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Are we listening to community health workers? Experiences of the community health worker journey in rural South Africa

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Abstract

Access to healthcare in developing countries remains a challenge. As a result, task-shifting to community health workers (CHWs) is increasingly used to mitigate healthcare worker shortages. Although there is solid evidence of CHW program effectiveness, less is known about CHWs' experiences of becoming and then working daily as CHWs – information that should play an important role in the design of CHW programs. We examined the experiences of a group of CHWs working in a government-run CHW program in South Africa's rural Eastern Cape Province. Semi-structured qualitative interviews (N = 9) and focus groups (N = 2) focusing on motivations for becoming a CHW and experiences of working as CHWs were conducted and thematically analyzed. Three themes were identified: 1) becoming a CHW, 2) facing challenges in the field, and 3) gaining community acceptance through respect and legitimacy.

In this study, CHWs were motivated by altruism and a desire to help their community. They faced a range of challenges such as limited training, lack of supervision, equipment shortages, logistical issues, and clinics with limited services. Respect and legitimacy through community acceptance and trust is crucial for effective CHW work. CHWs in this study described how confidentiality and their own persistence facilitated the process of gaining respect and legitimacy. CHWs have unique knowledge of contexts and requirements for successful programs and greater efforts are needed to include their perspectives to improve and develop programs. Recognition is needed to acknowledge the significant personal input required by CHWs for programs to be successful.

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Keywords

Community Health Worker (CHW); CHW programs; home visiting; rural health; South Africa; CHW experiences

Introduction

Access to quality healthcare remains a challenge in most low- and middle-income countries, particularly in rural areas, where patients face barriers to care that include long distances to clinics, scarcity of health care personnel, and medication stockouts (Laurenzi et al., 2020). Deploying community health workers (CHWs) is a key strategy to improve access to health care in these countries (Sachs & Sachs, 2015; Scott et al., 2018). CHW programs have been shown to reduce child mortality (Brenner et al., 2011; Haines et al., 2007), improve maternal caretaking behaviors (Gilmore & McAuliffe, 2013; Stansert Katzen et al., 2020), and facilitate access to health care (Scott et al., 2018). Much of the evidence for CHW effectiveness, however, comes from experimental studies, and there are challenges when programs are scaled up from research-based studies to wider implementation (Cunningham & Card, 2014; Rotheram-Fuller et al., 2017; Wilford et al., 2018). These challenges may include a lack of or poor supervision and equipment and transportation shortages that create barriers to delivering services effectively; these issues also negatively affect CHWs' motivation (Glenton et al., 2013; Mays et al., 2017).

Research prioritizing CHWs' experiences tends to emphasize effectiveness of programs (Pallas et al., 2013), logistical challenges and remuneration (Glenton et al., 2013), and integration with the health care system (Scott et al., 2018). Gaps exist in the literature, however, regarding CHWs' experiences of becoming and remaining CHWs, and their experiences of program implementation, particularly regarding the contexts in which they work (Kok et al., 2015).

Globally, barriers to effective implementation commonly identified by CHWs include inadequate training (Aseyo et al., 2018), poor supervision (Ndima et al., 2015), and limited access to transportation and equipment (Ruano et al., 2012). Additional barriers include challenges in integrating with the formal health care system (Glenton et al., 2013; Kok et al., 2014; Ludwick et al., 2018) and feelings of powerlessness within their work environments (Kane et al., 2016). Motivating factors include remuneration, social recognition, altruism (Glenton et al., 2013; Kok et al., 2014), and social support from families and communities (Greenspan et al., 2013).

CHWs have been deployed in South Africa since 1970 to support population health linked to malaria prevention, maternal and child health support, home-based care, TB, and HIV antiretroviral programs (van Ginneken et al., 2010). In 2011, through the "Re-engineering of Primary Health Care" program, the South African government-led CHW program was reorganized to comprise Ward-Based Outreach Teams (WBOT; Schneider et al., 2018). WBOTs work at a ward (sub-division of a municipality) level, comprising 6-10 CHWs who conduct home visits and provide basic information on non-communicable diseases, HIV/TB treatment, and maternal and child health. CHWs in WBOTs are supported and supervised by

a professional registered nurse (called a team leader), to whom they report at their primary health care clinic (Assegaai & Schneider, 2019; National Department of Health, 2018). Although the WBOT system is promising, there have been challenges with implementation, including a lack of adequate guidelines on supervision (Assegaai & Schneider, 2019).

Although limited, available evidence of CHW experiences from rural South Africa largely mirrors the global literature. CHWs in South Africa identify training (Nyalunga et al., 2019), supervision (Assegaai & Schneider, 2019), remuneration, and logistical factors (Austin-Evelyn et al., 2017) as issues shaping their work lives. Given the challenges in program implementation described above, a more nuanced approach to establishing strategies for effective program implementation and continuation is desirable; documenting CHWs' experiences of their work lives within programs can facilitate this process (Assegaai et al., 2021; Laurenzi et al., 2020; Scott et al., 2018). In this study we aimed to understand CHWs' experiences of becoming and working as CHWs in a government-implemented CHW program in the rural Eastern Cape of South Africa.

Method

Setting

The study was conducted in a district of the rural Eastern Cape province of South Africa. This district is one of the most under-developed and impoverished municipalities in the country; it ranks below national standards in terms of access to water, health care, and employment (Gaunt, 2010; Mitchell & Andersson, 2011). Health care is mainly provided by a government district hospital and surrounding primary care clinics, with few private health care practitioners in the area.

Eastern Cape Supervision Study

This study falls under a larger cluster randomized control trial, the Eastern Cape Supervision Study (ECSS), conducted by Stellenbosch University; the University of California Los Angeles; Philani Maternal, Child Health and Nutrition Trust; and the Zithulele Research Unit. Investigators involved in the ECSS examined whether increased supervision and support provided to South African government CHWs improved maternal and child outcomes. This article reports findings from qualitative interviews and focus groups conducted at the beginning of the trial. The aim was to understand the CHWs' experiences of becoming and working as CHWs in the government-implemented CHW program prior to initiating the trial. Participants were active as CHWs for varying periods of time prior to the implementing the trial. Interview guides included questions about how the participants became CHWs, their motivation, work challenges, and factors facilitating their work. The interview guides for individual interviews and focus groups were similar.

Sample

We used criterion sampling, i.e., sampling based on a pre-established criterion (in this case being a CHW in the intervention arm of the trial; Patton, 2002). All CHWs allocated to the intervention arm of the trial ($N = 18$) were offered an opportunity to participate in the study. Recruitment was conducted through telephone calls to CHWs' personal phones, and

participation was voluntary. As described in the introduction, CHWs in this study are part of WBOTs, employed by the Department of Health (DoH), and linked to primary health care clinics. WBOT CHWs are trained by staff from the DoH and supervised by team leaders at primary health care clinics. Although CHWs serve their communities at large, ECSS focused specifically on pregnant women, mothers, and young children. All participants had been working as CHWs between 10 months and 22 years, prior to being recruited into ECSS (see Table 1). The range of CHW experience reflected the "real world" situation of the study and was thus expected.

Data collection

Data were collected in 2018. The sample consisted of nine individual CHW interviews and two focus group discussions with nine CHWs in each. All CHWs in the intervention arm of the trial ($N = 18$) participated in the focus groups. CHWs from each of the four intervention clinics were included in both focus groups. The nine CHWs approached for individual interviews were randomly drawn from a hat. Individual interviews (average length = 95 minutes, range = 88 to 111 minutes) were conducted first, followed by the two focus groups (one was two hours long, one was three hours long). Focus groups were conducted with the aim of creating additional opportunities for participants to discuss their experiences, anticipating that the conversation among the participants would trigger new thoughts, thereby expanding data (Hennink, 2014).

Both individual and focus group interviews were conducted in a private space at a local training and research center. Informed, voluntary consent was obtained before any data were collected.

Given the small pool of participants, all of whom were employed by the Eastern Cape DoH, extra consideration was given to confidentiality. In the informed consent process, CHWs were assured that their interviews would be de-identified and anonymized and that their comments would not affect their work as CHWs.

Interviews and focus groups were conducted in isiXhosa—the first language of all participants—by a data collector fluent in isiXhosa who was not known to the participants and who was not linked to the trial in any way. The data collector had extensive training and experience conducting in-depth qualitative interviews. Each participant received a small incentive in the form of airtime (credits used for phone calls) to thank them for their participation. The lead author and data collector worked together to ensure data quality; each interview was discussed in detail immediately after it was conducted to address any instances where, for example, more detailed follow-up questions were needed. Interviews were translated into English and transcribed by a separate team who received de-identified audio recordings. The transcription team, comprising individuals who were experienced and well-trained in transcription and translation, was employed by the research institute but are not affiliated with this study. Transcripts were then sent to the entire research team. Transcriptions and translations were verified for accuracy by the interviewer and no discrepancies were identified.

Data analysis

Thematic analysis was used for data analysis, structured by the six steps by Braun & Clarke (2006): becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. ATLAS.ti software (ATLAS.ti Scientific Software Development GmbH) was used for coding, naming, and organizing data.

Participant identification numbers (PIDs) were used to de-identify participants. In addition, names of clinics and reference to geographical information including distance were removed from transcripts to further de-identify the data. In any instance where identification might have been possible, we removed information. Finally, if the first author had any doubt about confidentiality being compromised (however unlikely), the quotation in question was sent to senior authors and further screened for potential confidentiality issues.

Data were reviewed through a lens of factors shaping CHWs' work life. Transcribed interviews were reviewed and coded line-by-line by the lead author. A second researcher analyzed and coded a randomly-selected 20% of interview transcripts, as recommended by Creswell (2009). Because there were only minor discrepancies between the first and second authors' coding, the remaining authors did not engage in coding. Once codes were finalized, the first and second authors grouped codes into categories and then into initial themes as described by Braun and Clarke. Initial themes were reviewed against the data to ensure alignment before final themes were defined, named, and narratively written up. The coding scheme and corresponding themes were then presented to and discussed with the remaining authors.

Reflexivity

All authors had experience in qualitative and quantitative research relating to CHW programs in various settings. Previous research experience may have influenced the way the data were viewed; however, continuous discussions and data validation was done to mitigate this risk. The first and second author were aware that their backgrounds as privileged, highly educated women might influence the way they viewed the data. They therefore followed Creswell's (2009) guidance, continuously discussing their perspectives throughout the process. In the full team discussion about themes, each authors' background and experiences were taken into consideration to remain true to the data.

Ethics

This study was approved by the Stellenbosch Health Research Ethics Board (N16/05/064), by the UCLA Institutional Review Board (IRB#16-001362) and by the Eastern Cape Department of Health.

Results

Participant characteristics

Of the 18 CHWs who participated in this study, 16 were female and two were male. Their ages ranged from 25-58 years. The majority of CHWs (n=13) had been working as CHWs since at least 2009. Additional details are displayed in table 1.

Table one here

Three themes were identified as shaping CHWs' work life: 1) Becoming established as a CHW, 2) Facing challenges in the field, and 3) Gaining community acceptance through respect and legitimacy. These themes represent the process of joining a CHW program and followed participants along their journeys of becoming and conducting the work of a CHW. Quotations in the results section are labelled by PIDs, distinguished by individual interviews and focus groups.

1. BECOMING ESTABLISHED AS A CHW

1.1 Altruism and Community – motivation for becoming a CHW: The vast majority of CHWs had been unemployed prior to choosing to apply to become a CHW. Most described volunteering at local governmental clinics and eventually being employed as CHWs with a small stipend as remuneration. As CHWs spoke about their motivations for becoming a CHW, their desire to help their communities was the most important influence. Factors such as communities being located far from clinics and hospitals were often mentioned as a reason for motivating them to become a CHW in the village. In addition, altruism and love for people served as motivation for volunteering without remuneration. Several CHWs also mentioned working on evenings, weekends, and being awakened at night to provide health care, call ambulances, and even deliver babies.

> I took a decision to be a CHW because I wanted to help my village, to help them where I'm supposed to help them, where there is a need, then know that I'm there for my village.
>
> [Individual interview, PID 3]

Additionally, the hope of one day receiving remuneration for their work was often mentioned as a motivation for volunteering prior to becoming a salaried CHW. Once incorporated into a WBOT, CHWs earned a basic salary. Salary was an added motivation that was often mentioned as a means of tangibly improving their socio-economic status.

> I managed to build my own house with this money, I managed to educate my kids, they attend [school] in [nearby city] with this money…I can stand on my own even sending them to the initiation school with this money.
>
> [Individual interview, PID 4]

1.2 Characteristics and skills of a CHW: CHWs also spoke about the importance of traits needed for their roles. Behaviors such as always being polite, friendly, talkative, and giving compliments were commonly mentioned as central to carrying out the job. CHWs

repeatedly returned to the importance of possessing these characteristics and practicing these behaviors to facilitate the acceptance of their services in the community.

> You need to be a friendly person, you need to be someone who is able to talk…you need to…be approachable, people [need to] be able to ask you when they feel like asking you.
>
> [Individual interview, PID 9]

1.3 Growing sense of responsibility to look after others: Once participants had chosen to become CHWs, they described assuming a heightened sense of responsibility for supporting others. Relationships with community members and clients appeared to be critical to successful CHW work. Working alongside clients, as well as *for* them, was described as critical.

> In my understanding… [a CHW is] someone that looks at people's situations. For example, if I visit your household and you…explain about the problems you are facing on a day-to-day basis, you come trusting me…we face the problem together to try to get the solution.
>
> [Individual interview, PID 1]

2. FACING CHALLENGES IN THE FIELD—This theme illustrates CHWs' experiences delivering and implementing the intervention with clients. Three facets comprised this theme: (a) training, supervision, and teamwork; (b) practical and logistical challenges, and (c) the relationship between the CHW program and the clinic.

2.1. Training, supervision and teamwork: CHW participants stated that a supportive system characterized by effective training and supervision, coupled with supportive relationships with other CHWs, was crucial to effectively carrying out their work. Teamwork and the relationship between CHWs were also described as important for facilitating CHW performance. Support and advice from other CHWs were highly valued.

> It is nice to work as a team, we work together and we discuss about how to conduct/do our work and things that will make our work easy.
>
> [Individual interview, PID 2]

CHWs appeared to be positive about their initial training. There was, however, a lack of continuous training. The majority of CHWs had not been offered additional training since their initial training.

> I think you should get training regularly to remind yourself bit by bit…[otherwise] you end up forgetting [and] find out that there are so many trainings that you wish to attend but it is not easy to attend a training.
>
> [Individual interview, PID 11]

Limited in-field supervision was also common, with most supervision conducted at clinics. Participants reported that supervisors were unwilling to conduct in-field supervision and provide support.

> From my village to the clinic is [exact hours removed for de-identification] hours, she [clinic-based team leader] would say that she will never go to my village because it is far, she never supervised me even for one day.
>
> [Focus group 1, PID 8]

2.2. Practical and logistical challenges-- "I walk at least four hours a day" -: Once in the field, a range of challenges made it difficult to carry out CHW work successfully. A common challenge was distance, as CHWs covered vast distances with limited or no access to transportation.

> It's [exact hours removed for de-identification] hours walking…and there is no transport[ation] some cars are just passing me. Even when I come back it's the same thing, it becomes so painful but you don't have a choice because you have to go to work or you have to visit that house.
>
> [Individual interview, PID 3]

Access to transportation was a common recommendation to improve the program. Additional cars, motorbikes, and bicycles were suggested as possible modes of transportation. Mobile clinics were also recommended to facilitate access to key services, as some areas were extremely remote. Some CHWs also suggested employing more CHWs and supervisors to help cover large distances.

A major challenge commonly shared was the issue of personal safety. Several CHWs described being bitten by clients' dogs and sometimes having to skip a home visit, as dogs made access to the house impossible. A potential solution mentioned was to have telephones and airtime (credit for phone calls) to call the household members prior to a visit.

> You notice it would be hard to go to that house because the dogs will bite. I was once bitten by a dog. I even had a grudge that I would never go to that home again but then I thought, I have to go to that home because those people need help.
>
> [Focus group 2, PID 4]

Most of the CHWs described feeling unsafe in certain areas, specifically when having to walk through forests to reach households.

> Those villages are far from each other and…to get to other village you have to pass through the forest and that is not easy for ladies to pass through the forest because there is rape, phones are being robbed…so it won't be easy.
>
> [Individual interview, PID 11]

Lastly, access to necessary equipment was discussed in every interview. CHWs reported having highly limited access to any equipment to conduct their work. Blood pressure machines were mentioned as important and something the community wanted, as were diabetes test machines, HIV tests, and first aid kits. Equipment was described as a facilitator for gaining community acceptance through increasing program credibility.

> I wish we can be given…things like BP [blood pressure] machines and machines used to test diabetes, those are some of the things that we would like to have …

> when we visit these houses a person would ask “Don’t you have machine to check BP because we want BP checked, you don’t have [a] machine to check diabetes?”.
>
> [Individual interview, PID 7]

2.3 A triangular relationship between the CHW program and the clinic: Effective collaboration with local clinics was seen as important for CHWs to conduct their work. Clients were often referred to clinics with issues that exceeded CHWs’ abilities, and having a good relationship with the clinics was imperative. Respondents described a three-way relationship among CHWs, clients, and clinics, where the CHW served as a facilitator and link between the clinic and the clients. CHWs described how clients preferred being visited at home due to convenience and travel time. For example, one participant commented “the distance [to the clinic]…is too far” [Individual interview, PID 1] Clients also worried about being shouted at by healthcare workers at the clinic.

> Because they [the clients] are scared to go to the clinic, you will say “no one is going to bite you at the clinic. You will get there and explain your problem.” Maybe [the clients] are scared of other people. Other [clients] will say there is too much noise at the clinics. Other [clients]s don’t like to be shouted at. There are people who [are] loud in their nature.
>
> [Individual interview, PID 1]

Furthermore, respondents stated there were times when access to certain services at the clinics was limited. For instance, one CHW commented that when a client went to a clinic, “there were no pregnancy tests available…and immunization is not always available.” [Individual interview, PID 9]. Such supply problems created barriers for CHWs implementing effective services.

CHWs emphasized that home visiting meant having more time with clients, allowing them to express their needs without rushing. Furthermore, being able to see whole families at once was described as beneficial. Home visits were a way to provide basic health care at home while mitigating the long distances to clinics that posed a challenge for accessing health care.

> There are so many people in the clinic…at home you arrive and relax with your patient so that the mother can freely explain the problem and you have time to help her even if you don’t have anything to give but when you go out she would be satisfied.
>
> [Focus group 2, PID 6]

Having more time with a client supported CHWs’ ability to embrace the opportunity to build a relationship with the clients, described as key for CHW program implementation. CHWs’ positioning in their own villages facilitated relationship-building.

> I was born in [village name]. I also grew up there, they know me, so when I am talking they are able to ask what they do not understand…a person can say: “so what will happen with a certain thing?” They speak freely because they know me.
>
> [Focus group 1, PID 2]

3 GAINING COMMUNITY ACCEPTANCE THROUGH RESPECT AND LEGITIMACY—

Community acceptance was foundational for successful program implementation and an important goal that the CHWs needed to work towards. This theme illustrates how community acceptance shaped CHW work in the field.

3.1 Barriers to household acceptance: A challenge in achieving community and household acceptance was older community members who were reluctant to accept new knowledge. Furthermore, CHWs described some reluctance from individuals in wealthier households, where household members might have higher education levels than CHWs. Participants, however, often noted that they were able to earn household members' respect after repeat visits to the household.

> Someday in that house they will call you and tell you to get inside, you must not…ask what about when you chased me away because you are now called for a problem…you would feel it is a must that you get in there because…there must be a problem.
>
> [Focus group 1, PID 6]

CHWs also reported that some community members undermined CHWs because they saw them as voluntary workers, occupying a lower status than nurses. Although CHWs in this program earned a salary, there were discussions about the level of remuneration. Furthermore, CHWs were on temporary contracts as opposed to permanent ones.

> To them it is like we are not employed as compared to those who are working in the clinic so in that case we need to sit down with that person and explain to her about our job and try to show her the help we bring to the community.
>
> [Focus group 2, PID 9]

Furthermore, community-wide rumors posed challenges for CHWs gaining acceptance in the community. For instance, at times community members would be unwilling to disclose their HIV statuses and rumors emerged about CHWs only visiting people living with HIV.

3.2. Confidentiality and trust: The most critical factor that CHWs described to ensure acceptance was confidentiality. To be trustworthy and always maintain confidentiality was seen as imperative for optimal program functioning.

> When you are in villages, the things that those clients tell should end up between you and the client. You don't go out with them and you don't reach home and say "yoh where I come from this is what happens" (spreading information).
>
> *[Focus group 2, PID 5]

Also important was building a relationship with the client based on trust and mutual respect.

> It's important to be someone who is trusted within your clients…You must be that person who is trusted and be loved, because if you are not loved you will not be listened to what you are talking about.
>
> [Individual interview, PID 9]

Devotion to the job was also described in many interviews as a facilitator for gaining client's trust. CHWs emphasized that it was important to be available when community members called at night or approached them at community events to ask health-related questions. One participant described a situation where she had to use a wheelbarrow to push a woman in labor to the clinic because the ambulance was busy elsewhere. The CHW ended up assisting the mother to deliver the baby at somebody else's house.

Additionally, perseverance was described as a critical way to gain acceptance in the community. CHWs spoke about persevering with difficult cases, such as clients who repeatedly defaulted on their antiretroviral medication. The majority of participants described the importance of becoming a link between community members and health facilities. One CHW described her view of the program's impact in individual communities.

> They also like it when you persevere with them not that thing of insulting a person when they have done wrong. They like that we continue with them and hold their hands even if a person is falling. We always getting them up. That is why they are giving us the respect that they give us because we are the people that are doing a good job in the villages.
>
> [Focus group 1, PID 1]

Discussion

Our individual and focus group data with CHWs allowed us to identify factors shaping CHWs' work life as they participate in a government-run CHW program in the rural Eastern Cape of South Africa. CHWs in this study claim to be motivated by altruism and a desire to help their community. In their work as CHWs, they face a range of challenges such as limited training, lack of supervision, equipment shortages, logistical challenges, and clinics with limited services. Respect and legitimacy through community acceptance and trust is regarded as crucial for effective CHW work. CHWs in this study described how their persistence and their prioritization of confidentiality facilitated their work. Many of our findings echo existing literature about barriers and facilitators to successful implementation of CHWs programs (Glenton et al., 2013). As our data were collected in 2018, they reveal that similar challenges identified in previous literature from five or more years earlier (Glenton et al., 2013) have not been overcome.

A point often made by CHWs in existing literature is the importance of training and supportive supervision for successful program implementation (Aftab et al., 2018; Kok et al., 2014; Ndima et al., 2015). Findings in our study suggest regular supervision in the field was rare or non-existent, echoing current reports regarding supervision frequency when programs are implemented at a national scale (Assegaai & Schneider, 2019; Ndima et al., 2015; Roberton et al., 2015). Also reported repeatedly by CHWs in this study and others (Glenton et al., 2013) is that logistical and practical challenges play a major role in the implementation of CHW programs, particularly in rural areas. Vast distances and lack of transportation are major challenges described by the CHWs. Distance and transportation challenges are exacerbated by the extreme geography of the area. In addition, relationships and support between CHWs were addressed by the participants. It appears that CHWs

support each other in terms of knowledge-sharing and logistics, resonating with aspects of supportive supervision where teamwork is an important characteristic (Kok et al., 2018). Safety concerns were also often discussed by the CHWs as a barrier to reaching patients, with a focus on dogs and unsafe areas such as forests. Safety concerns are mentioned (Glenton et al., 2013), however not commonly discussed in the literature, yet they are described as a major hindrance to successful implementation in this study.

It is clear that CHWs face a range of challenges in executing their work, both relating to the setup of programs, for example area allocations, and to practical implementation issues such as a shortage of equipment. These challenges have been repeatedly reported by CHWs in program evaluations, yet, supervision, training and logistical issues remain a challenge.

Increasingly, the importance of involving end-users in health program design is being recognized (Foster et al., 2010; Gilmore et al., 2014). Efforts to co-produce interventions, however, often neglect to include the perspectives of service providers such as CHWs (Kane et al., 2016; Scott et al., 2018). Being context-specific when designing and implementing CHW programs is crucial (Kok et al., 2015). Yet, the opinions of CHWs who have unique knowledge regarding the context in which the CHW program is being implemented appear, at times, not to be solicited or heard. We need to consider how the challenges reported in our data and in the literature can be mitigated. Drawing from our data, one step towards alleviating these challenges is to consistently provide better logistical and practical support to CHWs, including equipment. Our findings further suggest that ongoing training and supportive in-field supervision would be beneficial to the program. Having supervisors who are present, aware of CHWs' daily challenges, and empowered to assist practically might also ease logistical and other challenges – and ensure that CHWs' perspectives are considered throughout the implementation process.

Our findings reinforce the importance of CHWs' personal input, characteristics, and skills as crucial for successful program implementation. The CHWs in our study were motivated through a desire to assist the community and a sense of responsibility to care for others. These findings echo existing literature (Glenton et al., 2013; Laurenzi et al., 2020). In recognizing and understanding the intertwining of CHWs' personal and professional lives, more research needs to be done focusing on the rights (Scott et al., 2018), needs (Laurenzi et al., 2020) and empowerment (Kane et al., 2016) of CHWs personally and professionally. Considering the vast personal input required by CHWs to carry out their work successfully (Laurenzi et al., 2020), there should be more emphasis on supporting CHWs. This emphasis might consist of program design and implementation that centers on increasing job satisfaction, reducing burnout, and promoting workplace well-being. Furthermore, it is evident in existing literature (Glenton et al., 2013; Pallas et al., 2013; Scott et al., 2018), and from our findings, that navigating household-level and community-wide acceptance and facilitating uptake of the intervention requires substantial interpersonal skills and personal input by CHWs. The interpersonal skills and input required by CHWs could be another focus for future research.

A journey of becoming and remaining a CHW was documented in our interviews – highlighting the many challenges that shape CHWs' work lives. Our findings furthermore

highlight the valuable knowledge and experience that CHWs have of their communities and clients. This knowledge has not been given adequate attention in literature or practice. In program evaluations, CHWs continuously report shortfalls in supervision, training, logistical support, and equipment (Glenton et al., 2013; Scott et al., 2018), yet it is not apparent these concerns are used to revise program designs or improve implementation strategies. Further efforts to mitigate these challenges need to be made. Drawing from our data, we suggest increased logistical support (equipment and transport) and increased ongoing training, support and supervision through supervisors who are empowered to facilitate change to mitigate these challenges. A first step towards achieving effective implementation strategies for CHW programs is to include and listen to the CHWs themselves and use this input to iteratively improve and expand programs.

Limitations

It is important to note the limitations of this study. Firstly, the CHWs interviewed are from a relatively small pool of Department of Health employed CHWs taking part in the larger trial. This may have caused concerns about confidentially and furthermore it may have had an impact on the level of honesty in the interviews, particularly with critical feedback. Nevertheless, we believe the risk of this is small given the measures we used to ensure confidentiality, where participants were de-identified through the use of PIDs and any names of clinics and geographical areas were removed. Furthermore, the interviewer was not previously known to the CHWs and was independent from the Eastern Cape DoH employing the CHWs, which we believe was an advantage. Secondly, we did not have the capacity to conduct individual interviews with the full sample and chose to randomly select CHWs for individual interviews. The full sample of 18 CHW, however, was included in focus groups.

Conclusion

CHWs' work lives are diverse and their experiences cover a range of topics and situations. Improved supervision, in-field training and practical and logistical support such as transport are domains where shortfalls are regularly reported and where program betterment is needed. CHWs' personal input is crucial for program success, as effective program implementation largely depends on CHWs abilities and the relationships CHWs build with their communities. The influence of CHWs on successful program implementation needs to be considered during the planning and implementation process of programs. Greater effort is needed to include the perspectives of CHWs themselves as they are the individuals who know the communities supported by CHWs.

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Table 1

Community Health Worker Characteristics

Variable	Mean, Median, Mode	Range
Age	Mean: 41.7, Median: 43 Mode: 43	25 – 58
Highest Education	Mean: Grade 10	Grade 5 – Diploma (obtained post graduating high school)
Male/female distribution	Two CHWs were male and 16 were female	
Marital status	7 - married, 10 - single, 1 – widowed	
Children	2.4	0 – 6
Year Started as CHW	Median: 2009	1999 – 2018
Number of CHWs in each starting year increment	1999-2003	3
	2004-2009	10
	2010-2015	0
	2015-2018	5

Note: CHWs who started in 2018 had worked for approximately 10 months prior to data collection.