"We Keep Each Other Safe": San Francisco Bay Area Community-Based Organizations Respond to Enduring Crises in the COVID-19 Era

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The COVID-19 pandemic revealed ways in which communities take care of themselves in deeply unequal times. Tracing a pandemic-year evolution of community-based organizations (CBOs) in the San Francisco Bay Area through twenty-seven semi-structured interviews with CBO staff, we argue that, through diverse approaches that we characterize as a politics of care*, Bay Area CBOs are reshaping their work in ways that could address social and structural determinants of health inequities in the long term. Their approaches call for rethinking the crisis framework around public health challenges such as pandemics. Our research confirms that, rather than an exceptional, short-term challenge, the pandemic crisis is a product of a longer trajectory of structurally produced inequities endemic to racial capitalism.*

Keywords: community-based organizations, COVID-19, health equity, politics of care, racial capitalism

With pressure on resources, resiliency, community connections, and, fundamentally, the health sector, the COVID-19 pandemic has shone a bright light on how communities take care of themselves amid crisis. As the pandemic unfolded, we began to track the experience of nongovernmental community-based organizations (CBOs) in the San Francisco Bay Area (Bay Area). CBOs quickly moved beyond bare survival in important ways. Indeed, in marshaling resources to address pandemic-related needs—often in the absence of full governmental support—Bay Area CBOs that focus on a broad array of concerns, from housing and homelessness

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to immigrant rights, from elder care to youth empowerment, engaged in a transformative politics of care.

Ultimately, this approach did far more than just support CBO and community resilience. Instead, as we argue here, through their work at this time, Bay Area CBOs have revealed the salience of health equity efforts in community work by CBOs not typically associated with health, through a heterogeneous set of approaches we characterize under the rubric of a politics of care. In doing so, Bay Area CBOs have offered a path toward reshaping health equity work in ways that could affirmatively address social and structural determinants of health in the long term. Our research also calls for a rethinking of the crisis framework around public health challenges like pandemics. Rather than an exceptional, short-term challenge, our research confirms the pandemic crisis as a product of a longer trajectory of structurally produced inequities endemic to racial capitalism.

The findings in this article took us by surprise. Although the Bay Area has a reputation as a progressive haven, leaders here have been consumed in recent decades by questions of how to address the region's extreme, and worsening, socioeconomic disparities and their differential impact. Whether in terms of affordable housing, access to education, environmental pollution, or policing, the discourse of the violent impacts of socioeconomic inequity, and debates around solutions, have literally been front-page news. Grassroots efforts have sought to address these complex issues at the organization, neighborhood, and policy levels. So, when confronted with the COVID-19 pandemic, CBO leaders drew on the knowledge they had built in their work on other challenges. This included both the knowledge that government is not going to meet community needs as well as the awareness that organizing to push for government support is necessary and effective. This also meant that these CBOs had long-built experience with struggle around what people understand to be questions of survival. After all, the Bay Area has been an epicenter for major crises, from HIV/AIDS to racialized worker exploitation to the housing and homelessness crisis, and more.

Our informants articulated this contradiction in a variety of ways, even finding some glimmers of hope within the scope of the most challenging year that many had experienced, in part because they took a long view of the role of the pandemic in their lives and work. For example, the leader of a group that advocates for unhoused people spoke about the incredibly difficult work of their organization, at a time when homelessness and housing insecurity are rising. Still, they told us[1]—while still reeling from the compounding traumas of the first pandemic year—that "When everything falls apart, and then you need to rebuild it, you have a space to rebuild something much more effective and much more beautiful." They held this hopeful view while articulating the entrenchment of historical injustices in the basic structures of everyday life. In this way they brought an analysis of endemic "race-class" (Brahinsky 2014) injustices within capitalism to the forefront, what Cedric Robinson (2000) defines as "racial capitalism."

PANDEMIC INEQUITIES

In the United States, the COVID-19 pandemic laid bare immediate needs and increased consciousness of the persistent structural inequities leading to uneven suffering (Ozkazanc-Pan and Pullen 2020). National political leadership abdicated responsibility for managing the public health and economic responses to the pandemic through the first nine months, putting extreme pressure on states, cities, and regions to develop their own modes of survival (Haffajee and Mello 2020; Akhmouch and Taylor 2020; Davis 2020; Dzigbede, Gehl, and Willoughby 2020). This brought health equity issues to the foreground of national, state, and local political debates, including access to care and the needs of those providing essential care to others. The nongovernmental sector has long been central in this field.

Our research builds on work on public health and on broader socioeconomic effects

1. We use the gender-neutral pronouns *they*, *their*, and *them* for all our informants to mask identities of participants.

of the pandemic and on decades of work in the health equity field. We draw from the World Health Organization's (2021) definitions of health ("complete physical, mental and social well-being") and health equity ("striving for the highest possible standard of health for all people [with] special attention to the needs of those at greatest risk of poor health, based on social conditions"). A health equity approach begins from an analysis of health as inequitably distributed (both unevenly and unjustly), such that people from more vulnerable backgrounds experience disproportionately worse health (Marmot et al. 2008). The health equity approach views these differences in health as preventable (Penman-Aguilar et al. 2016). This framework also identifies nonbiological social and structural forces—such as socioeconomic position (SEP), structural racism, or power imbalances—as root (or upstream) causes of these health differences, suggesting that it is necessary to address these social and structural determinants of health to achieve health equity (Laster Pirtle 2020; Williams et al. 2008).

In reckoning with the pandemic, scholars have renewed their attention to health equity and social and structural determinants of health as frameworks that can guide responses to it (Galea and Abdalla 2020; Krieger 2020). Recent research has documented the importance and impact of partnerships (for example, among CBOs and between CBOs and government) in robust public health interventions, noting a health equity lens as a critical framework to support already vulnerable communities (Michener et al. 2020).

Other researchers have shown links between the pandemic and other challenges, arguing that multiple and intersecting health crises of epidemic proportions collectively form a "syndemic" in which health crises such as the opioid epidemic are worsened as a direct result of COVID-19 (Burns and Albrecht 2022, this issue). In the Bay Area, for example, more people died in 2020 from accidental drug overdose than from COVID-19 (Nichols 2021). These connections point to the sociopolitical dynamics of health. Even before the pandemic, scholars and health-care practitioners alike aligned themselves with social justice activists in calling for a vision of "public health" that embraces social theory and learns "how to operate in the political realm" (Martinez 2018).

Through various stages of the pandemic, the inequalities of this moment have been made starker by the simultaneous emergence of nationwide uprisings for racial justice. The burden of disproportionate police violence, and the deeply uneven experiences of both the pandemic and economic inequities across racialized and marginalized communities, was laid bare (Tai et al. 2021; Clark et al. 2020). Indeed, the links between health equity and racism are unambiguous, particularly when viewed through the geographer Ruth Wilson Gilmore's definition of racism as "the state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death" (2007, 28).

SAN FRANCISCO BAY AREA CONTEXT

Although the Bay Area is often perceived as idiosyncratic or exceptional, the region's activities are important to analyze, given its longstanding history of testing new ideas in local governance and public health policy that come to be adopted more widely, from environmental policy to LGBTQ+ rights to health-care delivery. Meanwhile, CBOs are an important force in the region's political culture, influencing policymakers, whether by advocating for specific policies and budget priorities, seeking public funding for service provision, or creating new programs that fill in gaps in government safety nets.

The early days of the pandemic seemed to reveal the San Francisco Bay Area as a place of enlightened, science-based policymaking. As the first U.S. metropolitan area to institute shelter-in-place orders, the region saw a relatively robust civic response, with early and strong government-led restrictions and widespread compliance, which limited the spread of the virus. But from the beginning, the region has also seen highly uneven experiences, with marginalized communities that were already vulnerable faring the worst, both in core cities such as San Francisco and Oakland, and across the region at large (Vazquez 2020; Whitacre et al. 2021).

The pandemic also highlighted a host of challenges in the region, exacerbating an af-

fordable housing crisis marked by a rapidly growing unsheltered population, an ongoing crisis of residential displacement, extreme socioeconomic inequities (PolicyLink 2017), and in particular, persistent racial inequality (Shange 2019). In addition, civic life—and the region's capacity to protect its people from the pandemic—was strained in new ways as the largest to date climate-change wildfires tore through California, bringing the worst air pollution in recorded history to the Bay Area, plus the economic and social disruption of rolling blackouts that persisted through the contentious national election season.

These enduring problems, and the ways they have been even more exposed by the COVID-19 pandemic, challenge the region's reputation as a progressive stronghold. To the extent that this reputation still holds, it may be due to the persistence and resilience of the Bay Area's broad network of CBOs, which have a grassroots politics of care that shapes their work as well as the everyday life of the region. It is in this context that we sought to understand the ways that CBOs here were handling their work through the pandemic.

METHODOLOGY

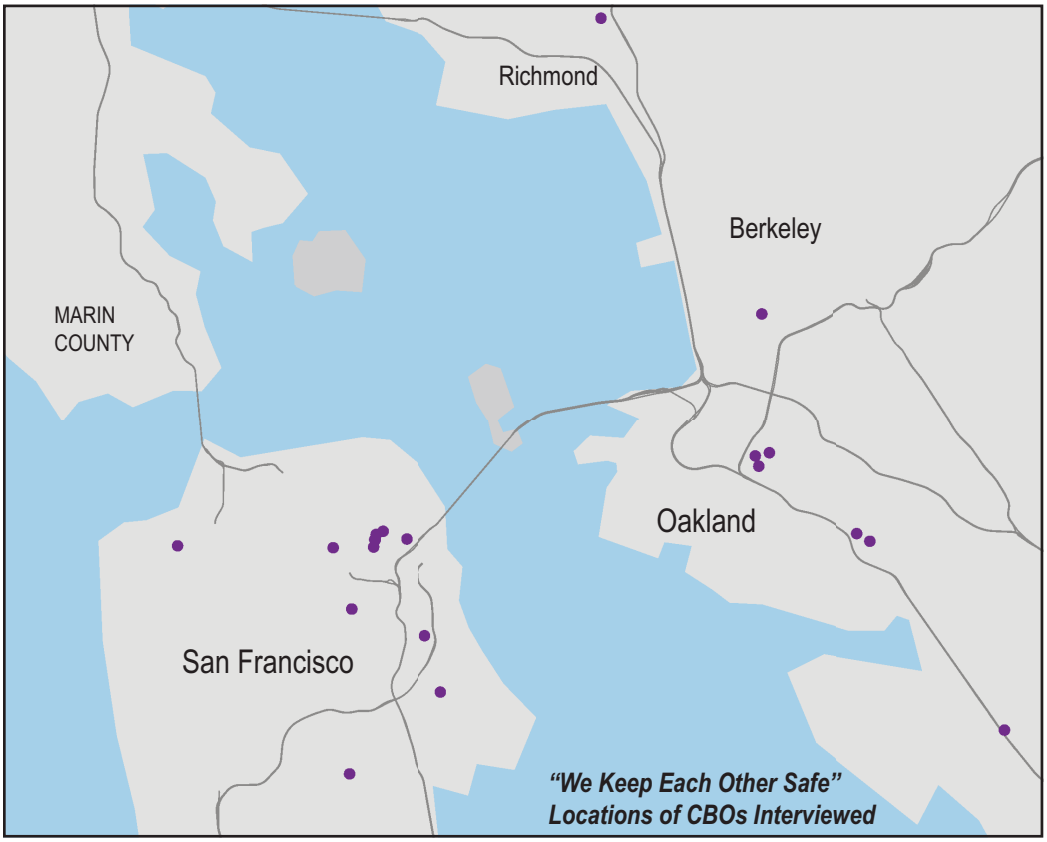
Our multidisciplinary research team includes a social epidemiologist, a human geographer, a political anthropologist, and a sociocultural anthropologist. Our research questions and analysis have thus benefited from rich debates about approaches and assumptions. Collectively, we were committed to a community-based approach to this work, to the extent possible. Within our fields of research and our decades of research with Bay Area CBOs, we brought expertise on different aspects of Bay Area studies, which strengthened our analysis.

Our data collection centered around a series of semi-structured interviews with CBO staff members we contacted through previous connections, snowball sampling, and cold-calls. Our interviews explored how our informants and their communities were responding to the COVID-19 pandemic. We wondered whether and how goals, priorities, and missions changed, and what future directions were emerging for their work. Our goal was to document the epistemological and political culture of CBOs in the Bay Area during the COVID-19 pandemic, understanding how they are thinking, understanding, and moving through this time. We interviewed twenty-seven people who worked at diverse nonprofit CBOs across San Francisco and the East Bay (figure 1). Each CBO chose their participant in this research. Interviews were conducted via phone and video call from May 2020 through July 2021 (most in the fall of 2020) and recorded and transcribed for coding. Each participant received a $100 gift certificate after completing the interview.

Most participants (78 percent) identified as women and two-thirds (67 percent) as people of color. Just over half of the CBOs (52 percent) had a focus on organizing and advocacy; the other half historically focused on direct service provision. The pandemic blurred this line, as advocacy organizations took on direct service projects and direct service providers participated in advocacy. Some CBOs were focused on housing and economic development ($n = 7$); others on immigrant and labor organizing ($n = 7$); and others on serving an age group (such as youth or seniors) in a particular neighborhood ($n = 7$). Other CBOs organized around racial justice, tackled environmental justice, and worked with people involved in the criminal-legal system.

We took a grounded theory approach (Glaser and Strauss 2017), using a targeted set of interviews to develop our analysis, followed by a content analysis of the interview data to drive our findings. We reviewed all transcripts, and did preliminary open-ended coding using an inductive approach. We held iterative, structured discussions as a team, drawing on the diversity of our disciplinary and research expertise, and continued inductive coding while also turning to the research literature to expand our contextual analysis. We re-reviewed the transcripts to conduct directed coding to capture any instances that we may have missed. Finally, following community-engaged research principles (Allen et al. 2019; Cashman et al. 2008), we shared a draft article with a subset of interviewees in the summer of 2021 to ground-truth our findings and generate dialogue, and used their engaging feedback and comments to thicken our analysis; these participants received an additional $100 gift certificate. Over-

Figure 1. Map of Organizations' Locations



Source: Authors' tabulation based on addresses listed on community-based organizations' websites. Map by Bruce Rinehart, using QGIS and OpenStreetMap (see openstreetmap.org/copyright).
Note: Organizations that requested complete anonymity are not mapped.

all, these informants reported that the manuscript resonated with and affirmed their experiences during the pandemic while offering important conceptual suggestions that we engaged with in our revisions.

FINDINGS

The political and social context evolved rapidly as we conducted research. This had an impact on the interviews, shaping both our questions and the framework for responses. We began this project soon after the implementation of sheltering in place, continued through weeks of mass street protests around racial justice, and then through weeks of wildfire-related air quality, all of which overlapped with an increasingly tense national election campaign that steeply affected our informants, their clients, and the dynamics of their work.

In addition to centering attention on the work of CBOs through changing times, the shifting context highlighted ways that our research raised larger questions about how the region's political culture has produced a rich web of community responses to the layered crises of our time. Health equity, for example, is perhaps an obvious framework in the time of a pandemic but was not an initial topic of focus—we thought we were looking more at organizational survival through the crisis—and the CBOs we included were not necessarily consciously centered around health equity. Nevertheless, it rose to the top in meaningful ways.

Ultimately, we found that CBOs' responses

to the COVID-19 pandemic highlighted pre-pandemic structural issues and pointed to the need for durable changes in policy and political culture going forward. In that context, we focus this article around three core findings. First, health equity has become a central lens for non-health-oriented CBOs in the region. This happened in a way that may support existing and future health-equity-oriented work because it makes more visible the large network of CBOs that could be involved in such work.

Next, we found that our heterogeneous set of groups moved forward and evolved in some parallel ways that point to a regional political culture that values and works within frameworks of a politics of care. Organizations that had a standing, longer-term engagement with care work were in a strong position to both care for staff and client immediate needs and advocate for policy in response to the crisis. We observed a politics of care grounded in feminist principles of mutuality and informed by critical disability justice as interdependence.

Finally, we observed an important conceptual framing, again across heterogeneous groups, which sustained their capacity through the pandemic. This was an understanding of the pandemic crisis as endemic to the larger and ongoing crises of racial capitalism. Some articulated this explicitly and others implied it. The recognition that the pandemic exposed the depth of existing racial and class inequalities and that the end of the pandemic would not end those problems, helped our informants take a longer view on the challenges they and their communities faced. The next three sections address each of these findings in depth.

Finding I: Health Equity as a Central Lens for Bay Area CBOs

In assessing the ways that the pandemic has pushed health equity to the fore, we draw from Paula Braveman and colleagues' (2011) conceptualization of health equity as a commitment to social justice in health, often operationalized as a fair and just opportunity to be healthy (Braveman et al. 2017). Health inequities are disparities in health that are preventable but have, unjustly, not been prevented (Marmot and Allen 2014). Braveman emphasizes the importance of addressing social determinants of health—that is, factors outside the health sector that can affect health—to promote health equity (Braveman et al. 2017). Such social determinants can include structural forces such as racism (Gilmore 2007) as well as resources such as housing (Swope and Hernández 2019). The nature of these determinants became clearer during the COVID-19 pandemic. For example, an informant who leads a worker center explained that the pandemic was "more validation of everything I know and understand from the economic system we live under . . . we understand and see capitalism and how it plays out in the lives of working-class and specifically immigrant communities."

One interviewee who came from a public health background remarked on the role of those same communities in providing essential public health services, noting, "I think [given the pandemic] that conventional and dominant public health systems are going to have to reckon a lot with how they have diminished the expertise of underresourced and oversurveilled community organizations that actually do public health." The organizations that are now framing their work as related to social determinants of health and health equity are important contributors to this reckoning. Ultimately, our interviews show that the region's CBOs, in stepping up to meet emergency needs, have revealed the salience of a wide range of community work to existing health equity efforts. The pandemic highlights how CBOs that tackle the full scope of social and economic conditions facing vulnerable communities are central to public health.

Some of the CBOs interviewed had been doing work grounded in health equity before the pandemic began, including an Indigenous land trust organization growing healthy food to share with community members, a public health organization focused on harm reduction to prevent opioid overdose, and a youth group focused on both political organization and healing. The youth-organizing group, for example, identifies as a "public health organization" and a "healing-centered organization [operating] from a theory of liberation."

Although they had not used the term *health equity* in their work, the staff person at the land trust explained that they "reclaim land and

make sure that it's available so people can have access to healthy and affordable food [and herbal] medicines," as part of their decolonizing efforts. When the pandemic began, they focused on food distribution to the communities they had already been serving, which they describe as "Black and Brown families and other communities of color who are also unemployed, and elders," while increasing their production of tinctures and hand sanitizers from the medicines that they were growing.

The harm reduction organization had already been working to address the opioid epidemic before the pandemic and was building infrastructure and capacity to sustain this work. They reflected that COVID-19 "absolutely magnified every challenge that our communities were experiencing and every harm that they experience. And the absolutely gross inadequacies of our city agencies and city systems to hold them in a way that is dignified." When the pandemic began, they were invited to join a local government effort to provide hotel rooms for people who were unstably housed (so they could have a safe location to shelter in place) and stop the overdose deaths spiking among people living in the hotels. Run by a team of two, the organization worked to ensure that Narcan and other harm-reduction resources were available to residents, which ultimately succeeded at curbing overdose deaths.

Others moved toward health equity organically, catalyzed by the demands of the pandemic. Increasingly, they recognized the health implications of their work, which tackled social determinants of health, such as housing and economic position, from beyond the health sector. As one staff person from an umbrella organization for community organizing groups explained, "the issues that came up during COVID were not new," providing examples such as homelessness, job security, low wages, and limited or no access to health care, and noting that "COVID just made it way, way worse." As they then emphasized, "our organizations and our communities have had to deal with these issues before and so they are the best ones to help respond."

Some of this was already beginning to happen but came into sharper focus with the pandemic. A staff member from a neighborhood development corporation that provides housing reflected that in 2019 they had begun "a strategic planning process, and really focused on a theory of change to get us to that ultimate goal and to get us to our mission, and we focused on Home, Health and Voice. Of course, we're a permanent supportive-housing provider. And so developing 'home' is sort of the bread and butter of what we do, but [during COVID-19], we really elevated health and [community voices as key] components of our strategy . . . what we have learned in the pandemic is really elevating that health piece." A resident services manager at another housing development corporation that had also started to make connections between housing and health before the pandemic talked about housing provision alone as not enough. They described their efforts to tackle wide-ranging needs, including free food and wireless internet.

The pandemic highlighted other issues as upstream determinants of health. As an advocate for the houseless noted, "what a health disaster it is to force . . . thousands of people to live outside," and to require sheltering in place with so many people unable to do so. The pandemic also highlighted the untenability and fragility of inadequate housing solutions for people who were unstably housed, such as shuttling between family or friends or both (as the homelessness advocate observed) or living in overcrowded homes (as a staff at an immigrant organizing group noted). A staff member at an affordable housing advocacy organization talked about shifting to working toward affordable housing providers "owning as much real estate and land as possible" to not only achieve community stabilization but also community health.

Finding II: Politics of Care

The Bay Area is home to strong racial justice, feminist, queer, and disability rights traditions. These political tendencies undergird community institutions that address issues of labor, housing, health care, immigrant rights, and direct services. Organizations we interviewed in these areas have different approaches but are collectively engaged in a variety of practices of mutuality in their responses to the pandemic, which we came to understand as a politics of

care. Specifically, our informants framed care work as a political act, often situated within broader social movements (but see also Pine 2013; Martinez 2018).

The politics of care framework has roots in feminist economics, ethics, and sociology of care. We observed it in our informants' use of intersectional analysis and praxis grounded in the experiences of women of color (Crenshaw 1989). Feminist economists have long highlighted the injustice of an economy dependent on the unremunerated reproductive labor of women (Federici 2012). Meanwhile, feminist ethicists have shown how the privatized, gendered division of care work marginalizes ethical commitments to care in debates over public policy and state priorities (Tronto 1987). In the United States, the history of care work, including domestic work, is rooted in both gendered and raced divisions of labor based in slavery and immigration (Glenn 1992, 2010; Nadasen 2016; Parreñas 2012). In recent years, service workers, care workers, and domestic workers have grounded political demands for fair pay and labor protections with demands for a broader social transformation in values to address legacies of racism, sexism, and xenophobia in law and culture (Poo 2016; Boris and Stein 2012). Principles of radical inclusivity, mutuality, and interdependence are legacies of the queer and disability justice organizing (Piepzna-Samarasinha 2018; Kittay 2011). During the pandemic, the proliferation of mutual-aid efforts drew on these diverse traditions and communities of interest as well (Spade 2020). Meanwhile, organizations rooted in working-class immigrant communities of color argued that the work these communities carried out, including historically devalued or invisibilized care work, was finally being recognized, though not compensated, as essential to the nation's social and economic infrastructure (Nicols 2021).

Beyond responding to the immediate needs of the crisis, and in light of the November 2020 elections, CBOs articulated their work as part of larger movements to demand the structural change necessary to advance health equity. CBOs have long offered blueprints for enacting care during crises that break from the reigning violent structures of capitalism, neoliberalism, and social hierarchies (such as racism, sexism, xenophobia). During the pandemic, they frequently combined responses to police violence against Black and Latinx people with attention to anti-Asian violence, and to the abandonment of the unhoused. The slogan "We Keep Each Other Safe" appeared in both public health messages about mask usage and activist communications including protests against racial violence. This belief in the power of community-based mutual care, along with state accountability and support, was a shared ethical perspective that permeated many of our interviews. Organizations with existing, longer-term engagement with care work grounded such work first in care for members of their community. They were in a strong position to both care for the immediate needs of their staff and clients while advocating for state funding for services and transformative policy change.

Among the foundations of this care-centered politics is an emphasis on supporting communities historically disenfranchised on the basis of gender, sex, race, class, or immigrant status. More generally, this political vision of care envisions the equitable distribution of life-sustaining resources and encourages community investment in resources and structures that ensure that everyone has what they need to "stay safe together and apart," from universal access to high-speed internet to universal access to health care (Emmer et al. 2020). In other words, a politics of care goes beyond helping and triage: it works to redirect and redistribute resources away from structures that favor hierarchical, concentrated wealth at the cost of universal well-being toward structures that permit all to live in dignity and health.

In addition to tending to their communities, many CBOs also centered care for their staff. CBOs considered recognition, remuneration, and protection for those engaged in "reproductive labor" (Federici 2012) both at home and at work as part of their pandemic response. This was especially relevant for staff who experienced precarity or were members of the communities served by their organizations; several such organizations noted that the basic work of keeping daily life and the economy of the region functioning has long been done by immigrant and low-SEP people of color. In addi-

tion to advocating for and serving as access points to public sources of care and support for care workers more broadly defined, many struggled over how, in times of scarcity, to correctly adjust their workplace practices to reflect these values. Some CBOs framed their work caring for their community and their staff as a way of modeling caring for the common good, aligning with the work of Bernice Fisher and Joan Tronto (1990) "in maintaining and repairing our world so that we can live in it as well as possible."

We found that politics of care as practiced by CBOs during the pandemic meant simultaneously caring about: their clients and communities (some were already doing direct service work before the pandemic; some were focused on policy work previously but shifted to include direct service); their staff (although some CBOs were doing this before, many were not, and many bolstered their efforts on this front); and the common good (such as advocating for policy changes, working to overcome the stigma experienced by members of some of these populations; some had already been engaged in advocacy work, others added advocacy to their portfolio).

External Politics of Care: Community

The Bay Area CBOs we spoke with exemplified a politics of care by engaging in health interventions during the pandemic that center *dignity* and *resource redistribution* to their community members. The work of two CBOs in particular personified this politics of care; one is an initiative that promotes harm reduction approaches to support people who use drugs; the other works with youth in a predominantly Black and working-class neighborhood. Both offer examples of enacting health interventions without surveillance, punishment, or control. They both prioritized community buy-in and navigated people's diverse needs.

One interviewee described how both caring for the unhoused population who were sheltering-in-place in hotels and working to prevent overdose deaths within these hotels was a "fraught" process. The CBO worked to equip hotel floors with biohazard containers and lifesaving Narcan, offering a more caring approach for drug users to help mitigate the overdose crisis in these settings. Yet this intervention was complicated: the installations may have been a radical act of care to protect drug users but could also be triggering and thus agitating (counteractive to caring) for some members of the community. This example hints at some of the real challenges and contradictions generally underresourced CBOs faced in implementing universal care strategies for people facing diverse and ongoing experiences of trauma and crisis.

A primary concern for our informants was addressing the "drastically unequal distribution of bodily vulnerabilities" (Ahmed 2014) that their communities face. Many CBOs mobilized to provide personal protective equipment (PPE), such as masks, and other related supplies, like hand sanitizer. One interviewee at the youth-oriented center, whose central approach to PPE distribution was community buy-in and leadership development, noted, "I brought my community, because we started taking care of ourselves when it came to community. They take that . . . initiative to look out for community, if they ever get the opportunity to."

Internal Politics of Care: CBO Staff

The pandemic also catalyzed an organizational focus on care internally. Working for these CBOs during the pandemic often required intense time, energy, and emotional labor and was sometimes traumatizing for staff. Additionally, as one informant in a mutual aid organization noted, care work also involves confronting the gender inequities of care work, in which women disproportionately shoulder the burden.

Although they were largely strapped for resources, many CBOs worked to protect the health and well-being of their staff. Some organizations provided stipends to outfit work-from-home arrangements, and one provided organic produce bags to their staff in addition to community members. The leaders of one worker rights organization had already been working to encourage their staff to use their paid sick leave (staff would often come into work while ill), and redoubled their efforts once the pandemic began, as part of an emphasis on the importance of sustainable work practices.

This was amplified by the fact that their work included advocacy for workers' right to paid leave.

Other CBOs struggled with getting staff to take advantage of their updated paid time off policy during the pandemic to encourage taking more time for self-care—staff generally appreciated the policy but felt like there was still so much to be done. In several cases, CBO leaders worked on encouraging staff to prioritize self-care and made adaptations to their initial policies to better align with how staff might use the time. Some CBOs revised productivity expectations for staff, especially in the early months of the pandemic, to encourage self-care and have freedom to address other pandemic-related challenges outside their job.

Some organizations created new limits to the formal working day to encourage working fewer hours and increase flexibility for staff. One organization noted that "this is a new way of being" and that it was important to be "supporting the folks that are supporting [the members] directly." This work was grounded in what staff members needed, and many organizations iterated their initial efforts to encourage staff to work less to reach the solution that best supported that goal. One organization created an internal team focused specifically on caring for fellow staff. Notably, among those we interviewed, the CBOs doing the most innovative work on this front were primarily led by women of color, had primarily women and people of color among their staff, and organized primarily with low-SEP Black, Indigenous, and people of color (BIPOC) populations. Thus this approach to caring for staff could also have implications for health equity.

In the decades before the COVID-19 pandemic, the public sector—including public health, health-care, and social service systems—experienced systematic defunding and devaluing. The pandemic starkly exposed the impact of this long disinvestment. Many CBOs, including those that had been focused on direct service provision, identified the importance of policy and advocacy work. In many cases, CBOs worked to change narratives about their communities that reproduced marginalization and accelerated health inequities. In public testimony, media statements, art and design, they framed child care providers and in-home caregivers, day laborers and domestic workers as essential and deserving of better pay and regard for their work. They humanized people from stigmatized groups (including incarcerated people, people experiencing homelessness, people who use drugs, and people living in public housing) argued for providing them access to social and health resources accordingly.

Politics of Care at the Intersection

Sarah Ahmed (2014) critiques neoliberal notions of self-care as individual responsibility that becomes "a technique of governance: the duty to care for one's self often written as a duty to care for one's own happiness, flourishing, well-being." Following Audre Lorde, she asserts that self-care is instead an act of self preservation and agency, warfare against systems designed to subordinate if not destroy oppressed communities. Many CBOs discussed how their care work operated at these intersecting levels, focusing on the complexity and importance of simultaneously doing interpersonal work and political work to support people through a pandemic. One interviewee explained: "our philosophy toward our work is sort of to organize people as whole people, as whole workers. So, we're fighting for rights at the workplace but we're also taking on issues that they face in their lives." Others talked about how affirming people's existence as individuals through relationships of support was a political act. One participant asserted that community leadership and decision-making was a necessary antidote to enduring colonial legacies in local government, public health, and academic medical institutions, both enabling and transforming more effective interventions and partnerships between communities of color and predominantly white institutions.

Finding III: Rethinking "Crisis"

A strong dynamic across the interviews was a sense that, for those served by Bay Area CBOs we interviewed, the pandemic crisis built on many enduring crises that communities have faced. As Arundhati Roy (2020) wrote early in the pandemic, "The tragedy is immediate, real, epic and unfolding before our eyes. But it isn't

new. It is the wreckage of a train that has been careening down the track for years." In rethinking the nature of the pandemic crisis, Roy and others suggest that viewing it as both an extension and product of prior crises helps clarify why the pandemic has played out so unequally, and how to rethink interventions for future challenges.

We asked about Roy's perspective in the interviews. Many informants had not read Roy's article, but their experiences and the way they understood their work cleaved closely to this vision: the pandemic was a tragedy in and of itself but was even more tragic in the ways it extended, exacerbated, and expanded existing crises. This was true across service categories and client base, and we began to see the pandemic as but one significant moment in the long crisis for marginalized communities. Although most had not planned for the contingency of a pandemic, they were experienced with crises more broadly and relatively quickly viewed the COVID-19 crisis on the whole as not unexpected. Additionally, they saw that it is not likely the last of its kind and that it is linked to a host of other major socioeconomic challenges. One informant put it this way, "The revealing and awakening and 'rethinking' that the COVID pandemic compelled exposes those underlying structural realities and, hopefully, motivates a more direct confrontation with the core problems, for example—policy advocacy that changes the conditions within which daily services work operates."

This stance on crisis calls up political-economic frameworks that emphasize long-term thinking about how to approach socioeconomic challenges like those accelerated by the pandemic. Here we draw insights from critical geographers who emphasize the longue durée of economic crises as inherent to capitalism and from racial capitalism scholars who reveal the embedded nature of racial inequities with other social stratifications (see, for example, Gilmore 2007; Robinson 2000). Jodi Melamed (2015) clarifies that racial capitalism is, centrally, capitalism itself, writing, "Capital . . . can only accumulate by producing and moving through relations of severe inequality among human groups. . . . [And] racism enshrines the inequalities that capitalism requires." As Stuart Hall (1980) wrote decades earlier, his investigations into race and class revealed that "race is a modality through which class is 'lived,' the medium through which class relations are experienced." Indeed, BIPOC communities have fared the worst through the COVID-19 pandemic. The reasons vary, but limited access to health care, lack of access to safe workplaces (remote work), and existing health conditions that stem from poverty are key factors (Azar et al. 2020; Mackey et al. 2021). These factors all have deep roots in economic inequality, also foundational to capitalism (Harvey 2006; Piketty 2014).

Beyond embeddedness, we also draw on intersectionality theory, pulling from Kimberlé Crenshaw's (1992) theorizations that highlight the impact of layered and interlocking challenges on particular groups. Her work shows us the ways that marginalized groups are not only multiply marginalized (through race, class, gender) but that the experience of living at the intersection of such marginalizations is uniquely challenging and creates a particular set of experiences.

We found a range of articulations of these theories in the everyday work of CBOs. For example, as a staff member at a youth-organizing group explained, "We know as a racial justice organization that when pandemics or, you know, large cataclysmic events occur, it's our folks that are going to continue to be the most harmed, because the conditions are already that way [and] we're going to continue to bear the burden." The organization sees part of its work as training its community in theorizing its position as vulnerable across the long term, which they view as an analytical position that could help lead to change: "We really try to make a place where things don't come as a surprise and shock because. . . young people are blindsided every day in our community, especially by the systems responsible for them. So we really try to be as predictable as we can [because] our communities are often the last to know. You know: first to be problematized, last to be supported or acknowledged—and so we really want to shift that."

In a different vein, a staff member at an organization that focuses on Black community resilience faced community disbelief about the

pandemic, which they understood as rooted in the community's enduring perpetual crises at every level. There were questions about the virus itself, but, more significantly, many believed that the Black community would be treated poorly by government or health-care institutions no matter the true nature of the virus. Clients felt that day-to-day life could not get much worse: "This is just everyday." This organization cited continued uncertainty about future planning and said that focusing on routine needs was primary: "We are meeting the moment, constantly." This posture of resilience at the intersection of multiple challenges was amped up during the summer of racial justice demonstrations. It was not that police violence was by any means new, but that the broader attention to it and the call to march, paint, yell, and theorize about it was louder than ever. This was motivating but also meant that the labor of explaining what life is like at the intersection of, for example, Black identity, poverty, and excessive policing, became an urgent burden as well.

In response to community fears, the CBO worked not only to educate but also to expand its community of care, to include more people in the immediate neighborhood and others across the city; some of this work shifted community perception of COVID-19 and of the potential for public institutions to support them. Still, other CBOs continued to feel the struggle around information flow and trust. For immigrant groups or some workers, the last-to-know phenomenon framed the experience of crisis. In some cases, janitorial staff or domestic workers were not always notified about any increased exposure risk at their workplace. When they were notified, the required isolation often pushed them into unsuitable living conditions—such as self-isolating in cars—without paid time off or other material support from employers.

As the pandemic wore on, another trust and information challenge loomed on the horizon: as vaccine approval began, a youth-services organization centered in the Black community found that clients believed they would be last in line for vaccines and so were not optimistic that vaccines might change their lives in a meaningful or immediate way. Echoing this concern, another CBO leader, who works on labor issues, explained, "A lot of our folks live through so much. . . . We've normalized crisis and trauma and survival."

Others expressed their pandemic response as almost seamlessly incorporated into their existing work, largely because of their well-articulated longer view of crisis. For example, when they began to strategize approaches to the emerging pandemic, a group that works toward Indigenous urban land and food sovereignty reflected on the many crises their community has prepared for, specifically in the Bay Area. As they explained, "We think of when people need to evacuate when the air quality is poor, and people need to find someplace to be safe. Or their water [or electricity] goes out because of an earthquake. . . . Where are they going to go? So we started to think about those things, because of the [PG&E-mandated] power outages that were already happening. And then all of our experiences of growing up in California, [such as living through] the Loma Prieta earthquake." Their view was that these were each distinct but deeply connected disasters, and that it was important to understand their interlocking nature. This constant need for readiness in California, the ongoing state of crisis, shaped their approach to the pandemic. At the same time, the pandemic pushed them to formalize some of their existing structures: "Our disaster preparedness, we named it *himmetka*, which means 'all together in one place.'" This approach guided the development of further preparedness planning, including water supplies, a tool shed, and other things that simultaneously support both ongoing work and disaster preparedness.

Other groups we spoke with echoed this in different ways, noting that the pandemic pushed them to reorient themselves around basic needs like creating food pantries, grocery delivery, and other essential service delivery. This was widespread across organizational types. In some cases, informants speculated that this work might continue beyond the pandemic. Organizations that were already working on the notion of "just transition" or "just recovery" told us that they found that these modes were relevant now again (for example, the Green New Deal).

For others, the pandemic highlighted and accentuated their existing tendencies to think jointly about social problems. For example, a labor-community alliance leader explained, "Our philosophy towards our work is sort of to organize people as whole people, as whole workers. So, we're fighting for rights at the workplace but we're also taking on issues that they face across their lives. Where they might be tenants or they're facing police violence, or they're struggling with underfunded schools. So, we really see that as all part of organizing together."

Significantly, many CBOs' long history of community organizing before the pandemic enabled their capacity to manage this crisis while looking ahead to long-term solutions that would play a role in any future pandemics or other major events. For example, a CBO that works on multiracial coalition building told us that, before 2020, "I would say we never explicitly had a conversation about pandemics or natural disasters, but I think the nature of our coalition [and] the relationships that we've built make it so that if something were to happen, we do have a rapid response, and the network is there and could serve that purpose. But it's not explicitly anywhere saying like . . . we're working together in case there is some natural disaster. . . . I don't think I've seen that in anything. But the infrastructure that we have facilitates that communication."

These infrastructures of organizing were also crucial in producing material support for affected communities. Several CBOs created new no-strings emergency funding pools on their own and in collaboration with others. Many engaged in food and PPE distribution. Some framed this as restitution for long-term marginalization: "This isn't financial assistance. This is a return of resources that already belong to our communities."

Along those lines, the economic shutdown produced by shelter-in-place policies created space to use the current crisis to creatively offer solutions to the longer-term crises. For example, when hotels emptied, and as it became clear that tourism could be affected indefinitely, advocates for deeply subsidized affordable housing developed a new dream: "I feel like doors are open. I mean, this idea of buying hotels, for example, is another one. That's a new one; we never really thought about that. Or we've not really thought that the SROs are that great, but hotels have these wide hallways and they have air systems and they have bathrooms and . . . oftentimes, they have enough space where you can turn them into studios. I mean, I don't know. I had never thought of buying a hotel and turning it into, you know, a hundred studio apartments."

Looking ahead, the long-crisis frame seems to help our informants stay level headed about what challenges may come, and what aspects of this year's triage work will serve them. As the leader of a labor-community coalition noted, "I think [the pandemic] accelerated some factors, right. [And] there's something in the idea that it was structurally flawed and weak already, and then you had like one tremor or something—like an earthquake or something—and the house collapses, right? That's kind of how I feel about it. Like I definitely feel like, yes, those flaws were already there, and those are the structural flaws that led to the pandemic."

Knowing this, several informants worked to balance the challenge of leveraging the possibilities of the crisis with enduring the longue durée. One described this as "a moment that will hopefully give us some greater political leverage to rethink or improve upon how our society's economic system and our political system are structured. But . . . that's going to be a heavy lift in many respects. . . . I wish it didn't take a pandemic and the economic fallout from that to happen."

CONCLUSION

In a year of extremes, the survival of communities in the Bay Area relied on a thick web of community-defined strategies, from the formal to the informal, from grassroots to in some cases government led. In the midst of a crisis that is an extension of prior crises and that has exacerbated inequalities and vulnerabilities, the strata of political and community workers that work through CBOs stepped forward and carried their communities in ways that should inform policy and community organizing going forward. In addition to research on health equity during the pandemic (for example, Fields et al. 2021), our project sits in conversation with

others investigating the ongoing effects of the pandemic, particularly in relation to political culture (James, Tervo, and Skocpol 2022, this issue), the complexities of intersecting dynamics between public health efforts with other community interventions (Burns and Albrecht 2022, this issue), and degrees of trust in government at multiple scales (Pears and Sydnor 2022, this issue).

Our twenty-seven interviews elucidated the political nature of work to promote health equity and care during the crisis of the COVID-19 pandemic. We posit that a more political framing of health equity is necessary. As the pandemic has illustrated, the health sector cannot singlehandedly address health inequities; we also need social and political solutions that are intersectoral (such as breaking down silos to work across health, housing, workforce development). The insights of these CBOs, most of which were outside the health sector, can support work to address the underlying fundamental causes of health inequities (Phelan, Link, and Tehranifar 2010).

Similarly, many CBOs we spoke with are, deliberately or not, striving to develop a collective politics of care. This was not a characteristic we sought in choosing participants but it became apparent as a dynamic. This broadly construed politics of care takes various forms, but includes being grounded in caring for clients and communities of CBOs, CBO staff, and the common good (such as policy and prevention work). CBOs did this work without bypassing the responsibility of state institutions for public health. At the same time, organizers' insistence that community keeps us safe tied public health to the autonomous capacity of local collectives and nongovernmental institutions to analyze and address their needs.

Finally, our informants, in finding ways to understand their working conditions, drew on an understanding of the long crises of racial capitalism. Significantly, this pushed them to take a long view on the pandemic and its relationship to other community challenges. It also moved them, albeit often implicitly, toward understanding the pandemic as endemic to capitalist structures that produce both class and race disparities. One stressed the importance of contextualizing CBO resilience within the linked systems of racial capitalism and white supremacy that create the need for such resilience in these communities. She explained: "We don't want our . . . resilience to be the measure of success. That is supremacy-maintaining."

Our study's strengths include a rich grounding in the Bay Area. The first three authors have each lived here for twenty-five or more years and have a history of doing community-based research in partnership with CBOs in the region, including some of those interviewed. At the same time, this study was conducted in one region only, one that weathered the pandemic comparatively better than other U.S. metropolitan areas. Our heterogeneous interviewees are a core strength of the study—they came from diverse CBOs working within diverse communities with diverse foci. It is possible that staff from particularly overstretched CBOs were less likely to participate in our study, limiting the generalizability of our claims—although, given our team's strong ties with many CBOs and the flexibility within which interviews could be conducted (such as during a commute, outside business hours, and at any point over a multiple-month span) made it more possible for a broad range of interviewees to participate. Finally, although we sought diversity of perspectives among our informants, for several reasons most identified as women, and this could affect the kinds of responses we logged. Because we did not include questions about gender in our protocol, we are not prepared to draw broad conclusions about how it shaped the perspective of our informants or the work that they do. We also encourage future researchers to interrogate gendered dynamics embedded within a politics of care.

All told, these findings point toward lessons for CBOs ongoing, and for funders and researchers working on the intersecting issues that face urban communities. Practitioners might consider framing their work as addressing social determinants of health inequities, and funders committed to health equity should look beyond the health sector for possible solutions with broad community impact. CBOs may also be interested in building more permanent networks to extend their politics of care work across multiple crises. Future research

should explore whether these trends persist as we emerge from the pandemic and whether these trends emerge in other regions as well. For example, nonprofit community organizations led by and serving people of color around the country may share both values and increased need for support as they respond to both racism and the need for structural changes to effectively address COVID-19 in their communities (Building Movement Project 2021) as was evident in Bay Area organizations we interviewed led by and serving women of color. In addition, our project did not investigate the specific legacy of the region's experience with HIV/AIDS on these organizations' advocacy and care work, but this would be a fruitful site for further research. Finally, understanding the relationships between funding, funders, and organizational capacity in a city or region was outside our scope. It would, however, likely offer key insights as to how such structural factors enabled or limited CBOs' effective responses to the pandemic.

In sum, the pandemic altered the social and political dynamics of Bay Area CBOs in ways that offer a model for sustained, long-term work toward health equity. Doing such work to strengthen community infrastructure that centers a politics of care and addresses social and structural health determinants could not just help us out of the long, wide reach of this pandemic, but also help mitigate the broader impacts of future crises (such as future pandemics) as well.

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