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# “This is what community care looks like:” emotional labor and relational care among U.S. community health workers<sup>☆</sup>

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## ABSTRACT

Community Health Workers (CHWs) play a critical role in advancing health equity by bridging the gap between health systems and the communities they serve. Although research on CHWs in the US has focused primarily on health outcomes and return on investment, less is known about CHWs' engagement in emotional labor and how they may be impacted by the emotional demands of their work. This ethnographic study examined how CHWs employed in one metropolitan area in the Mountain West experienced and made sense of their daily roles. We used a multimethod research design that included field observations, respondent diaries, semi-structured interviews, and participatory data analysis workshops to explore CHWs' relationship-building practices, emotional experiences, and strategies for sustaining themselves in their work. Findings highlight that emotional labor and relational caregiving were central components of CHW practice, including expressing empathy, validating clients' experiences, and persisting through systemic barriers while managing their own emotional responses. CHWs described both fulfillment and strain in navigating clients' needs within fragmented healthcare and social systems and often felt responsible for addressing structural inequities beyond their control. They managed these emotional demands through self-sustaining activities and peer connection and problem-solving. Drawing on social reproduction theory, we argue that CHWs' emotional and relational labor constitutes a form of essential yet undervalued care work that sustains community well-being and public health systems. Recognizing and resourcing this labor is critical to workforce retention, program sustainability, and equitable health system transformation.

Community health workers (CHWs) have long served as trusted liaisons between health systems and the communities they support, and in the contemporary U.S. context their roles are expanding across clinical, public health, and community-based settings. They play a critical role in addressing health disparities by building connections, delivering health education, and facilitating access to medical and social services (Ingram et al., 2012). CHWs are uniquely positioned to serve historically marginalized communities due to their shared lived experience, cultural understanding, and close ties to the communities they support (Delgado, 2020). CHWs advocate for people who are underserved by healthcare and social services and help community members engage in healthy behaviors (U.S. Bureau of Labor Statistics, 2025). They are employed in

a variety of settings, including nonprofit organizations, community health clinics, hospitals, schools, and increasingly in state and local health departments (U.S. Bureau of Labor Statistics, 2025). While CHW roles vary widely, common functions include conducting health screenings, offering health education, coordinating care, providing culturally competent support, and linking individuals with social services such as housing, food, and transportation (Ingram et al., 2012; U.S. Bureau of Labor Statistics, 2025).

An underexplored area of research concerns how CHWs perform emotional labor in their everyday work, including how they manage emotionally demanding encounters, sustain relationship-based care, and cope with the cumulative effects of supporting clients through complex

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barriers. CHWs engage in significant care work that is not often explicitly recognized as part of their formal scope of work, yet is central to their effectiveness (Logan, 2022). Emotional labor, the process of managing one's feelings to meet the emotional requirements of a job, is integral to CHW practice and can involve outward displays (e.g., performing empathy) and deeper internal processing of client distress (Pandey & Singh, 2016). This emotional labor often goes unrecognized, even though it has important implications for workforce sustainability and may contribute to moral distress and burnout when organizational support is limited (Abresch et al., 2023; USAID, 2022).

With CHWs' roles in the U.S. becoming more professionalized, understanding how workers navigate and sustain the emotional work required in their roles is crucial for shaping equitable and sustainable workforce policies (Logan, 2022). Here we use "professionalization" to refer to increased institutional integration into health systems (e.g., embedding CHWs in clinical/public health teams), formalization of roles and competencies, and expanded expectations for documentation, performance metrics, and supervision structures. In more formalized roles, the relational and emotional dimensions of the work can become simultaneously more central to effectiveness and more difficult to recognize or resource within systems that prioritize specific measurable outputs.

This study addresses that need to better understand emotional labor in the everyday practices of CHWs by centering their perspectives through an ethnographic exploration of their daily work in a small metropolitan area of a predominantly rural, Mountain West county. Focusing on the emotional and relational dimensions of CHW practice, we investigate how CHWs build relationships with clients, experience emotions, and cope with the emotional demands of their work. By highlighting CHWs' lived experiences and emotional labor, this study shifts attention from programmatic outcomes to the everyday realities that comprise frontline community health work.

## 1. Literature review

### 1.1. History of CHWs and current expansion of CHW roles in the US

The modern CHW movement has been traced by some scholars to China in the 1920s (Perry et al., 2014). The first cadre of community-based health workers were trained to record births and deaths, vaccinate against smallpox and other diseases, deliver basic first aid, provide sanitation support, and give health education talks in rural areas (Rifkin, 2008). These early versions of community-based health workers foreshadowed China's "barefoot doctor" program in the 1950s (Rifkin, 2008). "Barefoot doctor" and other community health programs grew rapidly and globally in the 1960s and 1970s in response to the limitations of Western medical models in addressing rural and underserved populations (Rifkin, 2008). The World Health Organization (WHO) reinforced this shift in the 1978 Declaration of Alma-Ata, which recognized CHWs as key providers in a primary health care model aimed at achieving "Health for All" (Perry et al., 2014).

The 1980s, however, saw a decline in large-scale CHW programs, largely due to global economic pressures, structural adjustment policies, and underinvestment in community health (Berman et al., 1987; Segall, 2003). CHW programs suffered from inadequate training, poor supervision, insufficient pay, and a lack of political and financial support, which contributed to their marginalization within formal health systems (Berman et al., 1987; Walt, 1988). Despite setbacks, several countries implemented successful national CHW programs including Brazil, Bangladesh, and Nepal. These programs demonstrated significant improvements in population health, particularly in maternal and child health and disease prevention (Perry, 2000).

In the United States, state and local health departments increasingly integrated CHWs into public health infrastructure, either through direct employment or partnerships with community organizations (Knowles et al., 2023). The CHW workforce has proven effective in reducing

emergency department visits, increasing screening and preventive care, and addressing social determinants of health (Ignoffo et al., 2024). For example, programs in cities like Detroit and El Paso led to reductions in healthcare utilization and improvements in health behaviors through CHW-led interventions (Ignoffo et al., 2024). The CDC's investment in CHWs through the American Rescue Plan during the COVID-19 pandemic underscored their value in public health emergency response and long-term system transformation. In 2022, \$225 million was allocated to support CHW training and deployment beyond the pandemic, solidifying their role as integral to the public health workforce (Ignoffo et al., 2024).

### 1.2. CHW roles and settings

CHWs in the United States today perform a diverse array of roles that reflect both the flexibility of the profession and the needs of the communities and institutions they serve. While their roles are not universally standardized, they generally align with core competencies identified in national frameworks such as the Community Health Worker Core Consensus (C3) Project (Rosenthal et al., 2021). These competencies include cultural mediation, culturally tailored health education, care coordination, informal counseling, advocacy, outreach, capacity building, and support for evaluation and research. CHWs commonly engage in health promotion and education, chronic disease management support, assistance with health system navigation, resource referral, social support, and community mobilization.

CHWs are employed across a spectrum of settings and their specific job activities may shift depending on their setting. CHWs may work at hospitals, federally qualified health centers (FQHCs), public health departments, nonprofit organizations, or community-based organizations (Ingram et al., 2012). CHWs embedded in clinical care teams may focus on care transitions, patient coaching, and closing gaps in preventive screenings (Collinsworth et al., 2014; Roland et al., 2017). In contrast, CHWs working in community-based organizations (CBOs) often emphasize outreach, informal counseling, community education, and organizing (Ingram et al., 2012; Malcarney et al., 2017). This variation in scope of work across settings contributes to CHWs' flexibility but can also pose challenges for workforce professionalization and role clarity (Delgado, 2020; Malcarney et al., 2017).

### 1.3. Gender, race, and emotional labor in the community health workforce

Women make up the majority of the global CHW workforce (Perry et al., 2014; Swartz & Colvin, 2015). Though CHW workforce data in the US is limited, in a survey of CHWs conducted by the National Association of Community Health Workers, 89% of respondents were women (NACHW, 2023). The role of CHWs involves having close relationships and shared life experience with underserved communities. In the US, this has resulted in many CHWs being from Black, Native American, and Hispanic communities, though the racial and ethnic composition of the CHW workforce varies based on geography, region, and local context (Delgado, 2020; NACHW, 2023). The gendered and racialized nature of the community health workforce is important context when considering the ways in which emotional labor forms a substantial component of CHWs' work.

Emotional labor is woven through everyday CHW practice and is often unevenly recognized or supported within formal role structures (Logan, 2022). The uneven recognition of emotional labor reflects the fact that relational and emotional support is difficult to quantify and therefore underrepresented in job descriptions, performance metrics, and supervision structures, making it more likely to be treated as an assumed "soft skill" rather than labor requiring training, support, and recovery (Logan, 2022; USAID, 2022). Emotional labor shapes everyday CHW practices, as they routinely hold space for clients navigating complex trauma, chronic illness, discrimination, and structural barriers

to care. They offer empathy, encouragement, and a nonjudgmental presence alongside practical support (Ingram et al., 2012; Knowles et al., 2023). For many CHWs, particularly women in resource-limited settings, the role not only involves performing health-related tasks but also fulfilling community expectations around caregiving, mediation, and emotional availability (Abresch et al., 2023; Pandey & Singh, 2016). This relational work fosters trust and continuity in settings where institutional systems have often failed to meet community needs (Malcarney et al., 2017). However, the emotional burden of consistently supporting others while managing their own well-being highlights the need for institutional recognition, supervision, and self-care support tailored to the realities of CHW work (Ingram et al., 2012; Logan, 2022; O'Brien et al., 2009).

Importantly, emotional labor is not merely a byproduct of CHW roles but is tightly linked to their role identity and social positioning. Many CHWs enter the profession after informal caregiving experiences within their families and communities, viewing their work as an extension of their identity as helpers and insiders (Mlotshwa et al., 2015; Swartz & Colvin, 2015). A USAID review of CHW behavior in international settings highlights that the emotional resonance CHWs share with clients can be both a strength and a vulnerability, as it enables empathetic care but also exposes CHWs to heightened emotional burden when client suffering cannot be alleviated due to systemic limitations (USAID, 2022). This pattern is especially consequential in a gendered and racialized workforce where care labor is often normalized but not necessarily supported.

Emotional labor also serves as a source of motivation and meaning for CHWs. Their work is often rooted in a deep commitment to improving conditions in their communities and gaining social recognition for their efforts (Delgado, 2020; Logan, 2022). The authenticity with which CHWs engage emotionally with their clients is a vital part of their relational power, but without adequate organizational support, reflective supervision, and recognition, this emotional labor may lead to moral distress and burnout (Abresch et al., 2023).

#### 1.4. Precarious employment of CHWs in the US

Despite growing recognition of their contributions to health equity and systems transformation, CHWs in the United States continue to operate within precarious employment conditions. US CHWs earn a median annual wage of \$51,030, with the lowest 10% earning less than \$37,930 (U.S. Bureau of Labor Statistics, 2025). These wages place them near or below the threshold for economic precarity, especially in high-cost areas. Although the occupation is projected to grow, this expansion has not been matched by improvements in compensation, benefits, or job security (U.S. Bureau of Labor Statistics, 2025). Many CHWs are employed in part-time, grant-funded positions that offer minimal job security, making their employment contingent upon external funding cycles rather than long-term systems investment. A notable recent example of this precarious job security can be seen in the abrupt early termination by the Trump Administration in March 2025 of the CDC's Community Health Workers for COVID Response and Resilient Communities grant program, upon which the current study is based and which funded CHWs in 67 organizations across the US (Partners in Health, 2025). Because of the overall precarity of the CHW workforce and reliance on grant-funded positions, such unexpected changes in federal funding may be even more devastating to CHWs than to others in the health and public health professions.

The CHW workforce is often excluded from the professional status and labor protections afforded to other health occupations (Sabo et al., 2017). These employment conditions may be compounded by insufficient integration into institutional hierarchies, where CHWs can lack opportunities for professional development or structured career pathways (Abresch et al., 2023). Despite being recognized as essential to addressing health inequities and connecting underserved populations to care, CHWs remain structurally positioned as low-wage workers within

the broader health workforce (Sabo et al., 2017; Smithwick et al., 2023). This precarity and positioning of CHWs near the bottom of the health workforce hierarchy (along with similar "para-professional" positions, such as patient advocates, doulas, and home or personal care assistants), reinforces gendered and racialized hierarchies in the healthcare workforce (Delgado, 2020; Logan, 2022; Smithwick et al., 2023).

Smithwick and colleagues (2023) further highlight the disconnect between institutional promotion practices and the qualities that define CHW effectiveness: while employers tend to prioritize formal education and credentials, CHWs and their allies emphasize lived experience, mentoring, and community leadership as indicators of readiness for advancement. Without structural changes that align compensation, supervision, and advancement opportunities with the unique strengths of the CHW workforce, the field risks continued turnover and the loss of experienced practitioners whose work is critical to advancing health equity.

#### 1.5. Current study

Previous research on CHWs in international settings has examined their history, roles, lived experiences, and the labor involved in frontline health work (see Mlotshwa et al., 2015; Pandey & Singh, 2016). Research on U.S.-based CHW programs, however, has tended to place emphasis on programmatic return on investment (ROI) and health outcomes (e.g., Kangovi et al., 2018; Kim et al., 2016; Viswanathan et al., 2010), with comparatively fewer studies foregrounding CHWs' own perspectives and daily work (for exceptions, see Logan, 2018, 2022; Palmer-Wackerly et al., 2020). Where CHWs' perspectives have been centered, qualitative findings underscore the relational nature of the role and the strain of navigating fragmented systems. Logan's (2018) photovoice study with CHWs in Indiana, for example, highlighted how CHWs described the role as a set of practices and dispositions, such as being nonjudgmental and observant, while also connecting disparate resources for clients navigating fragmented systems. Logan's subsequent work (2022) further examined how CHWs navigate boundaries of care, professionalization, and risks of burnout and compassion fatigue, emphasizing the centrality of relationship-building and advocacy in everyday practice.

We build on this work by tracing how emotional labor unfolds in the day-to-day flow of CHW practice and how CHWs sustain themselves over time using ethnographic and participatory methods. Understanding how CHWs themselves make sense of and sustain their roles under these conditions is necessary for informing workforce policy, training, and supervision models that support retention, well-being, program sustainability, and workforce equity. The present study responds to this opportunity by examining the daily experiences of CHWs employed in a metropolitan area within a largely rural county in the Mountain West during the implementation of a new federally funded CHW program. Our study was designed to center CHWs' perspectives on their own work through an ethnographic approach that combined field observations, daily diaries, semi-structured interviews, and participatory data analysis workshops. By situating CHWs as participants and co-analysts, we sought to challenge hierarchies of knowledge production in research and elevate the expertise of those performing frontline community health labor (Fertaly & Fluri, 2019).

We were particularly interested in exploring the emotional and relational dimensions of CHW practice. Emotional labor can build trust and networks between institutions and communities, but may also contribute to stress, burnout, and moral distress when systemic barriers prevent CHWs from meeting client needs (Abresch et al., 2023). This tension guided our inquiry into how CHWs themselves experience and interpret the relational and emotional dimensions of their work. The study was guided by three exploratory research questions: *How do CHWs' day-to-day roles reflect practices of relationship-building and caregiving? What emotions do CHWs experience as part of their role? How are CHWs impacted by the emotional demands of their work?* By addressing

these questions, this study contributes to a growing literature on CHWs' experiences that shifts analytic attention from program outcomes to the lived realities of the workforce, thereby underscoring how attention to CHWs' experiences is essential for strengthening and sustaining programs in the long term.

## 2. Methods

### 2.1. Study design

This study used a community-engaged, multimethod ethnographic research design (LeCompte & Schensul, 2010) as part of a program evaluation of a new CHW program funded through the CDC's Community Health Workers for COVID Response and Resilient Communities initiative. Community-engaged ethnography was selected to capture rich data on CHWs' daily activities, feelings, and behaviors (Maes et al., 2014) and to engage CHWs directly in data collection and analysis as "knowledgeable actors" (Goodson & Vassar, 2011). Ethnographic approaches often include the use of multiple data collection methods to capture "rich insights into the everyday" (Latham, 2010, p. 190) from a variety of perspectives. Our research design combined field observations, one-on-one interviews, and time/space diaries to document CHWs' day-to-day activities, successes, and challenges. CHWs also participated in data analysis workshops in which their additional reflections and insights were recorded to enrich the original data sources.

### 2.2. Context and setting

In 2021, the CDC launched a national initiative to strengthen the CHW workforce focused on addressing social determinants of health linked to COVID-19 disparities. Three organizations in a Mountain West city of around 120,000 residents partnered to create eight new CHW positions. Organization A, a Federally Qualified Health Center, serves over 18,000 patients annually through integrated care; Organization B, the county public health department, focuses on disease prevention and health promotion; and Organization C, an Urban Indian Health Program, provides integrated care services specifically to the area's American Indian/Alaska Native community. CHW positions were distributed across the three organizations, with four CHWs employed by Organization A, two by Organization B, and two by Organization C.

The new CHW positions expanded these organizations' capacity to address health disparities by improving access to COVID-19 and social services, making referrals for housing, food, transportation, and healthcare, and reaching thousands of community residents through education and health promotion. CHWs primarily worked within their home organizations but met biweekly as a group to provide programmatic updates, share resources, and conduct case conferencing and problem solving. Job roles varied somewhat both across and within the three organizations, with some CHWs developing a focus on certain populations such as refugees or youth, while others concentrated on community outreach and education. The extent to which CHWs were primarily clinic-based versus community-based also varied across organizations. The program experienced moderate turnover in these positions, with a total of 12 individuals filling the seven positions over the study period.

### 2.3. Data collection

Data collection and analysis occurred throughout the first three years of CHW program implementation, starting in 2022 and ending in late 2024. All data collection activities were reviewed and approved by the IRB of the University of Montana. Below, we provide a brief overview of the data collection procedures for each component of the study, which included interviews, field observations, respondent diaries, and additional data collected via focus groups at participatory data analysis workshops.

#### 2.3.1. Interviews

We conducted semi-structured baseline interviews with each CHW within one month of hire to explore their motivations for and expectations about becoming a CHW. We also conducted semi-structured exit interviews with CHWs who left their positions during the data collection period. These interviews were originally conducted for the purpose of program evaluation but were eventually included in the data set for the current study (with consent) to provide additional data regarding CHWs' expectations and experiences in their roles.

**Recruitment and Procedures.** Participation in baseline interviews was voluntary; all 12 CHWs hired during the data collection period chose to participate. Within three weeks of each new CHW being hired, the lead author contacted them via email, explained her role as the program evaluator, provided information about the purpose and nature of the interview, and asked the CHW if they would be willing to participate. Interviews were conducted virtually by the lead author and lasted approximately 30-45 min. No incentives were provided for participation, as CHWs were encouraged by their supervisors to complete the interview during work hours. All interviews were conducted in English. Prior to the interview, the interviewer explained the interview procedures and obtained the participant's verbal consent to participate. With participant permission, all interviews were audio recorded and transcribed using Otter.AI automated transcription, then cleaned by the research team.

Similar procedures were followed for exit interviews. Upon being notified by the CHW program manager or supervisors that a CHW would be leaving their position, the lead author contacted the CHW and asked if they would be willing to participate in a brief virtual interview about their experiences with the CHW program. Four CHWs left their positions during the data collection period; of these, one left suddenly without an opportunity for follow-up. The other three CHWs participated in an exit interview during their work hours prior to formally leaving their position (i.e., after giving their notice). Exit interviews followed similar procedures as the baseline interviews regarding consent, audio recording, and transcription.

Although baseline and exit interviews were originally collected for program evaluation purposes, during our analysis for this study, we realized they provided important context for the rest of the ethnographic data described below and additional reflections from CHWs about their experiences in their roles. We therefore attempted to recontact and re-consent the participants for a secondary research analysis. Of the 12 who originally participated in interviews, we were able to recontact eight CHWs via email, including the three CHWs who had participated in both baseline and exit interviews. The four CHWs who were unable to be contacted had left their positions without providing a personal email or other contact information. After explaining the purpose of the secondary analysis, all eight CHWs who were contacted provided written consent for their interview data to be used for this study.

**Materials.** We created a brief baseline interview guide to elicit CHWs' experiences, feelings, and perceptions about their new role. Interview guides were developed in consultation with the CHW program manager and supervisors, as well as informed by our review of the literature regarding common roles and skills of CHWs. The baseline interview included open-ended questions such as "What populations/communities are you hoping to work with?", "What aspects of your personal experiences are you hoping to bring to this work?", and "What challenges do you think you might face in this role?"

We also created a brief exit interview guide in consultation with the CHW program manager and supervisors. The exit interview was aimed at answering evaluation questions about CHWs' experiences with the program, alignment of the role with their expectations, and skills gained from the position. The interview included questions such as, "What was your overall experience like working for the community health worker program?", "How well did the job meet your expectations?", and "What was the most challenging part of your job?"

### 2.3.2. Field observations

To understand a “day in the life” of a CHW, we conducted field observations in which a graduate research assistant trained in ethnographic observation shadowed CHWs at work. CHWs were recruited in-person by the lead author, who routinely attended biweekly CHW group meetings as the program evaluator throughout the three-year grant period. No incentives were provided for participating in the observations, as these were conducted during the normal course of CHWs’ work and did not involve additional time or labor from the CHWs. Four CHWs agreed to be observed, including two from Organization A and one each from Organizations B and C. Prior to the observations, the lead author explained the observation procedures in person, provided a written study information sheet, and obtained written consent from the four CHWs.

The graduate research assistant did not have prior interactions with the CHWs and was introduced to them at a CHW group meeting as a researcher who would be observing them to learn about their roles. Over a six-week period, the research assistant conducted seven observation periods during which she shadowed the four CHWs. Observation periods lasted approximately 3 h and took place in both clinic and community settings. After each observation, the research assistant produced detailed field notes using thick description to capture behaviors, interactions, and reflections.

### 2.3.3. Respondent diaries

Written respondent diaries were used alongside field observations to collect data directly from CHWs regarding their daily activities, interactions, routines, and reflections (Latham, 2010). The lead author introduced the opportunity to participate in the diary activity at a CHW group meeting and provided written information about the study procedures. Six CHWs provided written consent to participate. Participants were compensated for their completion of one week of daily data collection in the form of a \$100 gift card. CHWs were provided with notebooks and written instructions on how to use the daily diary. The CHWs were prompted to create a new “entry” for each new activity, meeting, or interaction during the day, and to include details in each entry such as the time, location, activities conducted, and personal reflections. Examples of reflection prompts included: “How did you feel about the interaction or activity?”, “What were some of the challenging parts of the interaction/activity? What were some of the pleasant or satisfying parts?” and “How well does that interaction/activity reflect what you do as a CHW?” CHWs were encouraged to complete their diaries at multiple points throughout their work day. All six CHWs completed daily entries for a full work week. Diary entries varied in length and level of detail, from simple one-to-two sentence descriptions of activities that did not include personal reflections to detailed, paragraph-long entries that included CHWs’ personal reflections and insights. All diaries included multiple entries per day.

### 2.3.4. Participatory data analysis workshops – focus groups

After completing primary data collection (i.e., observations and diaries), we designed a series of workshops to engage CHWs in data analysis and collect additional personal reflections to enrich and expand on reflections collected via the respondent diaries.

**Recruitment and Procedures.** Due to CHWs’ limited availability during work hours, two 3-h analysis workshops were planned and held in the evening. The workshops both followed the same structure but covered different topics/portions of the data; thus, CHWs were invited to attend one or both workshops. Participation was voluntary, food was provided, and CHWs who participated were compensated with \$50 in cash for their time. Despite the authors’ efforts to schedule the workshops based on interested CHWs’ availability, only one CHW attended the first workshop and two additional CHWs attended the second workshop (see Table 1). One additional CHW expressed interest in participating but had last-minute scheduling conflicts that prevented them from attending. Due to the difficulty of garnering more

**Table 1**

Participants by data collection method and organization (N = 8).

Data Collection Method	Participants by Organization (n)		
	Organization A (N = 4)	Organization B (N = 2)	Organization C (N = 2)
Interviews			
Baseline interviews	4	2	2
Exit interviews	2	1	0
Field observations	1	2	1
Respondent diaries	3	2	1
Workshop focus groups			
Workshop #1	1	0	0
Workshop #2	0	1	1

engagement and the limited availability of the CHWs, the authors elected to move forward with the workshops despite small group sizes.

Workshops were facilitated by all study authors and structured to guide participants through sorting and analyzing de-identified data from the observations and diaries (see Section 2.5.1 for analytic details). The facilitators then guided participants through a focus group discussion of their analysis, which was designed to elicit CHWs’ thoughts and feelings regarding the nature of their work. Prior to the focus group portion of the workshop, the authors obtained written consent from all CHWs to participate and have their responses included as data for the ethnographic study. Focus groups were audio recorded and transcribed verbatim using [Rev.com](https://www.rev.com) human transcription services.

**Materials.** For the discussion portion of the workshop, we drew on the focused conversation method (The Canadian Institute of Cultural Affairs, 2000), which includes four phases (objective, reflective, interpretive, and decisional) and has been used across a variety of settings, including qualitative public health research (Fritzen-Pedicini et al., 2019). The authors created a semi-structured discussion guide with questions to move discussion through the four phases. Example discussion questions for each phase included “Which of these categories is most representative of your day-to-day work?” (Objective phase), “When you think about X category, how do you feel?” (Reflective phase), “What might be missing from these categories?” (Interpretive phase), and “What are three key takeaways for you about [X topic] from our workshop today?” (Decisional phase).

## 2.4. Participants

Out of 12 CHWs who were employed and eligible for participation during the study period, a total of eight CHWs participated in the ethnographic study across the data collection and analysis activities. This sample size is appropriate for in-depth ethnographic research in which the authors engaged closely with participants over time, collected multiple sources of data from or about all participants, and focused our analysis on depth, rather than breadth, of CHW experiences. All eight completed baseline interviews, three completed exit interviews, six completed respondent diaries, four participated in observations, and three attended workshops. Table 1 provides an overview of the study components and their respective participants. All data collection activities were voluntary; thus, some CHWs chose not to participate in field observations, respondent diaries, and/or analysis workshops based on their interest and availability.

We did not collect demographic information from CHWs in order to protect confidentiality given the small number of CHWs in this community. However, through the baseline interviews and additional data collected, we were able to capture basic information about CHWs’ backgrounds. CHW participants represented a variety of genders, races, and nationalities. Most had some prior experience or education related to public or community health, but their paths to becoming CHWs varied widely. None had specifically worked in the role of CHW prior to this

position, but several had related experiences such as being a patient advocate, peer support specialist, or working in health education and promotion. Four CHWs worked at the Federally Qualified Health Center, two at the public health department, and two at the Urban Indian Health Center.

## 2.5. Data analysis

Data analysis was an iterative process that began early in the data collection period. Our overall analytic approach drew on both participatory and non-participatory qualitative analytic techniques that were selected for their appropriateness in analyzing the various types of data we collected. Below, we outline our analysis in roughly the order in which it occurred – first, through participatory qualitative analysis of the respondent diaries and observations as the primary sources of ethnographic data, followed by additional analysis conducted by the research team to refine the preliminary participatory analysis and incorporate additional sources of data (i.e., interviews and workshop focus groups) to contextualize these findings.

### 2.5.1. Participatory analysis of diaries and observations

During the participatory data analysis workshops described above, we used a qualitative open sorting and grouping method to conduct preliminary analysis of the two primary sources of ethnographic data: respondent diaries and field observations. Qualitative open sorting and grouping methods have been used in a variety of participatory research studies to engage lay researchers in the analytic process (Best et al., 2022; Jackson, 2008). We designed an open sorting method similar to that used by Jackson (2008) as a low-tech, low-time intensity approach that would center CHWs' interpretations and enhance analytic trustworthiness. Analysis workshops were designed to facilitate CHWs' participation in the fundamental activities of qualitative coding—i.e., sorting, labeling, synthesizing, and interpreting the data.

Prior to the workshops, in a step akin to Jackson's (2008) phase of "preparing the data" the researchers grouped de-identified data segments into high-level categories (e.g., "CHW actions," "client request or need," "challenges") to help organize the large data corpus into manageable chunks for analysis given workshop time constraints. Data segments from the "CHW actions" and "CHW response to client request or need" categories were analyzed during Workshop 1; data segments from the "challenges" and "problem solving" categories were analyzed during Workshop 2. These researcher-generated categories were not otherwise used during the remaining analysis.

During each workshop, CHW participants and researchers worked in small groups to sort and stack data segments printed on notecards. Participants then created brief descriptive phrases with which to label each stack of data segments (e.g., "filling out paperwork"). In the second part of the workshop, CHWs were asked to share out the labels for each stack, then to "cluster" any similar labels together. Once all labels had been clustered, the group developed interpretive names for each cluster (e.g., "actions on hold until patient is available/able to participate").

### 2.5.2. Researcher-driven analysis and synthesis of findings

Following our participatory analysis of the diaries and observations, we moved into analysis of the workshop focus group data. We also realized that CHWs' personal reflections in prior interviews would add greater depth to the ethnographic data already analyzed. Thus, we decided to incorporate the CHWs' baseline and exit interviews into our data set and analyze these alongside the workshop focus groups. Given the CHWs' limited capacity and interest in attending more after-hours coding workshops, the interviews and focus groups were analyzed solely by the researchers. As part of this analytic process, we also refined the cluster names and descriptions from the diaries and observations that were generated through the participatory pile sorting method and synthesized themes from all data sources into our results. We shared the final results in written form with all CHW participants for their review,

feedback, and edits; no CHWs chose to provide feedback.

Our analysis was informed by Miles et al.'s (2020) analytic framework, which is a flexible, pragmatic, and rigorous three-phase approach to qualitative coding and analysis. This analytic framework was selected as appropriate for this stage of analysis because it is intended to be used flexibly across qualitative methodologies or "genres" (Miles et al., 2020, p. 20) and provides a cohesive set of analytic procedures to use across a variety of qualitative data types (e.g., interviews, focus groups, observations, etc.). This framework outlines three analytic phases or "concurrent flows of activity" (Miles et al., 2020, p. 8): data condensation, data display, and drawing and verifying conclusions. All analysis at this stage was conducted in NVivo software version 14 (Lumivero, 2024).

The first phase of analysis, *data condensation*, involved organizing and coding interview and focus group transcripts together in two coding cycles. During the first cycle of coding, two coders (the lead and third authors) independently applied descriptive codes at the level of sentences or paragraphs to summarize the data in a word or short phrase that helped categorize and inventory the data, such as "reflections on challenges of role." A single coder (the lead author) then developed and applied inductive codes to capture processes, emotions, and attitudes (e.g., "need for persistence in reaching clients," "exhausted by no-shows"). In the second coding cycle, two coders (the lead and second authors) collaboratively grouped and synthesized these inductive codes into higher-level pattern codes that were one level removed from the data. For example, the two example codes listed above were synthesized along with others into the pattern code, "drained by trying to move things forward with clients." The second phase of analysis, *data display*, involved organizing pattern codes into visual displays for further analysis. The lead author did this by creating data tables that organized pattern codes and exemplar quotes by research question and incorporating clusters (which were treated as pattern codes) from the participatory analysis of the field observations and diaries. This allowed the pattern codes to be further refined and synthesized into our final themes. Finally, the third phase of analysis focused on *drawing and verifying conclusions* by synthesizing findings from across all data sources and producing a final write-up of the results, which involved all authors.

To strengthen the trustworthiness of the analysis and verify our conclusions, we evaluated our analysis using Lincoln and Guba's (1985) four criteria of *credibility*, *dependability*, *transferability*, and *confirmability* of the analysis. The *credibility* of our analysis, or confidence in the accuracy of the findings, was enhanced by ensuring quotes and themes were representative of all participants, evaluating the prevalence of patterns and themes across and within cases/participants, and checking for negative evidence or exceptions to the themes (Miles et al., 2020). We sought to ensure *dependability* (i.e., replicability) by keeping a detailed audit trail throughout data collection and analysis in which we noted our methodological and analytic decisions, analytic notes and memos, and other details. We addressed *transferability* (i.e., how much the findings can be generalized to other populations or settings) by describing the CHW program and participants in detail, including characteristics that were unique to the study context or that may not apply to other CHWs. The *confirmability* of the findings—that is, the extent to which they reflect the participants' views and acknowledge the subjective biases of the researchers—was enhanced by including the CHWs in participatory data collection and analysis strategies, as well as through reflexive analytic practices of memoing, peer debriefing, and bracketing our own beliefs or inferences during observations. We also provided CHWs with an opportunity to review and provide feedback on our results. We have made our positionalities and philosophical assumptions explicit in Section 2.6 to highlight how these may have influenced the analysis.

## 2.6. Philosophical assumptions and reflexivity

Our analysis was grounded in the philosophical framework of social constructivism, meaning that we understand reality and knowledge to

be inherently subjective and co-created along with our research participants (Kukla, 2000). As analysts, the two lead authors were informed by feminist and Marxist critical theories. This background influenced the research questions developed for this study and the focus on emotional labor and care work, which are gendered and racialized in unique ways in the United States context. All authors were closely involved in data collection and analysis and had built strong, trusting relationships with the CHWs with whom we conducted the study through our participatory approach to the program evaluation. All authors are White, cisgender women with advanced social science degrees and, importantly, none of the authors have lived experience as CHWs. These differences between our own lived experiences and those of the CHWs informed our methodological choices to include CHWs directly in data collection through the daily diaries, as well as to co-analyze as much of the data as possible to ensure CHWs' interpretations and positionalities informed the final analysis.

### 3. Results

#### 3.1. Research question 1: CHWs' daily practices of relationship-building and caregiving

We sought to first understand the nature of CHWs' daily work and the ways it involved the building of relationships and/or provision of care. Our analysis of the extent and nature of this kind of labor in CHWs' daily work resulted in two primary themes: 1) CHWs establish relationships with clients using active communication and persistent outreach over time, and 2) CHWs provide holistic care through material and emotional support.

##### 3.1.1. CHWs establish relationships through active communication and persistent outreach

During intake appointments and initial meetings with clients, CHWs spent time getting to know them using probing questions and active listening to understand clients' needs and concerns. We observed CHWs using these techniques to identify clients' priorities and make suggestions about potential solutions, such as in the following example from an intake appointment with a new client, who was a mother with young children:

*[The CHW] asks [the client] if the children have a local pediatrician because a physical is required prior to each new school year. Mom does not have primary care for children and most recently went to the hospital when her youngest had an earache. [The CHW] offers to schedule a well-child physical for the children at [the Urban Indian Health Clinic].*  
–Observation of Participant 7

This interaction illustrates how CHWs used conversation to understand gaps in clients' healthcare needs and share information. In this case, the client may not have been aware of the need for her children to have annual physicals for school. By connecting her client to care for the specific need of school physicals, the CHW also sought to establish a primary care provider for the family, which may help prevent future hospital visits. In another example, we observed a CHW using active listening and communication techniques to facilitate a conversation between her clients (a teenage boy and his great-aunt, who acts as his guardian) and a school administrator after the teenage client dropped out of school:

*[The CHW] begins by stressing that [the teenage client] is not in trouble and they are only there to help ... [The school administrator] then explains different educational options for him to get his GED: job corps, online school, attending classes ... [The CHW and school administrator] make a plan to arrange an appointment to get him a social security card later in the month and to meet again to enroll in one of the educational options discussed. [The CHW] asks [the teenage client] to reiterate the plan, to confirm understanding. She reassures [him] that they will find a*

*niche for him. Despite his youth, [the CHW] values his agency and decision making in this process.* – Observation of Participant 5

In this example, the CHW used various communication techniques to engage and support the young person and his caregiver, including starting from a place of empathy, working with the client to create an acceptable plan of action, confirming the client's understanding, and providing emotional validation. As seen through these examples, CHWs spent much of their time in client meetings getting to know clients and their needs through this kind of active communication, which enabled them to establish strong client rapport.

CHWs' communication with clients involved engaging in persistent outreach over time to find, connect, and follow up with them, especially when working with hard-to-reach populations such as people who were unhoused, justice-involved, or had limited or inconsistent phone and email access. CHWs often described struggling to contact clients, as in this CHW diary entry: "10:00 a.m. – went to a new refugee house, no answer, second time there, tried texting and calling to meet them regarding SNAP and unemployment. No success!" (Participant 5). Many times, difficulties in reaching clients were due to housing instability, jobs, or other social circumstances that limited communication. For example, one CHW noted in her diary, "Corresponded via e-mail with one of my young houseless clients. He has a job and works a lot during my work hours nowadays, so we haven't been able to meet up in quite some time" (Participant 6). CHWs spent much of their time trying multiple methods of outreach and waiting on responses from clients, as summarized in a CHW's diary entry: "Wait, wait, wait/Phone, email and text" (Participant 5).

##### 3.1.2. CHWs provide care through holistic support

Most of CHWs' daily activities involved the provision of holistic material and emotional support to clients. CHWs provided numerous direct services to clients, including coordinating transportation and accompanying clients to medical and social service appointments. For example, one CHWs' daily diary entries captured the level of coordination and logistical support they provided before, during, and after their clients' appointments:

*After ultrasound appointment, I assisted with check-in again for walk-in x-ray. I also asked to provide the translation for client. We were done both ultrasound and x-ray appointment for the client around 4:30 ...*

*I called someone from [refugee agency] to order Uber for the client and I waited until the client left the clinic. I got back to the office around 4:50 ...*

*I arrived [at the hospital] at 9:00 am. I have 2 client appointments to navigate the hospital to get to their appointments and assist with check-in process. I also assisted the client to schedule her next appointments at [the hospital].* – Participant 4, diary entries

Other kinds of material support routinely provided included assistance with paperwork, helping clients with medication management, and picking up and dropping off medications and other necessities.

Alongside these acts of material support, CHWs spent much of their time during client interactions building relationships and offering emotional support. CHWs filled roles often performed by informal caregivers or family members, helping to support clients who did not have robust social networks or who faced barriers to accessing services. During one of our observations, we noted:

*[The CHW] inquires about what other resources the family needs. The mom requests help setting up Wi-Fi, help getting a security camera and clothes. She cites PTSD and her experience being discriminated against as a Native woman for her need for indoor security cameras. She says, "Authorities rely on minorities not being aware of their rights." [The CHW] validates the mom's negative experiences with past living situation and commends her for standing up for her rights.* –Observation of Participant 7

Here, the CHW attended to the emotional content of what the client was sharing – her experiences with discrimination as a Native woman – rather than simply focusing on the client's stated needs or ignoring her feelings.

Many CHWs took a similarly empathetic approach during client interactions, even going out of their way to provide emotional support in person when needed:

*I received a phone call from [client]. [She] is having a difficult time where she's staying. [Client] is staying with her boyfriend's grandmother, who is addicted to substances and has a TBI ... [Client] needs someone to tell her the current living situation is less than she deserves ... I drove to [client]. I felt [she] needed a hug and validation in person. –Participant 2, diary entry*

These sorts of interactions illustrate that, for many CHWs, their relationships with their clients went beyond simple exchanges of resources or information to a more person-centered understanding of the client and their individual circumstances. These relationships often felt deeply personal to both the CHW and the client and included gestures of care and affection. Together, material and emotional support were woven together as integral aspects of CHWs' daily work.

### 3.2. Research question 2: CHWs' emotional experiences

In our second research question, we sought to understand the emotions experienced by CHWs in relation to their work. Our analysis resulted in two primary themes: 1) CHWs experienced feelings of stress, frustration, and exhaustion tied to specific client challenges and systemic issues, and 2) CHWs experienced a deep sense of purpose, fulfillment, and joy in providing community care through their work. These themes together illustrate that the nature of community health work itself was emotionally laden, and that this emotional labor both contributed to CHWs' sense of fulfillment in their work and also took a toll on them.

#### 3.2.1. CHWs experience feelings of stress, frustration, and exhaustion

CHWs described feeling pulled in many different directions due to the broad scope of their role, which included direct work with clients, supporting other CHWs and providers, and engaging in community outreach activities and events. This sometimes led to stress or feeling overextended, as one CHW explained:

*[I feel] just stressed in general trying to figure out okay, how am I going to deal with this? When ... I have to be at an appointment, but then I have a programming event going on, as well. Okay, how do I juggle those two, so that I can leave this programming event and then get to my appointment with my client? – Participant 7, focus group*

Another CHW described the tension she felt between wanting to support other CHWs and needing to make sure she managed her own caseload: "I am happy to be a person [other CHWs] can call for support. I do have a difficult time managing my day with phone calls and requests. The requests ... turn into 'do you want to work with them?' Tricky" (Participant 2, diary entry). As this example shows, CHWs' strengths of caring about their clients and fellow CHWs sometimes had downsides, such as struggling to set boundaries around how much support they could feasibly provide.

In addition to feelings of stress or overextension, CHWs shared that they often felt drained by the amount of effort it took to follow up with hard-to-reach clients or make progress toward their goals. A CHW described her feelings of exhaustion at facing hurdle after hurdle in trying to help a client access a vital health screening:

*[I've] been trying to get this ... woman a colposcopy ... and there's, it's just like a constant, like, I can't find her and then maybe she's at the [homeless shelter]. And then she walks out of the appointment ... And then like, two weeks ago, I finally had it set up, we're good to go—she was in jail. I called*

*jail and said, 'Can I please just pick her up from jail and bring her there? You can come there,' like, no, court's at 11, appointment's at 11. It's not gonna happen. So just like the exhaustion ... - Participant 1, focus group*

As this example shows, CHWs sometimes hit a point of fatigue when, despite all their efforts at relationship-building and system navigation, they were unable to help a client meet a key health need or goal.

CHWs also expressed frustration about systemic barriers and the constraints they faced in trying to help clients meet their needs. Housing was a foundational need for many clients that prevented them from achieving their health goals, yet CHWs had little ability to expedite clients' access to housing options. A CHW described trying to help clients find housing as having to "sit around and wait. Like you do something, and then you sit around and wait. And it's challenging" (Participant 6, focus group). This CHW was frustrated by the lack of information and transparency from public housing authorities regarding their clients' placements on housing waiting lists that had recently been frozen: "What happens to them, you know, being on waiting lists now? Did they get booted off the waiting list? Do ... their profiles completely disappear? What happens, you know? So that's what's really kind of frustrating."

Another CHW expressed feelings of frustration about what she viewed as systems being "in the way of" her client's medical care: "And then systems are in the way of, like [the client is] on an out [i.e., temporarily barred] with the [homeless shelter], she's in jail, like these are all systems in the way of medical care. So it's frustrating" (Participant 1, focus group). This sense of frustration led some CHWs to feel that their role was to act as "band aids" for larger, systemic issues that they were not able to address:

*And so I feel like, especially in this job, it feels like we're putting band aids on things and plugging lots of holes, which is really important, but it feels like there's never a way to go upstream and look at the reasons that people find themselves consistently in crisis with no support ... It's hard to look big-picture and be like, how can we prevent people from constantly being in crisis? - Participant 6, focus group*

CHWs recognized that they played an important role in filling gaps within care systems and supporting clients through crises, but that the scope of the systemic barriers and challenges their clients faced went beyond what they could address.

#### 3.2.2. CHWs feel purpose, fulfillment, and joy in providing community care

Despite moments of frustration or exhaustion, CHWs also described feeling fulfilled by and grateful for their connections with clients. Many shared feelings of excitement when they were initially hired about the public-facing and relationship-oriented aspects of the role, stating they were "excited about the relationship building," "excited about ... connecting with families," and happy to be "working with people ... and be [ing] a helping hand to anyone who needs it" (Participants 1, 3, and 8, onboarding interviews). CHWs looked forward to building personal connections with clients, especially those who had similar lived experiences as them or who were underserved by traditional healthcare systems.

This initial excitement about working with the public grew into a strong sense of enjoyment in forging client relationships and witnessing client successes. A CHW who was herself a former refugee described her happiness in helping refugee clients access care: "I am ... really happy to have the refugee client[s]. And [act as] a bridge to get the appointment [s], because they are pretty new to the ... clinic" (Participant 4, exit interview). Another described their joy at getting to be a "supportive person" for their clients, especially for those who did not have other social support: "I feel really happy that I get to be a positive and supportive person in people's lives when they don't have anybody else and that I get to help them build trust in a service and a person again" (Participant 6, exit interview). This CHW also recognized their role as one of rebuilding trust with individuals who had been marginalized by

other healthcare providers or by the healthcare system broadly. Another CHW summarized her enjoyment of the role as rooted in getting to know clients' unique stories:

*I enjoy being able to initially meet with a family or an individual, and just getting to know their story. I've always been very interested in people's stories ... So that's always one of my things is just kind of finding out where did they come from? Where are they trying to go? What are they doing in order to get there? ... And how can I be of an asset to you in trying to reach that goal that you have? – Participant 7, focus group*

CHWs described a deep sense of fulfillment in supporting and connecting with clients and the broader community. One CHW shared, “I feel very grateful that I was able to connect with the ... community in a very intimate way that I wouldn't have had in many other positions” (Participant 6, exit interview). This CHW went on to describe how being a CHW felt like a “grassroots” model of care:

*This is what community care looks like. This is what ... grassroots mutual aid is, is one person caring for another person and like, helping them, lending them a hand. And I just wish that there were so many more community health workers.*

Another CHW shared the fulfillment he felt in fostering long-term client relationships and witnessing his client move through major life milestones:

*I've been able to connect with some of my clients long term ... they're only able to meet with their therapist once or twice a month, but they were able to meet with me three or four times in that month, and maybe [have] two or three phone calls with me ... I have a client that just got married and sold her house and bought a new house ... so being able to, like celebrate some of those things with people, and just see really healthy, really positive outcomes coming out with those folks. –Participant 3, exit interview*

This CHW recognized the unique role he was able to play as a more flexible and available support person for his clients compared to clinicians, who are limited in the frequency and nature of their client interactions. This more personal and frequent contact was part of CHWs' enjoyment of their roles and aligned with the reasons many of them chose to become CHWs in the first place.

### 3.3. Research question 3: Impacts of emotional demands on CHWs

As seen in the themes above, CHWs' work was highly relational and involved navigating difficult emotions – both their own and those of clients. Our third research question focused on how CHWs were impacted by the emotional demands of their work. We found that 1) CHWs experienced a high degree of emotional burden as a result of their work, and that 2) CHWs sought to manage this emotional burden through a combination of self-sustaining activities and peer connection and support.

#### 3.3.1. Emotional burden is a core feature of CHW work

The emotional burden of supporting clients was a prevalent theme across our data sources and took different forms, including sharing in clients' challenges, feeling a sense of responsibility to address these challenges, suppression of their personal feelings, and the constant emotional demands of the work. CHWs shared in the challenges and injustices their clients faced, as shown in this diary entry:

*I honestly can't believe we are moving a family of eight, with a baby, into a house in this condition. I could tell that the father felt the same way. I was slightly frustrated because the family had done a walk through the week before, without me, and chose to move forth with renting. I was very attentive to all the same things wrong with the rental, writing down and taking photos of each thing I noticed. I plan to go to [the property*

*management company] later this week to make them aware of the state of their rental. - Participant 6, diary entry*

CHWs often faced situations like this in which they witnessed their clients experience exploitative, unsafe, or unfair living conditions. Another CHW noted, “Listening to [the client] talk about her living experience makes me really sad. [She] has no control over her space, food or environment” (Participant 2, diary entry). CHWs were emotionally impacted because of their investment in their clients' well-being and often felt responsible for trying to remedy unjust situations.

CHWs were tasked in their roles with helping clients continue to make progress toward their goals, despite witnessing clients' setbacks and experiences of injustice. This led to situations in which CHWs had to withhold their own feelings or concerns. One CHW explained, “[The client] feels like the group home has lied to him so much over the past few months. I feel this. I can't tell him I know, I agree. It's hard not feeling totally confident” (Participant 2, diary entry). The same CHW described the roller coaster of emotions she felt leading up to her client's potential placement in a group home:

*I feel scared with him and joyous with him. I worry about the group home not working out. I am exhausted from the emotions from the last months. Everybody deserves to feel love and I know I'll always have space for this. – Participant 2, diary entry*

In order to provide empathetic support and bridge the space between clinical care and clients' needs, CHWs needed to invest emotionally in their clients. However, this emotional investment took a toll on their own well-being. A CHW described feeling like the role did not allow them to have a “bad day or an off day” because of the mental and emotional labor it required:

*I have ADHD and my own mental health issues, as do many of us. And it's hard enough for me to keep track of my own schedule, and it feels like I'm constantly trying to remember 15 different people's schedules ... And, yeah, it feels like a job where you have to be very emotionally supportive and stable. And there's not a lot of space for you to have a bad day or an off day. Because you always have to be the strong support person in this position ... – Participant 6, focus group*

Being “the strong support person” was an integral part of CHWs' work, yet as these quotes illustrate, doing so was emotionally strenuous.

#### 3.3.2. CHWs create moments for self-sustainment and peer connection

To manage the emotional burden associated with their roles, CHWs used various strategies for self-sustainment and resilience. CHWs described daily practices of affirmation, self-care, and regulating their emotions. For example, a CHW described how she dealt with feeling like she was not accomplishing enough in her work: “When I start feeling less than, I take out my list and look at the tasks with strike throughs. This fills my cup. I often need a tangible reminder of my time, emotions, etc.” (Participant 2, diary entry). Another CHW's diary entry captured a small moment of resilience in the face of frustration over a client missing an appointment with her: “A little upset, oh well. Going to eat some of my chocolate muffin and start on housing application [smiley face]” (Participant 5, diary entry). These examples demonstrate the ways in which CHWs managed their own emotions as they worked with hard-to-reach clients and navigated complex, burdensome healthcare systems.

In addition to personal resiliency strategies, CHWs relied on one another and other organizational staff for support and moments of connection. A CHW explained the importance of breaks and social time with colleagues for her ability to manage the emotional challenges of her role:

*Interspersed throughout my day are fruitful or sometimes just fun conversations with coworkers, sometimes work related, sometimes not. This time is so critical to me, as focusing solely on patient need and crisis all day, every day, without levity or a moment for the brain and emotions to repair is exhausting and does not lend itself to longevity. I do not feel bad*

*that I took 10 minutes to go eat cake to celebrate a social worker's birthday ... because these little breaks make me better at my job. – Participant 1, diary entry*

CHWs' constant attentiveness to clients in crisis took a toll on the sustainability of their role. In this quote, the CHW described actively deciding to engage in social connection and moments of joy with co-workers. Implicit in her description is a sense of resisting the internal pressure she may have felt to skip these breaks or rush to assist the next client.

CHWs highlighted the importance of having time to connect with peer CHWs through programmatic meetings and case conferencing sessions. A CHW explained the utility of these cross-organizational CHW meetings:

*Getting support from your coworkers and the other CHWs is a huge part of our problem solving ... We used to meet every other week ... and just do case conferencing, and vent and share resources. And being able to do that with the other CHWs and your coworkers is a huge part of problem solving. Because it feels so hard to think through all the things on your own, especially when you have so many clients ... - Participant 6, focus group*

As illustrated here, CHW meetings provided a space for problem-solving and information-sharing, but also for “venting” and providing/receiving emotional support from peers who understand the challenges inherent to the work. Another CHW commented in her diary on the emotions she felt during these CHW peer meetings, saying “Sad a co-CHW will be leaving. She is a good person! Just got to know her, wish her the best ... Staff, housing, burnout for us. Laughing some. Only 4 CHW[s] came this time, good down time” (Participant 5, diary entry). This entry captured the mixed emotions of witnessing CHW turnover, as well as the CHWs' commiseration combined with humor about challenges like “housing” and “burnout.” CHWs used this kind of “down time” together to collectively manage the stresses of their work and validate one another's emotional experiences. These strategies for self-sustainment and peer support helped CHWs weather the emotional ups and downs of their work and carry the emotional burdens they experienced on behalf of their clients.

#### 4. Discussion

Our findings highlighted several key themes related to the relational and emotional elements of CHWs' work. First, relationship-building and emotional support were central to the CHW role. CHWs described these as core functions that set them apart from other health and public health professionals and took the time to learn clients' stories, provide emotional validation, or engage in persistent outreach and communication. Second, CHWs experienced a wide and intense range of emotions related to their jobs, from stress and exhaustion to deep satisfaction and fulfillment. The emotionality of their work stemmed from the relational and advocacy elements of their roles, which required deep empathy while helping clients navigate complex and burdensome systems. Third, CHWs needed to regulate their own emotions throughout their workdays so they could show up as their “best selves” to support clients in crisis or facing overwhelming barriers. This emotional labor took a toll and led to feelings of burnout; however, CHWs actively talked about and resisted burnout through self-sustaining activities and peer connection.

In our study, CHWs emphasized that they were not only linking clients to services but also performing deeply relational forms of care including persistent outreach, active listening, emotional validation, and even small gestures like a hug. This labor sustains individuals' health, dignity, and daily lives, yet is often underrecognized or invisible in public health performance metrics that prioritize quantifiable outcomes in program evaluation and performance reporting (e.g., [Roland et al., 2017](#); [Viswanathan et al., 2010](#)). Our findings demonstrate the centrality of relational trust and emotional support to CHW practice;

they also suggest that these dimensions of the role are not always matched by commensurate structure for recognition and support. CHWs described carrying the emotional weight of clients' crises and system barriers as a routine part of their work and sustaining this work through peer-based practices and informal strategies rather than through dedicated institutional supports. For example, peer groups and case conferencing were vital precisely because institutional support was limited; supervisors in this setting held other full-time roles and were not dedicated solely to CHW supervision. Health systems may increasingly invest in CHW programs to improve healthcare utilization, but the relational and emotional aspects of CHWs' labor remain under-supported.

CHWs in our study also described the work as emotionally complex; they spoke of the joy and purpose they derived from client relationships, while also expressing frustration with systemic barriers such as housing shortages and bureaucratic delays. Their reflections on feeling like “band-aids” or temporary fixes within broken systems illustrates how CHWs are positioned to respond to the harm produced by fragmented health and social systems ([Logan, 2022](#)). These reflections highlight how upstream change is often constrained by conditions outside CHWs control. While CHWs can engage in advocacy and systems navigation, structural barriers such as housing shortages, administrative delays, and institutional policies frequently limit what can be addressed at the root-cause level through routine CHW work. In this context, health systems may rely on CHWs' affective and relational labor to mitigate downstream effects at the individual level. This work can thus be deeply meaningful, as expressed by CHWs in this study, but also emotionally taxing when upstream determinants of health (e.g., housing, income) remain unaddressed.

Social reproduction theory (SRT) provides a useful lens for interpreting the relational and caregiving dimensions of CHW work observed in this study. SRT highlights that labor sustaining everyday life and well-being—care work, relationship-building, and emotional support—is foundational to social reproduction yet is often difficult to render visible within dominant economic and institutional logics that privilege standardized outputs and productivity ([Katz, 2001](#); [Laslett & Brenner, 1989](#)). With this lens, care work can be profoundly valued by those who receive it while remaining structurally harder to recognize, measure, and resource than other forms of labor, particularly within capitalist systems where such work does not directly generate profit. The emotional labor performed by CHWs in our study, such as listening to trauma, offering nonjudgmental support, and navigating strained institutions, sustains both individual well-being and the broader social fabric of communities, aligning with what [Katz \(2001\)](#) described as the “fleshy, messy, and indeterminate stuff” (p. 711) that reproduces everyday life.

This study extends theories of social reproduction and emotional labor into understanding the U.S. CHW workforce. CHWs occupy a distinct location within healthcare fields. Their emotional labor is inseparable from their roles as culturally grounded intermediaries and advocates, yet it can be difficult to recognize within dominant measures of productivity and professional competence ([Delgado, 2020](#)). SRT helps interpret why this mismatch persists by locating CHW labor within long-standing gendered and racialized divisions of care work, work that is essential for sustaining life and well-being but is frequently devalued in broader economic systems ([George, 2008](#); [Glenn, 1992](#)). Our findings, for example, align with [Garcia et al.'s \(2022\)](#) participatory study on Latino CHWs, which illustrated that their community-based expertise and emotional labor were often under supported by health institutions, even as they were celebrated as cultural mediators. In this framework, CHW emotional labor may be especially vulnerable to devaluation because it is feminized, racialized, and embedded in resource-poor communities. Furthermore, structural constraints on the CHW role, including inconsistent funding and limited formalized career pathways, may restrict opportunities for advancement. Given that CHWs and other frontline care workers (e.g., doula and personal care assistants) provide essential services to health systems for relatively low wages, existing

system incentives may de-prioritize greater job stability, compensation, or advancement opportunities for these positions.

Our findings also highlight how CHWs engaged in practices to sustain themselves as workers, aligning with SRT's emphasis on "reproduction of the workforce" (Bhattacharya, 2017). CHWs described peer support groups, case conferencing, taking breaks, and practicing self-care as essential strategies to regulate emotions and prevent burnout. These practices constituted a form of reproductive labor directed inward; CHWs continually "reproduce" themselves to remain capable of sustaining others' health. Their accounts echo Whiley and Grandy's (2022) description of healthcare workers developing embodied rituals such as closing a door or changing clothes to absolve themselves from the "emotional dirt" they absorb in neoliberal health systems. Like the National Health Service workers in that study, CHWs in our study used both embodied and collective strategies to manage the strain of emotional labor.

While SRT offers a useful critique for understanding CHWs' experiences, the current growth of the CHW workforce in the US means that practical interventions are needed to support CHWs within capitalist health systems and underfunded public health programs. CHW networks and employers can implement policies that value CHWs' labor, support their self-determination, and contribute to workforce sustainability. Based on our findings, we offer several recommendations that may serve as pragmatic strategies.

First, because CHWs' effectiveness relies on outreach, emotional labor, and relationship-building, programs must recognize these as central to their role. Sustainability requires structuring CHW positions, workloads, and metrics of success in ways that value the time it takes to build and maintain relationships. For example, rather than prioritizing the number of clients seen or referrals made, organizations can focus on client-centered metrics like satisfaction and patient-centered outcomes. State policies that shift Medicaid and Medicare reimbursement toward "value-based" care models, rather than traditional fee-for-service models, may also support the integration of CHWs. Because value-based systems emphasize care coordination, prevention, and patient-centered outcomes, they may structurally incentivize the types of services that CHWs commonly provide (NationSwell et al., 2025). In this sense, value-based reimbursement offers an alternative to volume-driven incentive structures, which may limit investment in CHW roles.

Second, our findings highlight that responsibility for managing the burden of emotional labor often falls on CHWs, rather than being structurally addressed by their employers. Recognizing and resourcing CHWs' self-sustaining practices is critical to program sustainability. CHWs need strategies that move beyond "self-care" to promote equitable labor practices, supportive workplaces, and sustaining peer connections. Programs must listen to CHWs and formalize these practices, such as supportive supervision models, reflection groups, manageable case-loads, and structures that address systemic barriers (Garcia et al., 2022).

Third, policy-level interventions are needed to address the current precarity of the CHW workforce and ensure equitable compensation. CHWs and allies are engaging in advocacy and organizing to secure greater recognition through professional associations, self-defining roles and competencies (e.g., the C3 Project), and collaborating on technical assistance programs (e.g., [envisionchws.org](http://envisionchws.org)). State and national CHW professional associations have advocated for policy measures such as value-based care, Medicaid reimbursement, and alternative payment structures (NationSwell et al., 2025). At the federal level, the 2024 CHW Access Act aimed to provide Medicare and Medicaid coverage for community health services, but this legislation has not progressed. Given recent funding cuts to federal CHW-focused grants, stronger advocacy at the local and state levels may be necessary to achieve material gains in wages, benefits, and workforce recognition.

#### 4.1. Limitations

This study has several limitations. We did not originally conceptualize the study to focus on race or gender as they related to CHWs' emotional labor. Therefore, we were limited in the extent to which our findings could speak directly to gendered or racialized dynamics that are often implicated in emotional labor and social reproduction. To protect confidentiality within the small local CHW workforce, we did not systematically collect or report on participants' demographic characteristics. However, the CHWs in our study were predominantly women, several of whom were Native American or refugees. This aligns with the broader U.S. CHW workforce (which is predominantly comprised of women of color) and strengthens the potential transferability of the study's findings.

We also conceived the methodology to be more participatory, aiming to include CHWs throughout conceptualization, data collection, analysis, and writing. However, due to CHWs' limited availability, much of the final analysis and writing was conducted by the researchers. As illustrated in our findings, CHWs juggled multiple priorities and had limited time for evaluation and research, despite these being part of core CHW competencies (Rosenthal et al., 2021). Although CHWs were less involved in later stages of the research, we worked to ensure their perspectives were represented through ongoing partnership and member checking. Nonetheless, our analysis may differ from CHWs' own interpretations.

#### 4.2. Conclusion

CHWs are key frontline public health workers who provide vital emotional and relational support, performing the function of social reproduction for clients systematically underserved by fragmented U.S. systems of care. The emotionality of CHWs' work is both a source of deep fulfillment and of frustration, burnout, and fatigue. Findings from our study illuminate the nature of emotional labor among CHWs and underscore the need for strong policy and advocacy at all levels to ensure their labor is equitably valued, resourced, and sustained.

#### CRedit authorship contribution statement

**McKenzie Javorka:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Kaitlin Fertaly:** Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Tina Czaplinska:** Writing – review & editing, Investigation, Formal analysis, Data curation.

#### Declaration of generative AI and AI-assisted technologies in manuscript preparation

During the preparation of this work the authors used ChatGPT (OpenAI, San Francisco, CA) to assist with organization and language refinement of sections of the manuscript. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

#### Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

#### References

- Abresch, C., Gilbert, C., Johnson, M., Karki, B., Lyons, K., Meyer, K., Tibbits, M., & Toure, D. (2023). Understanding the emotional labor of public health equity work: A

- mixed methods study. *Journal of Racial and Ethnic Health Disparities*, 10(3), 1047–1057. <https://doi.org/10.1007/s40615-022-01292-9>
- Berman, P. A., Gwatkin, D. R., & Burger, S. E. (1987). Community-based health workers: Head start or false start towards health for all? *Social Science & Medicine*, 25, 443–459. [https://doi.org/10.1016/0277-9536\(87\)90168-7](https://doi.org/10.1016/0277-9536(87)90168-7)
- Best, P., Badham, J., McConnell, T., & Hunter, R. F. (2022). Participatory theme elicitation: Open card sorting for user led qualitative data analysis. *International Journal of Social Research Methodology*, 25(2), 213–231. <https://doi.org/10.1080/13645579.2021.1876616>
- Bhattacharya, T. (2017). *Social reproduction theory: Remapping class, recentering oppression*. Pluto Books.
- Collinsworth, A., Vulimiri, M., Snead, C., & Walton, J. (2014). Community health workers in primary care practice: Redesigning health care delivery systems to extend and improve diabetes care in underserved populations. *Health Promotion Practice*, 15 (2 suppl), 51S–61S. <https://doi.org/10.1177/1524839914539961>
- Delgado, M. (2020). *Community health workers in action: The efforts of "promotores de salud" in bringing health care to marginalized communities*. Oxford University Press.
- Fertaly, K., & Fluri, J. L. (2019). Research associates and the production of knowledge in the field. *The Professional Geographer*, 71(1), 75–82. <https://doi.org/10.1080/00330124.2018.1455519>
- Fritzen-Pedicini, C., Bleasdale, S. C., Brousseau, L. M., Moritz, D., Sikka, M., Stiehl, E., & Jones, R. M. (2019). Utilizing the focused conversation method in qualitative public health research: A team-based approach. *BMC Health Services Research*, 19(1), 306. <https://doi.org/10.1186/s12913-019-4107-0>
- Garcia, M. L., Sprager, L., & Jiménez, E. B. (2022). Latino community health workers: Meeting their community's emotional needs in intuitively culturally appropriate ways. *Progress in Community Health Partnerships: Research, Education, and Action*, 16 (1), 3–4. <https://muse.jhu.edu/pub/1/article/849508>
- George, A. (2008). Nurses, community health workers, and home carers: Gendered human resources compensating for skewed health systems. *Global Public Health*, 3 (sup1), 75–89. <https://doi.org/10.1080/17441690801892240>
- Glenn, E. N. (1992). From servitude to service work: Historical continuities in the racial division of paid reproductive labor. *Signs: Journal of Women in Culture and Society*. <https://doi.org/10.1086/494777>
- Goodson, L., & Vassar, M. (2011). An overview of ethnography in healthcare and medical education research. *Journal of Educational Evaluation for Health Professions*, 8. <https://doi.org/10.3352/jeehp.2011.8.4>
- Ignoffo, S., Gu, S., Ellyin, A., & Benjamins, M. R. (2024). A review of community health worker integration in health departments. *Journal of Community Health*, 49(2), 366–376. <https://doi.org/10.1007/s10900-023-01286-6>
- Ingram, M., Reinschmidt, K. M., Schachter, K. A., Davidson, C. L., Sabo, S. J., De Zapien, J. G., & Carvajal, S. C. (2012). Establishing a professional profile of community health workers: Results from a national study of roles, activities and training. *Journal of Community Health*, 37(2), 529–537. <https://doi.org/10.1007/s10900-011-9475-2>
- Jackson, S. F. (2008). A participatory group process to analyze qualitative data. *Progress in Community Health Partnerships: Research, Education, and Action*, 2(2), 161–170. <https://muse.jhu.edu/pub/1/article/240857>
- Kangovi, S., Mitra, N., Norton, L., Harte, R., Zhao, X., Carter, T., Grande, D., & Long, J. A. (2018). Effect of community health worker support on clinical outcomes of low-income patients across primary care facilities: A randomized clinical trial. *JAMA Internal Medicine*, 178(12), 1635. <https://doi.org/10.1001/jamainternmed.2018.4630>
- Katz, C. (2001). Vagabond capitalism and the necessity of social reproduction. *Antipode*, 33(4), 709–728. <https://doi.org/10.1111/1467-8330.00207>
- Kim, K., Choi, J. S., Choi, E., Nieman, C. L., Joo, J. H., Lin, F. R., Gitlin, L. N., & Han, H.-R. (2016). Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: A systematic review. *American Journal of Public Health*, 106(4), e3–e28. <https://doi.org/10.2105/AJPH.2015.302987>
- Knowles, M., Crowley, A. P., Vasan, A., & Kangovi, S. (2023). Community health worker integration with and effectiveness in health care and public health in the United States. *Annual Review of Public Health*, 44(1), 363–381. <https://doi.org/10.1146/annurev-publhealth-071521-031648>
- Kukla, A. (2000). *Social constructivism and the philosophy of science*. Routledge.
- Laslett, B., & Brenner, J. (1989). Gender and social reproduction: Historical perspectives. *Annual Review of Sociology*, 15, 381–404. [10.1146/annurev.so.15.080189.002121](https://doi.org/10.1146/annurev.so.15.080189.002121)
- Latham, A. (2010). Diaries as a research method. In *Key methods in geography* (2nd ed., pp. 189–201). SAGE.
- LeCompte, M. D., & Schensul, J. J. (2010). *Designing and conducting ethnographic research: An introduction*. Bloomsbury Publishing PLC.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (Vol. 75). Sage.
- Logan, R. I. (2018). Not a duty but an opportunity: Exploring the lived experiences of community health workers in Indiana through photovoice. *Qualitative Research in Medicine & Healthcare*, 2(3), 7816. <https://doi.org/10.4081/qrmh.2018.7816>
- Logan, R. I. (2022). *Boundaries of care: Community health workers in the United States*. Bloomsbury Publishing PLC.
- Lumivero. (2024). NVivo (Version 14) [Computer software]. <https://lumivero.com/products/nvivo/>
- Maes, K., Closser, S., & Kalofonos, I. (2014). Listening to community health workers: How ethnographic research can inform positive relationships among community health workers, health institutions, and communities. *American Journal of Public Health*, 104(5), e5–e9. <https://doi.org/10.2105/AJPH.2014.301907>
- Malcarney, M., Pittman, P., Quigley, L., Horton, K., & Seiler, N. (2017). The changing roles of community health workers. *Health Services Research*, 52(S1), 360–382. <https://doi.org/10.1111/1475-6773.12657>
- Miles, M. B., Huberman, A. M., & Saldana, J. (2020). *Qualitative data analysis: A methods sourcebook* (4th ed.). SAGE Publications, Inc.
- Mlotshwa, L., Harris, B., Schneider, H., & Moshabela, M. (2015). Exploring the perceptions and experiences of community health workers using role identity theory. *Global Health Action*, 8(1), Article 28045. <https://doi.org/10.3402/gha.v8.28045>
- National Association of Community Health Workers. Diversity of CHW: Respondents by geography, ethnicity, race and cultures. [https://nachw.org/wp-content/uploads/2023/06/CHW\\_diversity.pdf](https://nachw.org/wp-content/uploads/2023/06/CHW_diversity.pdf)
- Nation Swell, Sanofi, Atlas Clarity & National Association of Community Health Workers. (2025). *Strengthening public health with community health workers*. <https://nachw.org/wp-content/uploads/2025/07/Strengthening-Public-Health-with-CHWs.pdf>
- O'Brien, M. J., Squires, A. P., Bixby, R. A., & Larson, S. C. (2009). Role development of community health workers. *American Journal of Preventive Medicine*, 37(6), S262–S269. <https://doi.org/10.1016/j.amepre.2009.08.011>
- Palmer-Wackerly, A. L., Chaidez, V., Wayment, C., Baker, J., Adams, A., & Wheeler, L. A. (2020). Listening to the voices of community health workers: A multilevel, culture-centered approach to overcoming structural barriers in U.S. Latinx communities. *Qualitative Health Research*, 30(3), 423–436. <https://doi.org/10.1177/1049732319855963>
- Pandey, J., & Singh, M. (2016). Donning the mask: Effects of emotional labour strategies on burnout and job satisfaction in community healthcare. *Health Policy and Planning*, 31(5), 551–562. <https://doi.org/10.1093/heapol/cvz102>
- Partners in Health. (2025). *How federal funding cuts are undermining public health infrastructure*. <https://www.pih.org/article/federal-funding-cuts-undermining-public-health>
- Perry, H. B. (2000). *Health for all in Bangladesh: Lessons in primary health care for the twenty-first century*. University Press.
- Perry, H. B., Zulliger, R., & Rogers, M. M. (2014). Community health workers in low-, middle-, and high-income countries: An overview of their history, recent evolution, and current effectiveness. *Annual Review of Public Health*, 35(1), 399–421. <https://doi.org/10.1146/annurev-publhealth-032013-182354>
- Rifkin, S. B. (2008). Community health workers. In *International encyclopedia of public health* (pp. 93–102). Elsevier. <https://doi.org/10.1016/B978-0-12-803678-5.00083-7>
- Roland, K. B., Milliken, E. L., Rohan, E. A., DeGross, A., White, S., Melillo, S., Rorie, W. E., Signes, C.-A. C., & Young, P. A. (2017). Use of community health workers and patient navigators to improve cancer outcomes among patients served by federally qualified health centers: A systematic literature review. *Health Equity*, 1(1), 61–76. <https://doi.org/10.1089/heap.2017.0001>
- Rosenthal, E. L., Fox, D. J., St John, J. A., Allen, C. G., Menking, P., Brownstein, J. N., Hirsch, G. R., Redondo-Martinez, F., Holderby-Fox, L. R., Ibarra, J. M., Palmer, C. L., Hurley, A. R., Cole, M. C., Masoud, S. S., Wright, J. U., & Rush, C. H. (2021). The Community Health Worker Core Consensus (C3) Project story: Confirming the core roles and skills of community health workers. In J. A. S. John, S. L. Mayfield-Johnson, & W. D. Hernández-Gordon (Eds.), *Promoting the health of the community: Community health workers describing their roles, competencies, and practice* (pp. 11–35). Springer International Publishing. [https://doi.org/10.1007/978-3-030-56375-2\\_2](https://doi.org/10.1007/978-3-030-56375-2_2)
- Sabo, S., Allen, C. G., Sutkowi, K., & Wennerstrom, A. (2017). Community health workers in the United States: Challenges in identifying, surveying, and supporting the workforce. *American Journal of Public Health*, 107(12), 1964–1969. <https://doi.org/10.2105/AJPH.2017.304096>
- Segall, M. (2003). District health systems in a neoliberal world: A review of five key policy areas. *The International Journal of Health Planning and Management*, 18(Suppl 1), S5–S26. <https://doi.org/10.1002/hpm.719>
- Smithwick, J., Nance, J., Covington-Kolb, S., Rodriguez, A., & Young, M. (2023). “Community health workers bring value and deserve to be valued too:” key considerations in improving CHW career advancement opportunities. *Frontiers in Public Health*, 11, Article 1036481. <https://doi.org/10.3389/fpubh.2023.1036481>
- Swartz, A., & Colvin, C. J. (2015). It's in our veins: Caring natures and material motivations of community health workers in contexts of economic marginalisation. *Critical Public Health*, 25(2), 139–152. <https://doi.org/10.1080/09581596.2014.941281>
- The Canadian Institute of Cultural Affairs. (2000). *The art of focused conversation: 100 ways to access group wisdom in the workplace*. New Society Publishers.
- U.S. Bureau of Labor Statistics. *Community health workers*. <https://www.bls.gov/ooh/coommunity-and-social-service/community-health-workers.htm>
- USAID. (2022). Factors influencing community health worker behaviors: Literature review synthesis. <https://breakthroughactionandresearch.org/wp-content/uploads/2024/11/Factors-Influencing-CHW-Behaviors-Literature-Review-Synthesis.pdf>
- Viswanathan, M., Kraschnewski, J. L., Nishikawa, B., Morgan, L. C., Honeycutt, A. A., Thieda, P., Lohr, K. N., & Jonas, D. E. (2010). Outcomes and costs of community health worker interventions: A systematic review. *Medical Care*, 48(9), 792–808. <https://www.jstor.org/stable/25750559>
- Walt, G. (1988). CHWs: Are national programmes in crisis? *Health Policy and Planning*, 3 (1), 1–21. <https://www.jstor.org/stable/45088727>
- Whiley, L. A., & Grandy, G. (2022). The ethics of service work in a neoliberal healthcare context: Doing embodied and “dirty” emotional labor. *Qualitative Research in Organizations and Management: An International Journal*, 17(1), 136–157. <https://doi.org/10.1108/QROM-08-2020-2005>