where their contributions to targeted health interventions and primary care delivery, but also their exploitation as low-paid workers or volunteers have been debated for decades (Ballard *et al*. 2021). Yet CHWs also have many long traditions in the US. Although media and US-based international NGOs like to describe CHW models as relatively recent imports from the Global South, first major CHW initiatives date back to at least the 1960s, with programmes in the Indian Health Service (Kalm-Freeman 2009), the Migrant Health Program (Johnston 1985), and the Community Health Center movement (Ward and Geiger 2017). CHW roles and names vary between states and projects, and their number is accordingly difficult to determine – one estimate speaks of over 61000 US CHWs (US Bureau of Labor Statistics 2022), counting only *employed* CHWs (see below).

Available studies of CHW demographics stress that 'a significant portion of [CHWs] represent the communities for which they serve' (National Association of Community Health Workers 2022a, p. 2). This refers to CHWs' self-identified race and ethnicity and thus the fact that, different from largely white doctors and nurses, CHWs are much more racially diverse. In a recent national survey of over 800 CHWs, these were '43 per cent White, 32 per cent, African American/Black, 9 per cent Multi-racial/not listed, 8 per cent Latin American, 5 per cent Native American/American Indian, 1.6 per cent Asian/South Asian and 1.5 per cent Pacific Islander' respondents in the national survey (ibid.). In a Californian survey, 65 per cent of respondents identified as Latino/x, 12 per cent as White and eight per cent as Black, which reflects the strong 'promotor/a de salud' tradition among Latino/x communities in that state (Chapman *et al*. 2022, p. 18). Where CHWs are not representative is gender. The workforce is traditionally female, with shares between 79 per cent (Chapman *et al*. 2022, p. 17) and 88 per cent (National Association of Community Health Workers 2022a, p. 1). As Banks observes for Black community activism, it is a site of *women's* social reproductive work (Banks 2020). This observation extends to community medicine as well.

Policymakers appreciate CHWs as a workforce that can reach the most vulnerable and 'complex' (read: costly) patients and address broader determinants of health. In recent years, public health leaders even speak of a CHW 'boom' in the US (Kangovi and Asch 2018). CHWs were named as a valuable workforce in Obama's 2010 Affordable Care Act, received new federal grants under the Biden/Harris administration (Biden Harris n.d.), and the outreach work of CHWs during the Covid-19 pandemic only underlined the impression that they are valuable for US health policy.

Yet, such support of CHWs remains full of contradictions. Despite periodic public endorsements, CHW jobs and roles are mostly provisional. Lacking stable funding or roles in health settings, CHWs keep being mobilised *ad hoc* for short-term, grant-funded initiatives, with salaries not always nearing living wage, or volunteering for stipends at best.[1]

Methodology

My research explored US CHWs' and their allies'[2] struggle for recognition of this workforce. Between 2021 and 2023, I conducted in-depth qualitative research about efforts to promote CHWs as a coherent workforce with unique skills and characteristics. I analysed public health debates and CHW organising efforts with a focus on two aspects: professional identity and/or certification, and funding sources for CHWs. I extensively consulted research papers, training manuals, CHW association websites, policy papers, and conference proceedings from across the US and specifically California. These sources are complemented with 43 in-depth interviews with 45 key informants: 15 CHWs and 30 allies (2 of them former CHWs) such as researchers, managers, and trainers in diverse public health, safety net, community-based, and adult education institutions.

Most interviewees (41) were based in California, allowing me to understand the contentiousness of certifying and thus 'professionalising' CHWs in a state where policy reforms have been launched to tap more public funding for CHW activities. California is home to many CHW traditions, and to long-standing debates around CHW identity, certification, and remuneration. It is a relatively progressive state, which nevertheless exposes the repair needs posed by illegalisation, incarceration, cost of living, homelessness, and racialised health inequity. I strived for diversity and interviewed key informants from different counties, organisations, and programmes. Additionally, four interviewees, based in other US states,[3] provided background regarding national level organising. Given the evolving pandemic situation, I conducted both in-person and online interviews. All interviewees provided written informed consent.[4]

The work of repair

Plugging holes in the safety net

CHWs originated in spaces with deficient health and social protection. This includes migrant *colonias* between the US and Mexico (Ford *et al*. 1998), 'streams' of mobile farmworkers (Johnston 1985), or First Nations served by the Indian Health Service (Kalm-Freeman 2009). They were part of self-help initiatives in Latinx and Asian American organisations,[5] worked in the Black Panther's health services (Nelson 2011), and in the network of US Community Health Centers that originated in the 1960s and morphed into what is nowadays known as 'safety net clinics' for the poorest (Ward and Geiger 2017). Today, public safety net clinics and CBOs – the 'safety net of safety nets'[6] – are main worksites of CHWs.

Arguably, the 'safety net' does not provide economic or health security to any American, yet for poor and racialised communities, even vital medical, food, or safety services often only exist on paper. In this context, many CHWs describe their work as one of addressing unmet need, always confronted with emerging fault lines of the safety net, and the limits of a patchwork of targeted programmes. For example Clarice,[7] a CHW employed through an asthma project in Oakland explained to me: 'The problem is that the programme grant does not allow us to give this education to the unsheltered because the whole idea is you're telling them how to curtail their environment' – and only housed people were able to do so, not the masses of unhoused poor in the Bay Area. Or CHWs were telling about trying to get clients with multiple serious health burdens or housing issues into publicly funded programs – and then those clients did not qualify because they did not make the necessary threshold of emergency department visits in a given period.[8]

CHWs highlight improvisation within such constraints as a key part of their work, often illustrated with variations of home visit stories. For example, a home visit that shall support a client to adhere to diabetes medication might reveal that they do not have a fridge to store the insulin or are food insecure and therefore cannot focus on managing their condition. Hence, a service where the fridge can be retrieved from, or food, must be found. CHWs become experts in finding services and resources,

be it food banks or immigration lawyers. They use informal CHW networks, WhatsApp groups, or lists maintained at organisations to do so.

The necessity of such work not only emerges for CHWs on the ground but is also amply debated in US public health, where CHWs are valued because they tackle so-called 'social determinants of health' (Peretz *et al*. 2020). Yet, funding their work is a constant challenge given that CHWs do not fit extant reimbursement models for closely circumscribed medical services. Tinkering and national circulation of policy advice on 'how to fund CHWs' is endless (California Health Care Foundation 2018, Rush and Mason 2023). Federal agencies such as the Center for Medicare and Medicaid Innovation and the Center for Disease Control launch programmes through which states and health plans can experiment with healthcare models addressing social determinants. Lately, several states including California initiated amendments to public health insurance regulations to permit reimbursing community care services for the worst-off patients. Usually, such initiatives include funds for CHWs. Some providers make use of budgetary discretion to deploy CHWs in a manner that reduces overall expenses, for example by targeting 'complex' patients and 'high utilisers' of hospitals and especially emergency departments.

In this situation, one coveted tool for health providers and CBOs is to be able to demonstrate a quantitative 'return on investment' for CHW activities. For example, Olivia, manager of a safety net clinic network told me, while pulling their 'incredible bottom-line data' from the wall in the office to read it out, their team was just 'super, super proud' of the monthly reduction of care cost per patient achieved through CHWs. However, Olivia also expressed frustration that in the end, their ROI was more of a *fix* to a dysfunctional system rather than transformative, since sometimes you 'just want to burn it all down to the ground […] because it's such a terribly complicated system and we're not really, we're not doing fundamental change, right'. This is also felt by CHWs who warn that focusing on ROI-yielding activities and more generally, integrating with health providers will diminish their ability to respond to community needs. While in the current state of affairs, non-profit organisations actively support CBOs in learning to calculate an ROI and thereby attract funds, the risk of CHWs' concomitant 'medicalisation' (see Malcarney *et al*. 2017) is widely debated. Such medicalisation could also undermine CHWs' role as 'bridges':

Bridging rifts between communities and the welfare state

CHWs are often described as 'bridges and mediators' between communities and the healthcare system (Wiggins 1998, p. 24), and defined as a 'liaison/link/intermediary between health/social services and the community' (American Public Health Association 2021). This role is premised on the CHWs' identity as a 'trusted member of and/or [someone who] has an unusually close understanding of the community served' (*ibid*.). While community can mean many things in US political language, most of the time this here refers to ethnically defined communities or communities sharing the same (poor) living conditions.

The work of bridging is crucial in a social topography where poor communities experience the state as discriminatory, punitive, and barely legible/accessible, often already due to linguistic barriers. Multilingual CHWs support non-English speaking clients, accompany clients unfamiliar with medical jargon, or offer services in languages other than English (Wiggins 1998, pp. 25–6). Bridging has manifest physical dimensions as well. CHWs largely work outside of health facilities – in cars driving to remote clients, in homes discussing parenting or checking for asthma triggers, in homeless shelters and encampments checking on unhoused clients, or organising events in schools and other communal spaces. As workers 'connecting people to services', CHWs must communicate with both community members and welfare state representatives – which can be health providers, but also law enforcement officials when it comes to neighbourhood safety or parole issues.

This is no easy work given that the welfare state is not always a benign force in the poor's life – quite the contrary. Histories of medical violence, most drastically the abhorrent Tuskegee experiment letting Black men die of syphilis (Jones 1993), shed doubt on the benevolence of medicine

toward Black bodies. Doctors and nurses are trained and incentivised to disregard patients' socio-economic challenges (Holmes 2013), contributing to the 'perception that "the professionals" have repeatedly failed us' (Gilkey *et al*. 2011, p. 180). Medical schools eager to reach the poor encounter community suspicion (Kaufman *et al*. 2017), and public health departments are met with 'mistrust' and remain alien 'helicopters' in the communities they reach out to.[9] From the perspective of CHWs, bridging implies that patient rights must be constantly advocated for (Logan 2019), and that health providers must be held to account so that they do not deny poor patients their rights or intimidate them with bureaucracy and medical jargon.

The punitive face of the welfare state, especially mass incarceration, further increases the need for bridges. Given dramatic post-incarceration health risks and the ongoing stigma faced by people returning from prison, it is telling that one of the most reputed CHW programmes in the US is by and for returning citizens. The Transitions Clinics Network (TCN), created in 2006 in California but meanwhile operating in over a dozen states, works with previously incarcerated CHWs who support the coming home process especially for people with chronic conditions – which are the majority within this group.[10] The CHWs help returning individuals get through – basically survive – the first weeks and months out of incarceration, and to try and build a stable life until 'graduation' out of the TCN support programme.[11] For clinics, working with TCN is an opportunity to address a key plight especially in Black and poor communities, where mass incarceration has become rampant, and given that 'the resources that we have to provide for them do not equate to their [returning citizens'] complexities'.[12] For CHWs, TCN provides employment – which is difficult to find for returning citizens – and allows them to respond to acute needs. As Peter, a CHW working for TCN explained to me, he saw daily the acute need for 'on the ground, uh, in the neighbourhood, helping men and women, just try to feel normal, treating them like normal, making sure that when they come in the clinics for help, they are treated well, I think this is really important'.[13]

While clinics working with TCN usually need to seek and stitch together finances from many sources to fund such work (California Health Care Foundation 2018), the California government has meanwhile launched a programme to make CHW services by and for returning citizens a public health plan benefit (Hwang 2023). And as CHW experts in Oakland and Los Angeles were observing beyond the health sector, police departments in several US counties now contract services from previously incarcerated CHWs for community outreach and de-escalation.

Finally, the bridging role of CHWs has long been crucial for migrant communities (Johnston 1985). In a context with everchanging migration rules and the spectre of deportation for migrants without legal residence, migrants worry how service seeking impacts their immigration status (Sullivan 2022). Many rely on self-help groups, churches, and CBOs. Migrant CBOs have manifold traditions of working with CHWs, both as volunteers and as hired workers, to create support systems and multilingual spaces. The urgency of immigrants' situation is also felt in CHW graduation ceremonies, some of which include the commitment to 'immigration reform' in the ceremonial pledge.[14] And it marks the working conditions of those CHWs whose residence status does not permit them to be employed. In Latino/x Californian CBOs, many promotoras can only receive a meagre stipend, but no salary due to legal constraints. Yet even volunteer promotoras invest considerable time in the work and further training through CBOs, and many of my Californian interviewees feared that volunteer promotoras would be left behind in any formalisation of CHW training and certification.

Bridging requires that CHWs in some way belong to and be trusted by the addressed community. Yet, however valuable this belonging may be from the viewpoint of 'community outreach', it also demands of CHWs a further and fundamental work of repair, the work to transform their own lived experience.

Transforming lived experience

Confronting suffering, supporting the most vulnerable, even in the face of fear and isolation in pandemic lockdowns, is hard work. Yet, as Peter said: Compared to incarceration, it can feel easy.

'Coming out here and, it's kind of cushy to, to me [laughs] you know, it's kind of easy you know it's just, it's just, it just does not hit us like it does everyone else. Covid […] this is just a lightweight lockdown for us'. He stressed how hard-leaned resilience, an ability to set boundaries, but also 'guilt and shame' for the crime were part of his life and work, and that other people often did not understand the trauma from experiences in prison that his clients had to grapple with.

Work with returning citizens is one, but far from the only example where personal first-hand 'experience that can't be taught' (The Commonwealth Fund 2015) is valuable. The ability of CHWs to bring 'lived experience' to their jobs is stressed in definitions of the workforce (Chapman *et al*. 2022, p. 3) and in discussions of CHWs' unique expertise and ethics (Gilkey *et al*. 2011). At CHW conferences and in trainings, CHWs serving as mentors explain how they had to heal and survive personally to become CHWs. Similarly, videos accompanying an internationally used textbook from the City College of San Francisco share stories of CHWs from many walks of life – one, for example, sharing her feeling guilt having escaped war, the struggles of immigrants, an excruciating day job and studies at night in the community college, and prejudice against lesbians (Berthold 2016). Other CHWs might find it daunting to become a CHW having thus far been a mother and (immigrant) housewife waiting for their papers, or because they grew up in struggling families at the brink of, or going through episodes of, homelessness. For example, when Liliana remembered starting CHW training, she apologised for being 'very emotional. I was just remembering that I was homeless with two kids'.[15] Like many CHWs, Liliana had been 'discovered' (my term) by a CHW organisation because she was already volunteering in her immigrant community, and she was used to 'learning in so many ways' (for example, how to deal with bureaucracy, funerals, taxes) because 'we come from the bottom' – and thus had acquired crucial CHW skills through life. Yet other CHWs might stress that becoming a CHW basically means finding a useful job near home, without emphasising the struggle to get that job.[16] Yet as Maria, a promotora and promotora teacher summarised her (and many CHWs') experience gained in a 'troubled neighbourhood': 'statistically, I should be either dead, in prison, pregnant, whatever'.[17]

Still, CHWs' skills and the lessons they pass on amongst each other and their clients go beyond mere coping or resilience. Several CHWs described their job in a CBO, or an ability to teach other CHWs, as a 'dream' come true. Others proudly showed me their workplace in CBOs, or gifts from patients, or asserted that they had learned to be 'proud of my accent'. I attended joyful CHW graduation ceremonies, and next to stories of struggle in hierarchical and classist workplaces heard stories of comradeship, allyship, and thus individual and collective flourishing.

It is hard though to get credit for these skills and labours. Acknowledging their biographical disadvantage, CHW trainings in CBOs, but also in community colleges are tailored to adult learners from immigrant or low-income communities for whom the formal school system has not worked – but who can excel if schedules are adapted to their livelihood, and if teaching and exams tap practical experience, for example through popular education tools (Berthold 2016). Since such training does not lead to professional licenses, CHWs remain at the lowest rungs of healthcare teams. Even managers who appreciate their CHWs find it hard to understand certain differences. For example, Janice, a director in a Californian safety net centre, is fond of her CHWs and how 'effective' and 'smart' they are. Yet, she also wonders about a 'theory' she has given some CHWs' difficulties with documentation and technology: 'Maybe [they] never got diagnosed as having any kind of learning issues, had bad experiences in school where this kind of stuff became almost traumatic'. Given the importance of trauma for many CHWs, other CHW advocates told me that they desperately wish for more trauma-informed approaches among CHW line managers. Where trauma-informed approaches are lacking, employing institutions take the ongoing personal repair work of CHWs for granted.

Conclusion: repair and reparation

I have argued that community care work is an important site of coping with the gendered and racialised harms of US welfare capitalism. I have conceptualised CHWs' care work as repair work and

suggested that this work is skilful, laborious, necessary, and devalued. Yet, as noted in the introduction, can't community care also be a space of organising for change? In international health history, CHWs have often been idealised as a transformative and liberating force, even though such hopes have often been disappointed (Frankel 1992). For the US, Logan (2019) has shown how central advocacy is to CHW self-understanding, but also explains that the actual, day-to-day advocacy efforts of US CHWs are mostly small-scale and focused on specific workplaces and clients, while CHWs often lack resources or power to elicit broader structural change. Still, alliances of CHW associations with health equity, environmental justice, migration or anti-racist movements are always possible and sometimes forged.

Beyond the question of community organising and (dis)empowerment, the struggles of US CHWs point to professionalism as a force that reproduces oppression, but that can be, and is, rethought by CHWs. I have indicated that safety net and other providers seek to standardise CHW tasks to be able to reimburse them, and to calculate an ROI. Yet, CHWs are seeking ways to become recognisable without being medicalised – or diminished in their skills based on lived experience. Since the 1990s, several attempts have been made to shape an occupational identity that allows CHWs to achieve some autonomy and influence project design in ways that reflect CHW realities (Rosenthal *et al*. 2011; Rodela *et al*. 2021). CHWs have repeatedly resisted top-down professionalisation or certification attempts that might crowd out 'genuine' CHWs who might have strong community ties, excel at their work, be experienced and skilful, but lack formal schooling.[18] Participatory projects have sought to articulate the role and skills of CHWs beyond medicalised or *ad hoc* (re)inventions of their roles by healthcare organisations and grant agencies. CHWs and their allies have also introduced 'grandfathering' pathways to occupational recognition for uncredentialed but experienced CHWs, and promoted CBOs instead of academic institutions as certifying organisations – which reminds of calls for reparative justice through autonomous Black organisations (Klein 2023). Not the least, CHW advocates promote CHWs as experts and authorities in policy rounds and at conferences, where most of the time, their voices are barely heard.

Taking up Thomas' (2011, p. 238) idea of a 'reparative' way of thinking as a 'sustained conversation about history' to 'envision the future in new ways and on new terms': CHWs' struggle to acquire a professional identity and recognition invites just such an alternative envisioning. Their struggles for recognition can and should be part of a historical conversation about the twentieth century triumph of 'scientific medicine' and its dispossession of Black and rural colleges and communities (Brown 1979), the medicalised understanding of health as a medico-professional prerogative (Freidson 1970), and the exploitative nature of credentials-based meritocracy (McMillan Cottom 2017). Repairing the harms of raced welfare capitalism also means challenging its elitist, professional order, and the control that professionals exert over the scope and power of community-based care work.

Finally, the concept of repair work invites thinking across socio-ecological domains including environmental repair work (Corwin and Gidwani 2021). Valuing eco-repair work on its own terms could mean, for example, to support Indigenous self-determination and 'systems of community caretaking' (Temin 2024, 4) of nature, and to reward such 'earthwork' (ibid.) in a way that does not perpetuate destructive accumulation. Community caretaking of health and nature, just like domestic care, offers 'provisioning values' (Elson 1998, 2) that would benefit economic life at large.

Notes

1. There is no comprehensive data on CHWs, yet a 2021 national survey of 867 CHWs found that eight percent of respondents were volunteers, working for per diem rates or gift cards/honorariums; only 46 percent agreed or strongly agreed that pay was equitable and offered a liveable wage (National Association of Community Health Workers 2022b). In California, a convenience sample of 329 CHWs surveyed in 2021/2, mostly representing employed CHWs, yielded that nine percent of respondents were not working or volunteering; 49 percent earned between 20 and 25US$ per hour (Chapman et al. 2022), which was below living wage in California unless the worker was childless or had a co-earning spouse (https://livingwage.mit.edu/states/06).
2. The term 'ally' is widely used in CHW organisations for non-CHW members. I use it for non-CHW supporters of CHWs based in formal CHW organisations, health and community organisations, and academia/education.
3. Mississippi, Oregon, Rhode Island, and Washington DC.

4. The study was approved by the Research Ethics Committee of the London School of Economics, reference 19545.
5. See https://asianhealthservices.org/history-of-ahs/.
6. Interview with leader of Californian non-profit organisation working with CHWs, 9 May 2022.
7. Names are pseudonyms. Interview conducted 26 May 2022.
8. CHW interview, California, 15 April 2022.
9. Terms used by public health official, California, interviewed 11 June 2021.
10. See https://transitionsclinic.org/transitions-clinic-network/ [Accessed 22 December 2022].
11. Term used by Peter, quoted more extensively below.
12. Interview with safety net clinic officer, California, working with TCN, 26 April 2022.
13. CHW interview, California, 19 April 2022.
14. A CHW graduation ceremony I attended at an adult education center in the Bay Area in summer 2022 had a vow that included the pledge to work toward immigration reform. A CHW ally whom I interviewed reported having seen a similar pledge in Arizona.
15. CHW interview, California, 16 June 2022.
16. CHW interview, California, 20 April 2022.
17. CHW interview, California, 5 August 2022.
18. Which protracts negotiations about a Californian CHW certificate, see https://hcai.ca.gov/workforce-capacity/initiatives/community-health-workers-promotores-chw-p/?utm_source=HWDD&utm_campaign=2106bb280f-EMAIL_CAMPAIGN_2023_06_27_06_01_COPY_01&utm_medium=email&utm_term=0_-ead1687a73-%5BLIST_EMAIL_ID%5D [Accessed 15 December 2023].

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