Navigating Knowledges: Community Health Workers as Liminal Professionals

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Abstract

Community Health Workers (CHWs) occupy a liminal position in two senses: they are situated between the communities they come from and serve, and the health and social service professionals with whom they connect patients; and also between two forms of knowledge. In interacting with health and social service institutions, they draw on the "technical knowledge" that dominates these settings. However, they must also draw on "communicative knowledge," which is the situated and embodied knowledge needed to gain the trust of their community peers and to carry their voice, but which is often relegated to a secondary position (Rennstam & Ashcraft, 2014). In this US-based study, we analyze interviews with CHWs, their supervisors, and advocates of their work, to better understand how CHWs mobilize discursive resources to combine these two forms of knowledge and, in doing so, constitute their liminal position as an essential asset. Our findings support valuing CHWs' incorporation within healthcare teams, so that health and social service professionals can directly interact with CHWs' situated and embodied knowledge of patients.

Keywords: knowledge; professionalization; liminality; healthcare; discursive resources; community health workers.

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The COVID-19 pandemic has exposed many pre-existing inequities suffered by communities of color in the US and around the world. Longstanding health-related inequities, for example with respect to maternal and child health, chronic diseases, and healthcare access, underlie the disparate impact of the pandemic on African American, Latinx, American Indian, and economically disadvantaged communities (Hooper et al., 2020). Addressing these inequities requires interventions that "consider the nuances of population, community, family, and individual differences" (Hooper et al., 2020, p. E2). In turn, such considerations demand a deep understanding of local communities and an engagement with them in mutual partnership.

We focus here on an occupation that embodies this understanding and partnership model: the Community Health Worker (CHW). CHWs are frontline public health workers who are trusted members of the communities they serve and have been identified as a powerful resource in the elimination of health disparities (e.g., Zahn et al., 2012). CHWs function as liaisons between their communities and health and social service organizations, facilitating access to services, and serving as community champions. Concomitantly, CHW programs, typically combining extensive in-service training with the performance of their liaison roles, empower the individuals who serve in these roles and build community capacity (Matos et al., 2011). Because they are members of the communities in which they work, or have special knowledge of those communities, CHWs are assumed to be able to interact with residents in a culturally relevant manner and to bridge divides between provider organizations and vulnerable community members (Arvey & Fernandez, 2012). CHW interventions have been extensively evaluated and reported on (CDC, 2014; Scott et al., 2018), with significant evidence pointing to their effectiveness in a variety of contexts, especially chronic disease management in culturally and

linguistically diverse populations (e.g., Goris et al., 2013), and maternal and child health (Lewin et al., 2010).

CHWs the world over, however, face the thorny challenge of demonstrating their efficacy and constituting their "professional" identities while simultaneously navigating their commitments to the communities they serve, the health and human service institutions they seek to connect their clients with, and the spaces in between. Literature has suggested that demonstrating professional ability is a matter of gaining and displaying knowledge in relevant manners (Bourgoin & Harvey, 2018; Huising, 2015). Establishing professional identity is thus intimately related to the ability to command multiple forms of knowledge. A better understanding of how CHWs accomplish this may make a practical contribution to supporting their professional legitimacy as well as contribute to extant theorizing on knowledges and knowing in organizational settings.

Literature Review: Knowledge and Knowing in a Liminal Position

Knowledge and knowing

To understand how CHWs constitute their professional identity, we consider in this US-based study not only knowledge, understood as a body of facts, information and codified skills, but also *knowing*, as a practical and collective effort of figuring out "how to get things done" (Orlikowski, 2002, p. 249). In considering such a practical understanding of knowledge and knowing, we draw on conceptions of "technical knowledge" and "communicative knowledge." Descriptions of CHWs' work (e.g., Matos et al., 2011) suggest that their success hinges on their ability to skillfully *integrate* dominant forms of "technical" knowledge, prevalent among healthcare and human service providers, with "communicative knowledge." Rennstam and Ashcraft (2014) define the latter form of knowledge as "*situated and embodied knowledge* about

interaction that is also created and used in *interaction*" (p. 4, emphasis in original). CHWs' communicative knowledge develops from being part of their community and is enhanced with training by the community-based organizations that employ them.

"Knowledge work" has become an important theme in academic research (Barley, 1996), with technical knowledge often described as dominant, and leading to the marginalization of other forms of knowing (Barley & Kunda, 2004). Indeed, cognitive forms of knowledge have traditionally been valued more than their situated and embodied counterparts (see Blackler, 1995), not least because the latter are often associated with feminine and lower-class occupations (Rennstam & Ashcraft, 2014). However, there is also growing criticism of the assumption that "knowledge-intensive" work is exceptional or in some way better than other forms (Alvesson, 2011).

Indeed, it has been observed that several occupations rest on "aesthetic and social skills" rather than on specialized and codified knowledge; those workers know what tone of voice, kind of dress and levels of energy to employ, and can "consciously use their emotions and corporeality to influence the quality of the service" (Thompson et al., 2001, p. 923). These skills are often considered to be in opposition to cognitive or encoded forms of knowledge (e.g., Carlile, 2004).

However, rather than assigning "alternative" knowledge to particular kinds of work, another position maintains that all work supposes the combination of forms of knowledge, including those anchored in the body and its senses (Beyes et al., 2022). For instance, and of particular relevance to our focus on CHWs, physicians and other healthcare professionals – who are typically considered as possessing vast technical expertise – also rely heavily on embodied knowledge (Hindmarsh & Pilnick, 2007). It is partly through embodied practice that they learn

their trade (see, for example, Zemel and Koschmann's 2014 study of teaching and learning surgical techniques) and uphold their medical standards when faced with opposing pressures (see Matte and Bencherki's 2019 analysis of intercultural interactions between Doctors Without Borders physicians and local Kenyan medical staff and caregivers in which ethical conflicts around patient care are "materialized" and resolved through embodied interactions).

Rennstam and Ashcraft (2014) argue that communicative knowledge plays a growing role in our contemporary economy, even in presumably technical professions since they require not only expert knowledge but also bodily performance and relational skills (see Huising, 2015). Indeed, “work respectively presumed technical and communicative actually contains and prioritizes ‘the other’ in surprising ways that counter cultural constructions of the work” (Rennstam & Ashcraft, 2014, p. 19). Yet, even workers who in fact combine forms of knowledge have been observed to privilege technical and codified knowledge and devalue alternative ways of knowing, resulting in what Minei and Bisel (2013) describe as “epistemic denial.”

The view of the two forms of knowledge as oppositional, and their association with specific occupations, is particularly troublesome for CHWs. While these workers are increasingly embedded in health programs (Matiz et al., 2014) and contribute to improving access to healthcare (CDC, 2014; Scott et al., 2018), their acceptance by traditional professions (such as medicine and social work), as well as by government agencies that control payment for health services (in the US, the Centers for Medicare and Medicaid; national healthcare systems in other global locations), remains mixed. As a reaction, some voices call for an increased “professionalization” of their role, for instance through formal credentialing (i.e., the creation of specific education and training requirements). Others, however, express skepticism and even concern about such a trend.

CHWs as Liminal Professionals: Combining Communicative and Technical Knowledge

CHWs thus find themselves in a liminal position (e.g., Long et al., 2022), not only because they serve as bridges between, on one hand, healthcare professionals and institutions, and on the other, the communities they serve, but also because their work straddles forms of knowledge that are perceived by some as traditionally opposed. CHWs' liminality positions them "betwixt and between the original positions arrayed by law, custom, convention and ceremony" (Turner, 1977, p. 95), which can be construed as a liability, but may also be liberating and provide unique opportunities (Long et al., 2022).

Liminality itself is a discursive construction and results from people envisioning themselves as being either in a transitional situation or as finding themselves in an in-between situation for a prolonged time (Ybema et al., 2011). Thus, a liminal position is at once the cause of negotiating between knowledge forms, and the outcome of those negotiations. Paying attention to how people construct their in-between situation can reveal how they give meaning to their liminality, which can become, for them, a "dwelling place" (Shortt, 2015). This means that, while liminality is often conceived as a temporary waystation where "usual practice and order are suspended," workers can also devise for themselves "new rites and rituals" that define who they are (Czarniawska & Mazza, 2003, p. 267).

Certainly, the successes of CHW programs in the United States lends support to the idea of liminality as a strength. However, as they attempt to make a "dwelling place" for themselves, CHWs often face a lack of recognition from others. In spite of CHWs' demonstrated contributions, many public health experts agree that the full potential of CHWs remains unrealized as a result of their not being fully integrated into the healthcare system (Bir et al., 2018; Zahn et al., 2012). Some CHWs are directly embedded in healthcare teams in hospital

settings, and as such are more accepted members of those teams (see, for example, Matiz et al., 2014). More commonly, though, CHWs are employed by community-based organizations, with the consequence that their work may be less well understood and valued by institutional providers of healthcare and social services.

The liminal position of CHWs, in between health and social service providers and community members, and their incomplete institutional embeddedness, are paralleled in the ambiguous nature of the knowledge they need to perform their work effectively. CHWs have some widely accepted areas of competency, reflected for instance in the recommendations of the NYS (New York State) Community Health Initiative (NYS being the site of the study reported on here), including outreach and community mobilization, community/cultural liaison, case management and care coordination, home-based support, health promotion and health coaching, and system navigation (Matos et al., 2011). However, at this time, there is no standard certification for CHWs in NYS (as there are for other healthcare occupations), leaving their knowledge base somewhat ambiguous, and also potentially contributing to lack of recognition and funding support from the major public funding agencies of healthcare in the US, Medicare and Medicaid. Balancing standardized training with inclusiveness in the selection of CHWs is thus an important debate among stakeholders, and is addressed in training recommendations from national organizations such as the National Association of Community Health Workers. Those calling for credentialing the occupation suggest that it would also allow CHWs avoid the ambiguity of their position and gain better institutional recognition, while others fear excluding people with valuable community experience (Zahn et al., 2012).

Discursive Resources in the Construction of Liminal Professionals

Our aim is to better understand how CHWs turn their liminal position into an asset in brokering between healthcare professionals and their historically marginalized and underserved patients. To do so, we must observe how they perform knowledge, i.e., engage in *knowing* practices, while they accomplish their everyday work. Consistent with our view of both knowledge forms and liminality as discursive constructions (Ybema et al., 2011), and with our constitutive orientation to discourse, we also draw on Kuhn and colleagues' (Kuhn, 2006, 2009; Kuhn et al., 2008) concept of "discursive resources" to inform our exploration of how CHWs draw on such resources (such as such as existing narratives and ongoing conversations about their work) as they experience their in-between position and integrate technical and communicative knowledge. In this structurationally informed conception of organizing, "discursive resources" – understood as "concepts, expressions, or other linguistic devices that, when deployed in talk, present explanations for past and/or future activity that guide interactants' interpretation of experience while molding individual and collective action" (Kuhn, 2006, p. 1341) – exist at multiple levels. Consequently, understanding CHWs' work requires examining their discourse about their work, as well as the discourse of those who directly supervise their work, and as those we designate as "advocates." This last category includes academics, training program providers and CHW program managers who promote the utilization of CHWs by speaking out about their value in public forums (e.g., the American Public Health Association's conferences) and in so doing shape public discourse about them.

Following Kuhn and colleagues, our assumption was that the latter two categories of actors formulate the framework that offers the discursive resources CHWs use to negotiate their liminal position. Advocates' and supervisor's talk about and to CHWs thus constitutes the

"discursive resources" (Kuhn, 2006; Kuhn et al., 2008) that enable or constrain CHWs' own attempts to constitute a dwelling place for themselves. CHW discourse is thus formed in relation to those discursive resources, and as they describe their own activities, they are also "exposing rules for appropriate activity" as defined in those discursive resources (Kuhn, 2006, p. 1341). Thus, while CHWs' effectiveness in their role hinges on their ability to combine forms of knowledge, it also depends on how others have defined the playing field where that work takes place.

Our inquiry, therefore, aligns with Matte and Cooren's (2015) view of discourse as a site where people concretely engage with different forms of knowledge and reconcile apparent tensions. The discursive resources evident in the discourse of advocates are by definition part of the public discourse on CHWs' work, which provides an institutionalizing function as it shapes the training of CHWs and is picked up and reproduced at the organizational level by supervisors, and ultimately by CHWs themselves.

Research Questions

We situate our study within interrelated streams of research on knowledges and knowing, liminality, and discursive resources' shaping of identity and action in organizational settings. In doing so, we note the need to rethink the relationship between forms of knowledge and organizational actors and organizations. Extant research has tended to associate different forms of knowledge with different occupations or different demographic features of individuals, or, alternatively, to consider them as being simultaneously present within a single occupation despite one of them being more prevalent. Little research has considered cases where *the same person must deal, from a liminal position, with different domains of practice, each of which values different forms of knowledge*, as is the case with CHWs. The role of such negotiation in

constituting an occupation's position as liminal has also been overlooked. Moreover, the importance of embodied, place-based identity in this negotiation has been under-elaborated. Therefore, our study is guided by the following research questions: How do CHWs discursively integrate different forms of knowledge? More specifically, how do they do so while drawing on discursive resources from advocates and supervisors and carving out a liminal "dwelling place" for themselves between their communities and healthcare institutions?

Research Procedures

Data Collection and Participants

To answer those questions, we analyzed interviews drawn from a broader project whose purpose was to document CHWs' adaptive strategies for working under COVID-19 pandemic conditions in the northeastern United States during the first year of the contagion. The project was funded by an internal grant from the first author's institution.

As mentioned above, the study was designed to include perspectives from multiple levels, including CHW advocates, program managers/supervisors, and CHWs. We look at advocates and supervisors, in addition to CHWs themselves, because they regularly have to legitimize the work of CHWs to stakeholders who may be unfamiliar with their work or skeptical of its value, but also because, in the course of doing so, they (re)produce discursive resources that shape CHWs' understandings and performance of their work through the training they are provided and their day-to-day supervision. Thus, we consider interviews as not only producing information about CHWs and their work, but as situations that call upon CHWs, supervisors and advocates to produce a justification for the researcher's benefit (Alvesson, 2003; Alvesson & Ashcraft, 2012) and that draw upon the same "discursive resources" (Kuhn et al., 2008) they use in other situations.

Participant recruitment was designed to include diverse locales throughout NYS, including both downstate (in and around the greater New York City area) and upstate (north of the city), and in both rural and urban settings. The programs were also diverse with respect to their area of focus (i.e., specific health issues focused on) and to institutional arrangements (i.e., public versus private funding). The most common content areas of focus were maternal-child health (MCH) and chronic disease management (CDM). Recruitment was accomplished through a statewide professional association for healthcare organizations, through the NYS Department of Health, by direct emails to CHW programs receiving funding from NYS (publicly available information), and by referrals.

A total of 52 individuals participated in the study, including 33 active CHWs, 14 supervisors (many of whom were former CHWs), and 5 CHW advocates. Most CHWs were interviewed in groups of three or four, whereas almost all the remaining participants were interviewed individually, resulting in a total of 30 interviews, averaging approximately 1 hour each. All interviews were conducted by the first author between October and December 2020 over Zoom and other video platforms. The interviews were recorded and professionally transcribed, resulting in 546 pages of transcript data. The transcripts were then imported into the NVivo software program to facilitate analysis.

To keep barriers to participation low, participants were not asked to self-report demographic data in a questionnaire separate from the recorded interviews. General information about characteristics of CHW participants was drawn from supervisor accounts, who characterized their employees as representing the demographics of the communities they served in terms of race and ethnicity, as well as age and gender. This meant that CHWs in urban MCH programs were characterized as being predominantly younger women of color, whereas CHWs

in CDM programs were characterized as often being somewhat older. Participants were promised that no information they provided would be specifically attributed to them as individuals, and that their specific program name or location would not be divulged. All participants were offered a $25 gift card in appreciation for their participation. The study protocol was reviewed and approved by the first author's Institutional Review Board.

Data Analysis

Analysis of the interview transcripts was an iterative process informed by the constructivist grounded theory approach articulated by Charmaz (2001), as the categories of findings and the interpretations we present here both emerged from the data we collected and were shaped by extant theory and research. To analyze the interview transcripts, we began by "index coding" (Deterding & Waters, 2021) the entire body of interviews in NVivo, which entailed indexing the transcripts' contexts to 8 major content areas identified by the first researcher as encompassing the main topics addressed by the interview guide, and the responses that participants produced. These topics included: the nature of CHW work, CHWs' new connection strategies, challenges and barriers to adaptation, new areas of support provided by CHWs, resources needed by CHWs, socioemotional impact of the pandemic on CHWs, pandemic silver linings, and vaccines.

The topical category most relevant to the focus of the analysis reported on here was "the nature of CHW work."[i] Using NVivo to extract all references to this index code, the first author then intensively annotated the text, following Owen's (1984) principles of recurrence, repetition, and forcefulness, both within and across categories of participants. For example, the phrase "lived experience" was repeated both within and across advocates' interview accounts (repetition) of essential characteristics of effective CHW. It also appeared in other related forms

in interviews with advocates, but also in interview accounts from supervisors and CHWs themselves that referenced the embodied experiences of CHWs, such as residing in the same neighborhoods as their clients (recurrence). Moreover, all three categories of respondents spoke passionately about the importance of this characteristic (forcefulness).

Thus, the categories presented in our findings below represent the results of this process of reflexively and collaboratively cycling between the data and relevant research literature. This led us to the theoretical framework that we introduced earlier, with the constructs from Rennstam and Ashcraft's (2014) exposition of communicative knowledge and its relationship to technical knowledge, augmented with the notion of liminality, in order to fully account for the findings and their significance. In the next section, we present the results of our analysis by showing the specific discursive resources produced and drawn on by advocates, supervisors and CHWs, and how they help CHWs speak of their liminal position in between their community and healthcare institutions, but also in between forms of knowledge.

Findings and Interpretation

There was repetition of themes across the categories of participants, consistent with the understandings about the interrelationships among the different levels they represent (as described above). However, and also consistent with these understandings, we construe their deployment of discursive resources as constituting different types of performances. Specifically, we understand (a) advocates' accounts as operating at the institutional level and reproducing discursive resources deployed in public forums for the purpose of legitimating CHWs' unique competencies in terms of how their work combines communicative and technical knowledge; (b) supervisors' accounts as operating at the organizational level and reproducing discursive resources with respect to CHW competencies that are heard in the advocates' accounts, but

fitting them more specifically to the day-to-day management of the activities CHWs are charged with, including the manner of their training and supervision; (c) CHWs' accounts as organizationally situated accounts but focusing on the performance of their day to day work, through which we can see threaded the same discursive resources. Elements that the more specific situationally fitted discursive resources all draw on include (a) the role of lived experience in the performance of CHWs' work and the related element of their embodied identities; (b) the importance of CHWs' training; (c) CHWs' bridging functions between the community and health and human service organizations; and (d) empowerment of CHWs and community members as the end goal. Figure 1 summarizes the categories of discursive resources most prominent in the accounts produced by each type of participant, each of which is discussed in detail below.

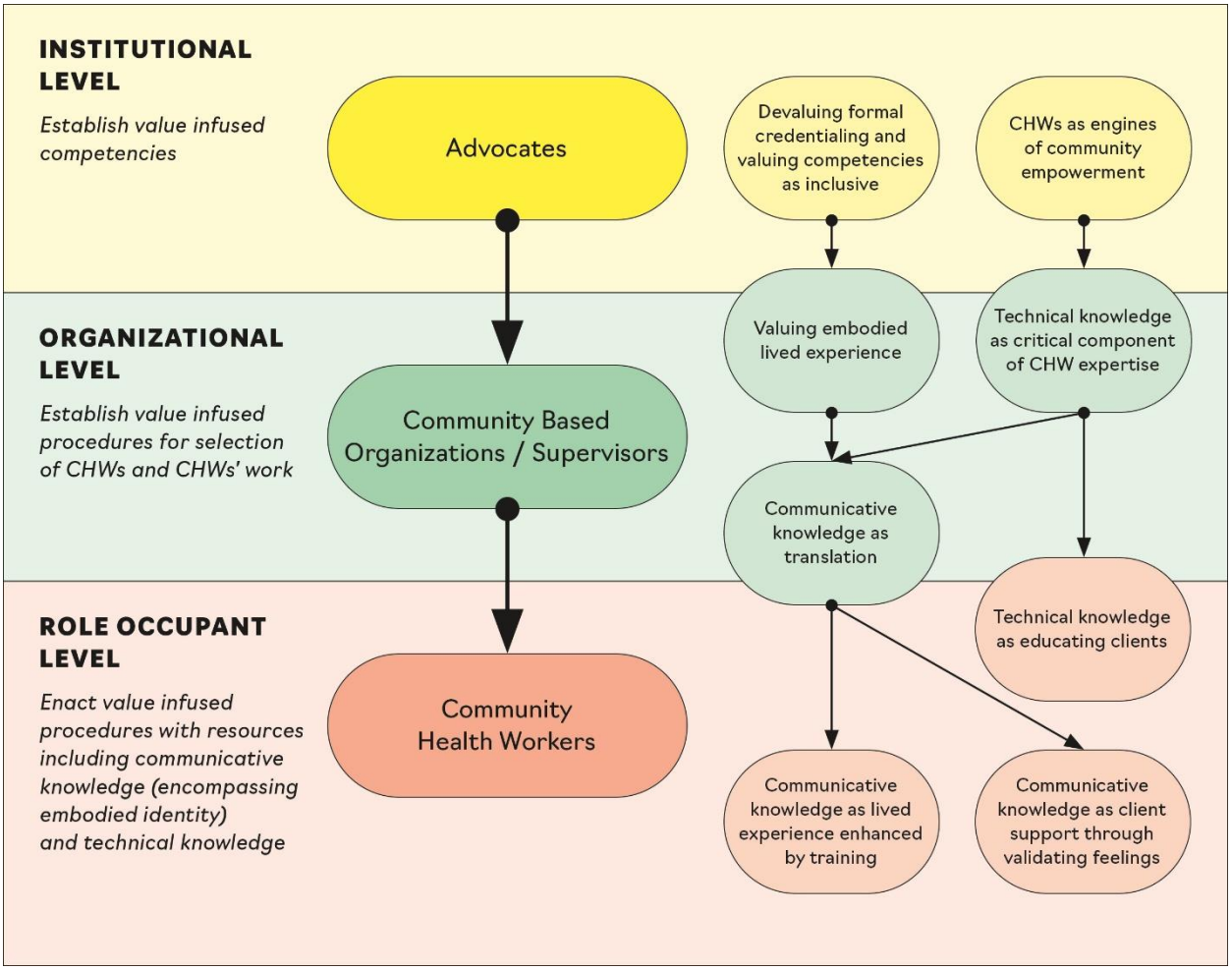

Figure 1: Discursive resources for enactment of the CHW role produced, reproduced, and transformed across institutional, organizational, and individual role occupant levels.

CHW Advocates' Discourse on the Nature of the CHW Role

The interviews conducted with CHW advocates revealed their concerns about the value of formal credentialing and the importance of CHWs' lived experience. Advocates tend to reject traditional credentialing and position it as exclusionary, preferring competencies achieved through CHWs' community embeddedness and enhanced through workplace training (such as in motivational interviewing). They also elevate and valorize the embodied, lived experience of CHWs as members of the communities they serve, as it enables them to gain trust and establish

connections with community members. CHWs are positioned as uniquely qualified to relate to patients and address social determinants of health.

Devaluing Formal Credentialing as Exclusionary; Valuing Competencies as Inclusive

As noted in our framing of this study, the lack of full acceptance of CHWs in more professionalized settings such as healthcare organizations and social service organizations may suggest to some that the solution is increased credentialing. Credentialing is also sometimes referenced as the key to sustaining CHWs' work financially by positioning the services they provide as "professional" services that can be reimbursed through the US government funded health insurance programs (Medicare and Medicaid) relied upon by many members of under-resourced communities. However, the advocates interviewed for this study produced a discourse in which traditional credentialing or certification was explicitly positioned as exclusionary and in direct opposition to the spirit and values of CHW programs. As voiced by one advocate:

> *I think the conversations around certification, a lot of the processes have seemed pretty arbitrary to me. . . . When I was first introducing the community health workers to our institution [I heard] "Well, who are they? What kind of degree do they have?" The need to have some sort of credential or certification to validate their role. It wasn't enough to say, "Well, they come with this amazing set of skills and with experience. Once you see them in action, you'll completely understand why they're unique and important and critical in this work." - Downstate Advocate 1 - Major healthcare institution*

Another advocate echoes this rejection of credentialing, adding that not only is it unnecessary, but it may actually exclude those who are most qualified to perform the role:

> *The whole point of their role is to really be folks who are part of the communities and connect to community members and, if it becomes credentialed, it could become over-credentialed to a point where community health workers aren't actually the folks who are best suited to do this work, and may not actually be able to meet the requirements to do it. - Downstate Advocate 2 - Training organization*

What advocates promote in place of credentialing are "competencies" achieved through training, in contrast to "formalized education" that may take years to complete and cost tens of thousands of dollars, which goes hand in hand with the discourse of traditional credentialing as exclusionary. Downstate Advocate 2 further points to the existence of some form of community of practice among CHW trainers, program managers, and CHWs with an agreed-upon set of "core competencies." As Downstate Advocate 2 explains, though, it's important to note that these competencies are accomplished through workplace training:

> *The training's really comprehensive and includes kind of a wide range of things such as core competencies and things like motivational interviewing. There's also health specialties, so things like asthma, diabetes, cardiovascular disease.*

This training both helps to enhance CHWs' innate communicative knowledge, for example, in the form of motivational interviewing, a widely shared approach to client interactions. As described by its chief proponents, Miller and Rollnick (2013), "MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion" (p. 29). Equally important, however, is technical knowledge related to specific health conditions and to the structures of health and human service organizations, which enables CHWs to navigate these systems and coach their clients on how to do so.

Valuing Embodied, Lived Experience as the Foundation of Trust

As implied by the previous discourse, at the same time CHW advocates reject formal education and traditional professional credentialing as a means for valuing the work of CHWs, they elevate and valorize their embodied, lived experience as members of the communities they

serve. Thus, value, as in other, more traditionally technical occupations, is achieved by the assertion of "difference," but not difference that can be acquired through exertions of technical rationality. As one advocate explains,

> *We're a social concept. We're not a technical... – you can't really go to college and get a degree and become a CHW. It's not like that. It's a personal... – it requires a number of personal options that you can't learn in school. It's kinda the stuff your mama gave you. - Downstate Advocate 3 - Training provider*

The phrase "lived experience" is frequently invoked to reference what we refer to as the CHWs' "communicative knowledge" and "relational embodied knowledge" of their communities:

> *I feel that they're uniquely qualified because of their lived experience because they can relate to our patients in a way that the other actors within a healthcare system cannot. - Downstate Advocate 1*

More specifically, the advocates reference embodied experiences of place in the community settings, and being subject to the same set of social and material forces that impact health and well-being, i.e., the same social determinants of health that impact their clients. These shared experiences, in turn, allow CHWs to gain the trust of community members, which enables them to do their work of helping the community connect with services and manage their health concerns.

> *So, because they are members of the communities that they are doing outreach and engagement with, folks tend to trust them. They oftentimes live in the same neighborhood or around the same areas. They've experienced the same social determinants as the folks that they're working with . . . and are able to connect with them on the same level in many ways that healthcare providers or health services or social services providers can't. - Upstate Advocate 2 - Training provider*

CHWs as Engines of Empowerment in Marginalized Communities

As mentioned earlier in our initial description of the CHW role, the development of this role was intended not only to improve the health of underserved communities, but also to empower the individuals who serve in these roles and thereby build community capacity to address health related concerns at the community level.

> *A part of even why we started this [program for training and placing CHWs] was both as a leadership development opportunity for community members to be able to find employment in a field that they want to be able to work in, and also to really serve as a bridge between the community and the clinical setting. - Downstate Advocate 2*

Indeed, some of the CHWs interviewed for this study shared that their pathway to becoming CHWs began with being clients of the programs that currently employ them. At the same time, the goal of CHW programs is not just to develop local experts who are able to combine their communicative knowledge of the community with their technical knowledge of managing chronic health conditions and navigating the systems in order to *assist* community members. The goal, rather, is to *empower* community members to identify goals and achieve them. This advocate's description of the CHWs' role encapsulates this perspective, which maps on to key precepts of "motivational interviewing."

> *I think the most important contribution that we've been to society is that we help people become empowered... And that's what CHWs do, they provide – they help people explore their experience, explore their lived experience and determine what are your hopes and what are your dreams, what do you wanna do. And then how can we get there? - Downstate Advocate 3*

The advocate's portrayal of the close connection between CHWs and their clients is underscored by the fact that the speaker begins by referring to CHWs in third person (*they* help), shifts to speaking directly from the perspective of the CHW who is speaking to the client, first

addressing the client in second person (what are *your* hopes) but then allying herself to the client by shifting to first person plural (how can *we* get there).

CHW Supervisors' Discourse on the Nature of the CHW Role – Communicative Knowledge as Expertise and the Necessity of Technical Knowledge

Turning to supervisors' interview accounts, these can be heard as discourse produced for external stakeholders (as in the advocates' interview accounts) but also as discourse that they might deploy with the CHWs themselves in the course of carrying out their supervisory functions of selecting and training CHWs to perform their organizational roles. While there is overlap between the discourses produced by advocates and supervisors, there are also distinct differences. In general, the supervisors' accounts included far less discourse on resisting credentialing, and more discourse representing what CHWs do, reflecting the fact that, unlike the advocates, they are directly responsible for the CHWs' work. Like the advocates, the supervisors' discourse legitimated the value of communicative knowledge in the form of "lived experience" and its relationship to trust (and therefore, in the interest of space, we will not reproduce their discourse on this topic). However, the supervisors, many of whom are former CHWs, relate far more detail on how CHWs leverage this lived experience to enact communicative knowledge in ways that more effectively connect their clients with healthcare providers and service organizations, by communicating effectively with all of the parties. This supervisor's description of the characteristics of an effective CHW spans both communicative and technical knowledge, drawing on the same fundamental elements of lived, embodied experiences and identity, the importance of training, and their bridging function.

> *We just know, culturally, it's very important for people to work with individuals that look like them, and that's pretty much the basis of a CHW worker; they are a reflection of the community and making sure that culturally*

> *and language and everything is a reflection of who you're working with. . . Also, empathy and being resourceful, making sure that they understand the community that they're working with, they're resourceful in looking at what's in the community, how to connect those individuals to the resources that they need, and that they're . . . able to . . . use the systems that we use to document the visits. . . And just being able to communicate both with the families that they're working with, but also the clinical providers that they have to work with, that they're comfortable and that they're capable of communicating on behalf and advocating on behalf of the patients that they're working with. . . - Downstate Supervisor 1*

Of particular interest here is how the supervisor positions the CHWs' communicative knowledge *between* the client and the healthcare providers, as well as the representation of the CHWs' technical knowledge requirements. We consider each of these in further detail.

Communicative Knowledge as Translation

CHWs' communicative knowledge of navigating the liminal space between their clients and the clients' providers is represented by supervisors as taking two forms. One form is serving as the client's voice, translating what is going on with the client for the healthcare provider. The other form is translating what the provider is saying for the client. This is translation not in the sense of serving as an interpreter from one language to another so much as from one world to another, that is, from the lifeworld to the clinic and back again. To illustrate the first form:

> *I don't think that the providers realize that there's an issue because some clients, they don't feel they have a voice. [Those clients] feel like they have to take what's given to them. So, they don't complain about it [to the provider], but they'll tell the doula or they'll tell the community health worker. - Downstate Supervisor 2*

Another aspect of this form of translation is that CHWs may share information on a client's behalf that helps the provider to a fuller understanding of the client's circumstances outside of the clinic, and how it impacts their health and healthcare seeking behaviors.

> *I like to always emphasize [CHWs] being the eyes and ears to the providers. I think oftentimes the providers are not aware of what's going on in a household, that often can create barriers to why a family or caregiver can't really prioritize the health of themselves or their children . . . It can look like neglect or a lack of care. But sustaining a household and keeping food on the table may have to be my priority as a mom right now, and that's why I may have missed my appointment. The CHW is often that communicator that brings that information back to the medical providers. - Downstate Supervisor 1*

Conversely, as the same supervisor goes on to describe, the CHW may be called upon to translate what the provider is saying for the client. Consistent with the "empowerment" discourse invoked by the advocates, the supervisors include coaching the client on how to interact more effectively with providers within the CHWs' repertoire of communicative knowledge.

> *So many patients are so intimidated when they go into their medical appointments, . . . a lot of "yes" and shaking your head and you leave the room and you really don't know what you said yes to. . . the CHW is the one who can really communicate that to you and help you understand it or speak on your behalf to say . . . "She really doesn't understand her condition. She doesn't understand how to use the medication. [A CHW can be] that person that advocates for them, that communicates with them or helps them feel comfortable, helps them jot down questions for their next visit, to say, ". . . Let's take your notebook to your visit, so you don't forget what you wanted to ask your provider."*

Technical Knowledge as a Critical Component of CHW Expertise

While communicative knowledge is distinctively associated with the CHW role, CHWs must as well acquire and enact technical knowledge to function effectively. This takes multiple forms, as described by the supervisors, including client education on health-related issues and navigating health and human service organizations (which is discussed further in connection with the CHWs' discourse) as well as documenting their work in the field. CHWs must "textualize" their embodied relational work by documenting it in writing, often within digital information

management systems, to be accountable to their supervisors as well as to the agencies that fund their work.

> *And, usually within, like I said, you want to complete that progress note within 72 hours the latest while it's fresh in your mind. And, they'll submit the progress notes to their supervisor. - Downstate Supervisor2*

CHWs' Discourse on the CHW Role Through the Lens of Communicative Knowledge and Technical Knowledge

The CHWs' accounts contain less representation of their work, compared with the advocates and supervisors, reflecting the fact that the CHWs are immersed in the doing of the work, with less distance from it. In a sense, just as the CHWs "translate" for their clients, the CHWs' supervisors and advocates translate or interpret on behalf of the CHWs and their work, representing in their discourse what the CHWs' work signifies and why it is valuable (i.e., as a complement to the more technical work of the more traditionally credentialed health and human service workers). What the CHW accounts provide is rich description of the enactment of communicative knowledge, but also technical knowledge (about health and about navigating health and human service systems), which connects them to both the technical workers and bureaucratized world of health and human service organizations, and to their clients, and serves to build a bridge between them. They can therefore be understood as drawing on the same underlying elements that inform the discursive resources produced by advocates and supervisors – lived experience and embodied identities, technical knowledge, bridging, and empowerment – in carrying out their work.

Communicative Knowledge

Developing Communicative Knowledge through Lived Experience Enhanced by Training. CHWs discursively position themselves as close to the communities they serve, and

their lived experience and embodied characteristics as an important source of communicative knowledge and an asset in connecting with community members. In some cases, as mentioned earlier, CHWs had even been clients of the programs that now employ them.

> *It's either we live in the communities and we also belong and identify with communities that we're advocating to and we're educating to, so I think that's a very strong asset . . . So, right off the bat, definitely how you look is a main factor in outreach, but then, also, once you get somebody engaged and comfortable, then that's when we're able to do the work that we can do and fully give people the information they need. - Upstate CHW 1*

However, as this CHW goes on to explain, the development of communicative knowledge that allows CHWs to interact effectively with community members and work toward the program's goals of improving clients' health is not only a matter of lived experience and embodied characteristics. It is enhanced by training in motivational interviewing, which can be recognized in the account below, although still combined with life experience.

> *I'd say when you're in the – a classroom environment, we always wanna think that somebody is always – so, we wanna always go with what the client or the patient wants to do in a classroom setting, and it's always the person knows what's best for themself. . . [But] I've seen where individuals – right off the bat – refuse the assistance that's being offered . . . people can be offended by the fact that they have a chronic disease, which was a new thing for me to see. So, it's a matter of wording things in a different way where somebody is like, "Oh, these resources could help me, I'm glad you explained it to me." – Upstate CHW 1*

Providing Support through the Validation of Feelings. On the communicative knowledge side, CHWs articulate the validation of clients' feelings as a crucial part of their role. Interestingly, and consistent with the sources of communicative knowledge examined just above, CHWs position this activity as the outcome of a combination of innate skill and training.

> *Definitely one who has good interpersonal communication skills. An effective listener, because a lot of the times the clients have issues and they*

> *need support, someone to just hear them out. I think basically just being able to communicate because that's really what we do is a lot of interviewing and just helping them with their problems. And how we can just I guess resolve their issues. - Downstate CHW 2*

The validation of feelings that the CHW describes below could also be understood as a form of collaborative sensemaking in the sense of determining what is reasonable to be sufficiently worried about that they should contact their provider.

> *The thing that I feel like we would do is just reassure them that your concerns are definitely valid, and always reach out to your providers… So, normally we're just trained to say we validate how you feel. - Downstate CHW 3*

Technical Knowledge

The CHW role is defined, across all categories of participants in this study, as including the education of clients. Repeated references to this activity are especially striking in the CHWs' interview accounts, as captured in this excerpt about the work CHWs do with clients.

> *And if they were interested in something like that, to have a CHW follow them. If they were pregnant, to follow them for the whole nine months. And then after, just to make sure they adhere to all their appointments, attend prenatal care, like I said, dental care things that are very important. Give them education for after pregnancy to prevent SIDS. Safe sleep is a big thing for our program. Following up with postpartum care and family planning is a big thing. - Downstate CHW 4*

It is notable that "education" is an interactional activity, if done effectively, and therefore draws on a significant store of communicative knowledge. However, it also draws on a body of technical knowledge because the education described by the CHWs conveys understandings about pregnancy and best practices for infant care that are institutionally sanctioned by the NYS Department of Health. CHWs thus skillfully combine communicative knowledge and technical

knowledge as they work to bridge the distance between marginalized community members and the health and human service organizations they seek to connect them with.

Discussion

Through this analysis, we have seen how CHWs, advocates and supervisors navigate within an ecosystem where both underserved communities and the health and the human service organizations established to serve them struggle to connect with each other. The success of all of these workers requires that they engage with both technical and communicative knowledge. Our study makes theoretical contributions and points toward contributions to practice.

Theoretical Contributions

In producing these insights, our study responds to Rennstam and Ashcraft's (2014, p. 13) call for "grounded inquiry into [...] how knowing practices unfold in various lines of work, beginning with those wherein communicative knowledge plays a central role plausibly," but also exploring how different forms of knowledge can in fact co-exist within the same "line of work" in relationships of "overlap, interdependency" (p. 17). In fact, the findings of our study demonstrate that some workers' skill resides precisely in integrating those forms of knowledge.

CHWs do not contradict technical knowledge – in fact, they also work with it, complementing it and allow it to reach new territories, i.e., the communities where health-related information is lacking. Thus, the negotiation between forms of knowledge should be understood as a reformulation and an elaboration of the dominant perspective through a different kind of knowledge. It can even be argued that technical knowledge requires communicative knowledge and cannot accomplish its intended purpose without the CHWs' mediation.

Liminal work in between forms of knowledge

Thus, our study answers Rennstam and Ashcraft's call by specifically showing how a non-credentialled occupation is shaped by discursive resources that constitute the nature and the relationships (and values) of communicative knowledge and technical knowledge. Moreover, drawing on the construct of liminality, we show how the combining of communicative knowledge and technical knowledge works in a differently structured setting from those that have been previously considered; i.e., it is a setting in which the role occupants are using their combination of communicative and technical knowledge to work *between* two domains (i.e., the clinic and the community), each of which is dominated by the other form of knowledge, and the community-based organizations that function as their home base (or "dwelling place"). While Rennstam and Ashcraft do argue that communicative and technical knowledge can be seen as co-present in the performance of a number of occupations, they do not theorize an occupational performance in which the role occupant is explicitly concerned with negotiating the tensions between the two types of knowledge as a liminar situated between two realms – the "lifeworld" (Mishler, 1985) and the "clinic" – each of which prioritizes, while not excluding, the other form of knowledge. Our findings also show that liminality is not only a transitional position between formally-defined roles (e.g., Czarniawska & Mazza, 2003), but that it is also constituted through the very negotiation of knowledge forms, and thus constitutes an alternative form of professionalism.

The role of the body in brokering knowledge

In addition, the concept of embodied relational communication has been left somewhat under-elaborated in the context of theorizing communicative knowledge, seeming chiefly to designate live interaction (perhaps not even face-to-face, if call center workers' practices are

included). We elaborate the notion of embodiment vis-à-vis communicative knowledge, foregrounding the importance of embodied identity and the importance of place (i.e., the material conditions of the community environment) in the constitution of identity. CHWs celebrate their identities as enabling them to "expertly" know their communities and their communicative practices. In one of our supervisors' accounts quoted from above, the supervisor uses the metaphor of the CHW serving as the "eyes and ears" of the healthcare provider – the embodied instruments of observation – which the provider cannot use in the community setting, because he or she is not physically present, whereas the CHWs' eyes and ears *are* out in the community, seeing and hearing what isn't seen and heard in the clinical setting. The CHWs, supervisors and advocates presented identity and experience as strengths through which they could gain the community's trust and better understand the patients' lived reality, in contrast to the healthcare professionals' technical knowledge and credentials. Embodied identity and experience, then, gain an epistemic status – they are how we know better.

Weaving knowledge forms through embodied practice

However, CHWs are not merely the instruments of healthcare professionals in bringing technical knowledge to marginalized people and eliciting their compliance with it. They also bring into the healthcare system the voices that it traditionally leaves out and encourage professionals to recognize the lived experience of their patients. In that sense, CHWs' skill is also about reformulating knowledge in such a way to enable and amplify the effectiveness of the encounter between both parties.

We suggest that integrating forms of knowledge is a unique skill that permits reformulating epistemologies and identities, and offers new relational configurations that redraw the connection between people, communities and knowledge(s). We propose "weaving" as a

metaphor that helps to specify more precisely the way the CHWs in our study integrate technical knowledge (about health and of providers and their organizations) with communicative knowledge (of historically underserved communities) to achieve their goals. In its literal sense, weaving cloth is accomplished on a loom, a device which holds one set of parallel threads in place (referred to as the warp) so that a second set of parallel threads (the weft) can be threaded through the first set perpendicularly. In this metaphor, the CHWs' home organizations may be understood as the loom, their communicative knowledge the warp, their technical knowledge the weft, and the whole cloth produced by the weaving as the accomplishment of the CHW program goals of connecting community members to service providers. The whole cloth does not exist without both sets of threads, but the distinctive character of both sets of threads is maintained rather than blended. Technical knowledge and communicative knowledge thus remain orthogonal to one another while together constituting a third entity: the whole cloth of the CHWs' embodied enterprise to assist and empower their clients.

Potentialities for Practical Contributions

Practically, this study's findings support the argument against credentialing, as it may exclude individuals best suited for the CHW role based on their communicative knowledge. However, it extends that argument by proposing that instead of credentialing as typically understood in health and human service occupations and institutions, what is needed is wider recognition of the nature of CHWs' work as an alternative form of professionalism, which we hope this study may contribute to.

Valuing CHW's knowledge and providing them with new discursive resources

More specifically, this study's findings may provide new discursive resources for advocates, supervisors, and CHWs themselves that position CHWs' work as drawing on forms of

knowledge with equal epistemic status to the knowledge of formally credentialled health and human service workers. The discursive resource that is widely invoked in discussing CHWs' work is "lived experience." We suggest that the term "experience," to those in the more traditionally credentialled occupations, may contrast unfavorably with "knowledge." Yet what the CHWs possess is indeed a form of "knowledge." In fact, in this study, they actually can be seen expertly weaving together both their communicative knowledge derived from their lived experiences and technical knowledge of health conditions, best practices for infant care, and information systems.

Communicative knowledge helps reach healthcare providers' goals

Moreover, our findings demonstrate the value of CHWs' communicative knowledge to healthcare providers and skeptics, such as funding agencies, and how it extends technical knowledge into the community. At the same time, as evident in the accounts provided by advocates and supervisors especially, their communicative knowledge allows otherwise voiceless patients to express themselves, while also permitting healthcare professionals to access what is unseen/unheard about their patients (for instance, due to a lack of trust or to characteristics of the way healthcare consultations proceed), thus helping technical knowledge reach its goals. By combining "lived experience" with "communicative knowledge" in the collection of discursive resources representing CHWs' work, and yielding something like "experiential knowledge," perhaps the advocates and supervisors could make a more persuasive case for the value of CHWs to skeptics in healthcare organizations and funding agencies and thus legitimate this form of professionalism.

Promoting institutional understanding of the CHW role

Continued advocacy for embedding CHWs into healthcare teams will also doubtless help to increase institutional understanding and appreciation for the CHW role. Simply having CHWs present in institutional settings has potential value for promoting their acceptance. In addition, though, just as supervisors and advocates are adept at presenting CHWs' work to outside audiences, CHWs themselves could also be coached in representing their embodied and situated experiences to share them within health and human service organizations. More generally, our study suggests that acceptance of CHWs depends on how they *perform* their distinctive blend of communicative and technical knowledge in the presence of providers. Being embodied, it has to be *seen* and *heard* to be understood. At the same time, however, healthcare institutions may need to learn to trust other forms of knowledge and find ways to include them in their work. Aas one supervisor noted, speaking of a program he participates in, "these providers know what the CHW does. They have bought into the CHW, so they use the CHWs for the things that they know that the CHWs are kind of experts at."

Future Research

This study has used interviews with CHWs, their supervisors and their advocates to study the discourse they produce regarding the relationship between communicative and technical knowledge in their work. Even more precision regarding the details of how this relationship is enacted on a daily basis could be gained from analyzing the CHWs' actual interactions with their patients and with their service providers. Such observations are challenging to arrange due to privacy concerns in healthcare settings, but prior interactional studies in healthcare situations, among others, provide enlightening precedents on how data could be collected while heeding privacy concerns (Denvir, 2012; Hindmarsh & Pilnick, 2007). Another avenue for research could

consist in collecting the perceptions of healthcare providers, both those embedding CHWs within their teams and those who do not, to help identify strategies for promoting the acceptance of CHWs and of communicative knowledge more generally. Given the growing importance of CHWs around the world, both in response to a shortage of healthcare workers (Laurenzi et al., 2021) and to clearly identified needs to better connect health and human service organizations with the communities they are established to serve (Peretz et al., 2020), this is an issue of significant consequence with bearing on health equity and social justice more broadly.

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[i] Discourse regarding “the nature of CHW work” was produced in response to interview questions that asked participants to summarize the main activities their program engaged in, to describe a typical day for CHWs pre-pandemic, and what characteristics an effective CHW must possess. The full interview protocol is available at [hyperlink – to be provided]