The Open Public Health Journal
DOI: 10.2174/0118749445334086240915172733, 2024, 17, e18749445334086
ISSN: 1874-9445

RESEARCH ARTICLE **OPEN ACCESS**

Important but Neglected: Job Description of Community Health Workers in the Eastern Cape: A Qualitative Study

Uchenna Benedine Okafor[1,*], Iyabo Obasanjo[2] and Daniel Ter Goon[3]

[1]*Public Health, Faculty of Health Sciences, University of Fort Hare, 50 Church Street, East London, 5201, South Africa*
[2]*Public Health, University of Maryland, Baltimore, United States*
[3]*Faculty of Health Sciences, University of Limpopo, C/O R71 Tzaneen Road and University Street Mankweng Township, Polokwane, 0727, South Africa*

Abstract:

Introduction: The role of community health workers (CHWs) in improving health system dynamics in developed and developing countries is gaining global attention. Because they connect the community to the health system, knowing their roles is crucial. This study explores CHWs' perceptions on their job description and activities, challenges, and the relevance of their roles.

Methods: This qualitative descriptive study included 10 interviews and 13 focus groups of CHWs. A semi-structured interview guide was used. Atlas.i was used to perform thematic content analysis.

Results: CHWs educated and advocated for health issues like HIV, TB, and healthy lifestyles. CHWs experience discrimination, assault susceptibility, lack of training and skill, local dialect constraint, and distrust. CHWs believed their services were needed and valued by their communities. Overall, CHWs were satisfied with their jobs and applauded the program.

Conclusion: The findings showed that CHWs are aware of their duties and perform them with enthusiasm and commitment regardless of challenges they face, and they are appreciated by the communities they serve. Our findings have implications for enhancing CHW program practise, policies, and future research recommendations, underlining the need of addressing the issues experienced by the clients and communities they served, since this impacts the quality of their work.

Keywords: Job description, Community health workers, Community, Challenges, Relevance, Semi-structured interview guide.

*Address correspondence to this author at the Public Health, Faculty of Health Sciences, University of Fort Hare, 50 Church Street, East London, 5201, South Africa; E-mail: ucheysonic@gmail.com

Cite as: Okafor U, Obasanjo I, Ter Goon D. Important but Neglected: Job Description of Community Health Workers in the Eastern Cape: A Qualitative Study. Open Public Health J, 2024; 17: e18749445334086.
http://dx.doi.org/10.2174/0118749445334086240915172733

Received: June 14, 2024
Revised: August 30, 2024
Accepted: September 04, 2024
Published: November 18, 2024

1. INTRODUCTION

Community Health Workers (CHWs) can play a crucial role in strengthening a nation's health system. There exists a range of definitions or nomenclatures for the term “CHW” across nations. Community distributors, community-directed health workers, health auxiliaries, health promoters, family welfare educators, health volunteers, village health workers, community health aides, and barefoot physicians are a few examples [1]. A defining characteristic of CHWs is their proximity to the

community they serve as they reside and work in the community and have a better knowledge of the socio-economic needs and culture of the community [2, 3]. Similarly, in various contexts or settings, CHWs have different responsibilities, skills, and employment conditions [4, 5]. Significantly, in low- and middle-income countries (LMICs), community health workers (CHWs) played crucial roles as health workforce adjutants who are integral to effective and equitable community health service delivery [4-7].

CHWs have traditionally been instrumental in providing health services, community advocacy and awareness/mobilization, health promotion, and preventive and clinical services [7-14]. CHWs also have provided assistance during disease epidemics; the outbreak of Ebola within West Africa is a classic instance [15-19]. CHWs have played a significant role in controlling COVID-19 in recent years [20-27]. A recent rapid review study found that CHWs administered vaccines in 20 of the 75 countries with documented CHW programmes [28]. Nevertheless, given the health care workforce shortages and immunisation equity gaps encountered by many countries, it is essential to integrate CHWs as vaccine administrators to improve immunisation access for remote, hard-to-reach communities [28].

In India and Ethiopia, CHWs were involved in promoting awareness about COVID-19 vaccination and encouraging uptake [29, 30]. Evidently, CHWs perform a vast array of roles within a health system. They are the nexus of views of the community health. They live and work in the community; thus, they have clearer understanding of the health issues of the community as they are also affected by the same circumstances that promote the negative health issues. As Zulu and Perry [5] argue, CHWs are now viewed as “an essential high component of a high-performing healthcare system” in both developed and developing countries. Clearly, countries that have recognised the significant impact of CHWs and have provided support and impetus to their optimal functioning and performance, such as Brazil, Bangladesh, Iran, Ethiopia, Nepal, and Malawi, are demonstrating significant improvements in their populations' well-being [31-36].

In South Africa, the primary healthcare re-engineering strategy was launched by the National Department of Health in 2010 as part of the efforts to transform the health system into one that is more preventatively oriented, and CHWs were utilised to drive the community health agenda of health promotion for primary health care [37, 38]. This model illustrates how community health workers (CHWs) provide comprehensive health and social care to households while also serving as an interface between healthcare and social service providers and low-income communities [38]. The CHWs are predominantly recruited and employed by the Department of Health and receive a small stipend Horwood *et al*. [39] in a bid to augment the shortage of health workforce required to serve marginalised, local population in South Africa. Community health workers serve an array of roles in the community. These include home-based care, identification of individuals at risk for HIV infections, adherence support for antiretroviral therapy (ART) and case tracing, TB treatment, health education/advocacy on various health issues (TB, HIV infection, infant breastfeeding practises, cervical cancer screening, drug abuse, gender-based violence, *etc*.), and data collection [8, 40, 41]. In addition, they are responsible for the provision of maternal and child health services in the households, including counselling on early antenatal care attendance, identification of danger signs in newborns, and support for breastfeeding, as outlined in the Department of Health's policy for community-based maternal, child, and newborn care [8, 40, 41].

While there are studies on CHWs from various perspectives in South Africa in diverse geographical settings [8, 38, 42-45]. there is hardly any study assessing the job description, challenges, and relevance of CHWs in Buffalo City Municipality, Eastern Cape Province. CHWs play an important part in the community health delivery agenda. They are at the intersection between the health system and the community; thus, supporting them could enhance how they perform in their roles. Consequently, it is necessary to explore their perspectives regarding their job description and activities, and relevance of their roles in the communities they serve.

2. METHODS

2.1. Research Design and Setting

This qualitative, contextual, exploratory study explored the difficulties confronting community health services, the tasks and responsibilities of community health workers, and the relevance of their roles to the communities they served. A purposeful sample of 23 CHWs was drawn from two conveniently accessible community health clinics, Nontyatyambo and Duncan Village Day Hospitals, and John Dube Clinic, all in Buffalo City Metropolitan Municipality, Eastern Cape Province. The Eastern Cape Province, founded in 1994, includes territory previously designated as the Xhosa homelands of Transkei and Ciskei, as well as parts of the Cape Province. It is one of the poorest provinces in South Africa [46] as a result of the past injustices of apartheid government policies, which compelled Black South Africans to live in sparsely populated, rural, and underdeveloped areas [38]. It is also a province with little resources and services, and the bulk of its residents live distant from clinics [38].

2.2. Participants

The individuals who were recruited as possible participants were community health professionals who had a minimum of three years of experience working in the field of community health, were at least 18 years old (which is the legal age of consent in South Africa) and were able to speak and communicate in English. Not only were the CHWs invited to take part in individual interviews (n=10), but they were also asked to take part in focus group discussions (n=13).

2.3. Data Collection Procedure

Data collection was between February and March 2023 utilising semi-structured individual and focus group interviews. Traditionally, a focus group of 6-8 individuals is advised [47]; however, focus groups can work effectively with 3 to 14 participants [47]. An interview guide was used to interview participants. The collective experiences of 13 participants in this study, like the one-on-one interviews, were effectively managed and coordinated to gain rich information on the job description and activities of community health workers, community health service challenges, and the relevance of their roles to the communities they served. In both approaches, the interviews were conducted by posing open-ended questions, and allowing respondents to express themselves freely. Individual interviews allow participants to focus on the questions and allow the interviewer to explore relevant ideas, deepening the understanding of client and community challenges as articulated by a single CHW. Both methods allow people to openly express their opinions on a topic, but the latter allowed CHWs who care about customers and the community to interact. Participants' concurrence and disagreement over client and community challenges was also observed. We employed individual and focus group interviews to improve data interpretation and credibility.

The participants were provided with the option to ask questions as well as add any relevant information to the questions and discussion, which was then incorporated in the data analysis. Individual interviews lasted 45-60 minutes, while focus-group interviews lasted approxi- mately 1 hour and 20 minutes. These interviews were audio taped with the permission of the participants. They were contacted through mobile phone for dates, times, and locations for their convenience to identify an acceptable date for their interview. An interview guide was used to conduct interviews with participants. In addition to the qualitative interviews, the CHWs were asked to rate on a scale of 1-10, how satisfied they are with their job, and the effectiveness of the CHW program in the promotion of healthy living, supporting people with accessibility to medical care, providing health education, and the overall assessment of the program.

2.4. Data Trustworthiness

Several methods verified the data's trustworthiness. Data collection and extended engagement with partici- pants in each health facility provided enough time to build rapport for open dialogue. Structured coherence was maintained by peer-checking, conversations, and reflective journaling to avoid unexplained conflicts between data and interpretations. The independent coder and authors additionally revised and discussed findings interpretations to reach agreement. The recorded data was listened to repeatedly to verify the responses of the participants were accurately transcribed. The interview data was comprehensively described. Participants' demographics, viewpoints, and own experiences were described in excerpts or quotes. A full account of the research process, field notes of all acts and decisions essential to all stages of the study, and peer-debriefings with a colleague. Additional member-checking transpired with study participants. Participants reviewed the interview transcripts to verify the authenticity and validity of the transcriptions.

2.5. Ethical Considerations

The University of Fort Hare, South Africa, Health Research Ethics Committee (Ref#2020=10=10=GoonD =ObasanjoI) granted ethical permission. The Eastern Cape Department of Health Research Ethics Committee gave permission. Participants provided informed consent prior to data collection. To protect the privacy of participants, the data was anonymized. Each participant completed an informed permission before participating in the study.

2.6. Data Analysis

This qualitative study employed thematic analysis [48-50]. Using a deductive method, a coding framework was developed based on the interview guide topics. The authors read carefully and became acquainted with the data. In addition, preliminary codes were generated, and themes related to the topic were searched for and reviewed. The themes were identified and grouped accordingly. Following that, the emerging themes on CHWs job description and activities, community challenges, and the significance of their responsibilities in the communities were developed. Major themes were developed and modified iteratively after the data was coded.

3. RESULTS

The sociodemographic characteristics of the CHWs are shown in Tables **1** and **2**.

3.1. CHW Job Description and Activities

3.1.1. Health Education and Counselling

The community health workers indicated that one of their roles was to provide health education and counselling on various health issues in the community and schools. These include HIV counselling, health advocacy, TB screening, importance of healthy living life-style and medications adherence such as antiretroviral (ARVs), TB drugs, and health implications of substance abuse. The CHWs affirmed that they were providing community-based healthcare.

Table 1. Demographic profile of the participants (n=23).

Variables	n
Sex	-
Male	8
Female	15
Education level	-

(Table 1) contd.....

Variables	n
Grade 11	1
Grade 12	16
Diploma	6
Marital status	-
Married	4
Single	17
Widowed	2
Number of children	-
One child	9
Two-three and above	12
None	2
Does anyone else live with you?	-
Yes	14
No	9
Who else live in your household?	-
Mother	2
Grandmother/ children	13
None	8
Main source of income for your family	-
Yes	23
No	-
Monthly stipend or salary earned	-
R2200	1
R4000	14
R4020	1
R4050	3
R4100	1
R4200	2
R4300	1
How long have you worked as a CHW for the health district?	-
2-10 years	17
11-20 years	6
Community served	-
Duncan Village	5
Scenery Village	5
Mdantsane	13

Table 2. Summary of identified themes and sub-themes.

Themes	Sub-themes
CHW job description and activities	Health Education and counselling
-	Health care and assistance
-	Community outreach
-	Data collection
-	Organization
-	Managing treatment defaulters
Community connections and services	Constant encouragement
-	Collective security
Community health service challenging experiences	Discrimination
-	Community attack vulnerability
-	Training and skill
-	Local dialect limitation
-	Distrust
CHWs' relevance to community	Community involvement
-	Health and risky behavior education

(Table 2) contd.....

Themes	Sub-themes
-	Youth engagement
-	Community support

"*...I do a lot of health education. Well, sometimes I start my day from the clinic before going to the community. The reason being that we usually come to the clinic to check the register and ascertain where we are going to work for the day...*" (CHW 01).

"*I do HIV counselling at the clinic because I have the training and years of practise. We do, however, go out to the community to educate people in their homes. Sometimes, we go to the taxi centres, the community hall, or the schools.*" (CHW 06).

"*When I go to work, I do TB screenings because I have been taught as a DOTs. Then you teach them. HIV didn't exist back then; therefore, it wasn't new for a lot of persons in the community to talk about their TB status. Is really a big deal now. I can tell you that the result was really good back then because we were more disciplined than we are now. And education is key. I think people now know more about what's going on. There is a lot of awareness now, and people can quickly look things up on Google, but the challenge is that people don't have any discipline at all*" (CHW 08).

"*We sometimes educate people on healthy living, the importance of adhering to chronic drugs like ARVs and TB treatments, and the dangers of drug abuse*" (CHW 03, FGD).

3.1.2. Healthcare and Assistance

The CHWs health care and assistance includes assisting with vital signs, taking clients' medication books to the dispensary, sorting patients' clinical cards, facilitating in the admission of patients, and assisting clients who do not know their way around, as reflected in their views:

"*Okay! My responsibility is to care for patients, particularly those in the assigned community*" (CHW 01).

"*It was back then during COVID after cleaning, we will be ask to come and assist in certain areas like in admission, taking vital signs etc and that is how we got to learn. However, they have informed us that they will be sending two individuals to the training simultaneously.*" (CHW 03).

"*Mostly, I... help with vital signs, take clients' medications books for the dispensary, and assist people who are unsure where to proceed*" (CHW 04).

"*Well, most of the time it's not that busy, but sometimes it is. I mean when we go out into the community for outreach, but here in the clinic, it's very busy from the time you get here until the time you leave. The sisters in the clinics use us because there are never sufficient staff to work there. For example, during admission, we are always helping to sort out patients' clinical cards*" (CHW 04, 07, FGD).

"...sometimes, we assist patients in collecting their medication from the pharmacy using their cards. *So, the clinic, as you can see, is extremely busy*" (CHW 03, FGD).

"*In the clinic, we do a lot of work. Sometimes we assist clerks at the admissions area, while others work at HIV/AIDS clinics for new client testing, and still others assist in the TB clinic section area*" (CHW 06, FGD).

3.1.3. Community Outreach

The CHWs implement a variety of community outreach activities, including visiting clients at designated locations such as schools, taxi stands, private residences, and community centres. In addition, they traced patients who are defaulters on ARVs or TB treatment. In the schools, CHWs addressed a variety of health concerns affecting children, including adolescent pregnancy, substance abuse, alcoholism, sexually transmitted diseases, and HIV/AIDS.

"*Aside from home visits, we occasionally visit taxi ranks, community halls, and schools*" (CHW 06).

"*When a person defaults, we check the register to find out why the person defaulted and why they are unable to come to the clinic*" (CHW 01).

"*I have also interacted with the community, but I always do so in the company of other CHWs.* (CHW 04).

"*Is as routine as every other day. I carry out my responsibilities. As outreach to the community*" (CHW 05).

"*...I will take the list of clients we are tasked with tracing and go out to find them. However, it is not always simple going unaccompanied in the community. I am always cautious about where I go, but I usually travel with colleagues*" (CHW 10).

"*We also go to schools for outreach at times. The principal often grants us permission to talk to the pupils about health issues such as substance abuse, teen pregnancy, alcohol misuse, alcohol usage, HIV/AIDS, sexually transmitted diseases, and so on*" (CHW 09, 04, FGD).

3.1.4. Data Collection

The CHWs assisted in data collection about the client's household registrations, defaulters, lost to follow up cases, traced clients, and performed general health screening of clients, record the data, which provide them with useful information about the signs and symptoms of disease for possible referral to the clinic they served for action.

"*In the Register, we also verify a person's address and phone number, as we will use this information to contact them*" (CHW 01).

3.1.5. Organization

Contrary to the contract, the CHWs do not make daily visits to the community. They indicated that, because of the clinics' heavy responsibilities, some CHWs assist the nurses

at the clinics.

"*We are supposed to go to the community every day because that is what the contract says, but we don't. So, we were split up into groups; some go to the community whereas others stay back to help at the clinic. We practise tasks division*" (FGD, CHW 9).

"*We are split up into groups, and when we don't work in the community, we usually work in the clinic*" (CHW 01, FGD).

CHWs indicated the organisations in which their various tasks belong under. For example:

"*After signing for attendance register, I then looked for folders and arrange them into categories like chronic, medications, etc. Then we will help them get to where they want to go*" (CHW 02).

"*Most of the time, I'll be assisting with the admissions and arranging records and folders*" (CHW 04).

"*So, when ward-based primary health care outreach teams (WBPHCOT) emerged, we were supposed to offer support to people in rural communities that the nurses couldn't reach because they work in clinics. So, they established WBPHCOT, but they don't keep up with it. When we make home visit to register the squatter camps, we don't have any stationaries materials. We check the immunisation cards for young children and those who are pregnant*" (CHW 02).

3.1.6. Managing Treatment Defaulters

The CHWs asserted that they are patient, persistent, and professional when trying to convince defaulters to return to the hospital to continue their treatment. Through health education and advocacy, CHWs do encourage clients on chronic medication and treatment to adhere to medications and treatment as prescribed.

"*For me, it is highly important that I maintain my work ethics with clients and avoid being too personal with them because they are manipulative. Sometimes they have good reasons for defaulting. They will now ask you gently to kindly get their treatment from the clinic when you're coming back, they will provide you with their identity booklets and their HBRS book (Medication booklet) to submit to the pharmacy for the treatment. In addition, we educate community members about TB, HIV, and other chronic diseases, as well as the importance of adhering to treatment*" (CHW 03, 07, FGD).

3.2. Community Connections and Services

Despite the prevalent insecurity, participants stated that they interface and connect with the community they serve *via* constant engagement with them through health discussions and talks about various health issues affecting the community. They believed that the community was pleased with their performance of these roles. There were two identified subthemes: constant encouragement and collective security.

3.2.1. Constant Encouragement

Participants asserted that they maintain a constant dialogue with the community regarding treatment noncompliance, and that during this dialogue, clients are advised and encouraged to take their medications.

"*Other times, I am assigned to work with chronic medication treatment defaulters. In the community, defaulters are very common. In fact, we talk with them daily because they are many. People do not take their medications because they are hungry, they smoke various types of marijuana and drugs, and many of them are alcoholics. So, this is a major problem*" (CHW 02, FGD).

3.2.2. Collective Security

Participants lamented the insecurity because of crime in the community, which inhibits their ability to freely move around and interact with community members. CHWs therefore move in groups to ensure their safety.

"*A lot of people use drugs, especially young people, and how do you talk to people who are constantly high?" Eish!! It is quite challenging. That is why the crime rate is so high; people without work want to use drugs and steal. Even those of us who work to educate these individuals aren't safe; we need to apply caution, otherwise they will steal from you and grab your phone. That's why we go out in groups for safety*" (CHW 01, FGD).

"*As community health workers, we are also afraid for our lives, which is why we like to go into the communities as a team or group. If you are a woman and you go to people's houses alone, you might be surprised. We are being careful because of this*" (CHW 04, FGD).

3.3. Community Health Service Challenging Experiences

The participant discussed their difficulties in delivering health care to clients and the community. Discrimination, community assault vulnerability, training and skill, local dialect limitation, and distrust were all highlighted as problems.

3.3.1. Discrimination

One participant stated that he experiences discrimination due to his sexual orientation as a homosexual.

"*Yes, you know I am a homosexual, not everyone knows about it, but some community members do know. Sometimes they treat people like us with extreme cruelty; they can even kill you in secret*" (CHW 10).

3.3.2. Attack Vulnerability and Safety

The CHWs voiced concern about being attacked because of some criminals in the community. Consequently, CHWs moved in groups due to the high crime rate.

"*I have also been exposed to the community, but I always go with other CHWs because of criminal attacks*" (CHW 04).

"*They stated that we must visit five houses per day, and keep in mind that these communities are not safe."Amaparas" (gang members) are usually hanging*

around with knives ready to stab their victims" (CHW 02).

"*We go as a team for safety reasons." Because there are some places where you cannot go alone because of amaparas*" (CHW 09).

"*A lot of individuals use drugs, especially young ones…The crime rate is really high… Even those of us who educate them aren't safe; we must exercise caution lest they steal from you and take your phone. That is why we go out in groups for safety*" (CHW 01, FGD).

3.3.3. Training and Skill

Some of the CHWs reported that they lacked the training necessary to perform certain skills, such as HIV voluntary counselling and testing (VCT). They maintained:

"*As a community health worker, I work with a lot of people. However, I don't go out all the time. Those of us who are newly recruited work here in Day Hospital because we haven't been trained*" (CHW 03).

"*I am one of those who hasn't gone for training yet, but we hope to go soon because they said we would*" (CHW 09).

"*We interact with everyone in the community who is sick. First, a list will be given to us in the offices so that we can find people who haven't been coming and encourage them to come back. Most of the time, I see people who have HIV and on chronic medication. I don't really socialise out with young people. Others do, but I don't. I usually point them to the right person(s) to talk to. Or, sometimes, I'll tell them to come to the hospital for volunteer counselling and testing (VCT). There are other CHW who are trained to do that, but I have not been trained yet*" (CHW 04).

3.3.4. Local Dialect Limitation

The CHWs stated that speaking the local dialect allows them to communicate more and create trust with the community; however, not everyone can speak the language.

"*Remember that not everyone speaks isiXhosa, the local language, and so not everyone can connect with you. However, it does help us a lot to break down barriers and get our point across.*" (CHW 03).

3.3.5. Distrust

Participants reported that some patients lacked confidence and trust in their capacity to provide healthcare. They asserted that some clients interpreted political overtones in their work and request them to leave. Patients can provide them with inaccurate contact information because of a lack of trust, rendering client defaulter tracing a difficult and frustrating activity.

"Yes, they don't trust us 100% because they think there's a political undertone to everything and that we're being sent. In fact, so we'll end up being insulted and asked to leave their homes, while some will listen and understand why we were there in the end. During our orientation, we were told to be patient and to understand other people. That implies that even when they are sceptical of our intentions and are angry with us, we must exercise patience and ensure that we educate our clients calmly. Because, in the end of the day, it is for their own good. There are trust concerns during interactions with the community" (CHW 03).

"There are so many defaulters, and they can lie; some will even give you the wrong numbers" (CHW 08)" (CHW 08).

3.4. CHWs' Relevance to Community

The CHWs perceived their services as relevant to the communities they serve. The support they received from the community's leadership exemplifies this. Despite some initial resistance from some clients in the community, they are eventually persuaded to listen to them.

3.4.1. Community Involvement

The CHWs understand the importance of involving the community in their interaction with clients in order to upscale health care services. They solicit the assistance and buy-in of the community head concerning health education/advocacy programmes in the community for optimal success. The community leaders seemed to be supportive of CHWs and the services they offer.

"The CHWs appreciate the necessity of incorporating the community in their interactions with clients in order to improve health care services. They seek the community head's cooperation and buy-in to provide health education/advocacy programmes in the community so as to guarantee their success. The community leaders appeared to be supportive of CHWs and the services they provide" (CHW 01).

3.4.2. Health and Risky Behaviour Education

In addition, as previously mentioned, CHWs provide a variety of health services, including health education and self-awareness on COVID-19, HIV and TB, drug abuse, chronic medication adherence, socially positive behaviours, avoidance of multiple sex partners, and use of protection sexual activities, despite obstacles. As "essential health workers," they feel engaged.

"Then, we focused more on COVID-19-related health education and self-awareness. Examples of some of the topics that we usually cover include HIV and TB, importance of taking their medications, importance of never sharing medications with family and friends especially those on chronic medications, importance of protecting their loved ones by practising positive behaviours, and also will typically educate the youth to avoid multiple sex partners and to always use protection during sexual activities." (CHW 01).

"*Of course, raising awareness about safe environments, like during COVID, is important, even though movement was restricted. We are classified as "essential health workers." We'll teach them how to keep and protect themselves by using a face mask, gloves, and sanitizer.*" (CHW 04).

"*We educate them (the young ones) how to use*

condoms. They have to adhere to their treatment, never mix drugs and alcohol, and always tell us so that we can help them." (CHW 05-07).

"*We teach them about things that effect the community, like HIV/AIDS, TB, teen pregnancy, and the use of drugs and alcohol.*" (CHW 01, 08, FGD).

3.4.3. Youth Engagement

The CHWs also viewed their roles as pertinent to community health-related issues, such as educating youth about the risks of practising risky health behaviours and the need to refrain from doing so.

"*We also sometimes, usually, go to high schools in the community. We usually ask the school for approval to talk to the children about risky behaviours and things like HIV, teen pregnancy, etc. (CHW 01).*" (CHW 01).

3.4.4. Community Support

CHWs assist in referring clients to social workers for further intervention. Additionally, they assist in collecting common prescriptions for people who are unable to visit the clinic for medication collection because of their age, their inability to pay, or even the fact that they are treatment defaulters. They described how they support the community as follows:

"*Those who could not come for treatment like collecting their routine medication, we collect and transport back to them. Some of them express their gratitude and happiness verbally after seeing the community health worker. We occasionally refer some clients to social workers, particularly young teenage mothers, for assistance and referrals to higher level services.*" (CHW 01).

"*I think that as community health workers, we help the community a lot because we help those who don't have help by going with them to the community clinics and bringing their medications home (with their permission).*" (CHW 04).

"*Even now, I have some people whose medicine I will take home to them today.*" (CHW 05-07).

"*Well, I will say that the programme has helped the community in many ways. But first, let me tell you what we do when we go to the community. When I go to the community, with the person's approval, I sometimes take medications (i.e., prescribed medications) to people, mostly the old or older adults who always complain about not having money for transportation to the Community Health Centre (CHC).*" (CHW 02, FGD).

"*You know that in our community, many people are poor and unemployed, and a lot of grandmother's care for their elderly parents and grandchildren, which places a significant burden on them. They survive just on grants. Sometimes people are sick, but they could not go to the clinic to get treatment because they do not have money for feeding let alone transport. I believe that the programme is beneficial to the community.*" (CHW 06, FGD).

"*There are people who are hungry and unable to feed themselves. They will occasionally forget to come and pick up their medication. Remember that these medications are for chronic conditions such as high blood pressure, diabetes, tuberculosis, and so on. We collect their mediation book as well as their identity card and come to the clinics to collect the prescribed medication and then deliver it to them. Some people also refuse to attend because they are afraid they will run into a person they know. This is mostly for HIV patients, particularly young people.*" (CHW 02, FGD).

4. DISCUSSION

Our findings demonstrated that CHWs were aware of their numerous roles and responsibilities in terms of providing healthcare to the households and communities they serve. Clients and the community acknowledge their importance and value of community health workers' roles. They identified their tasks as delivering health education and counselling on a variety of health concerns (teenage pregnancy, substance misuse, alcohol abuse, sexually transmitted diseases, and HIV/AIDS) in the community and schools. HIV counselling, health advocacy, tuberculosis (TB) screening, a healthy lifestyle, and medication adherence, including antiretroviral (ARV) medications, TB drugs, and the health repercussions of drug misuse, are examples. CHWs also acknowledged that they helped at clinics by taking patients' vital signs, clients' prescriptions, arranging patients' clinical cards, assisting with patient admissions, and directing clients to different clinic sites. CHWs also emphasise community outreach visitation activities (clients' schools, taxi ranks, individual homes, and community halls), tracing and managing patients on defaulters (ARVs or TB treatment), data collection (clients' household registrations, defaulters, lost to follow up cases, client's health screening, records data). In addition, they provide clients with information about the symptoms and signs of disease to refer them to the healthcare system, if necessary. Overall, the CHWs were aware of their scope of practice. Similar to ours, other studies have confirmed that CHWs comprehend their roles [8]. In various contexts and settings, community health workers (CHWs) are recruited to perform a variety of healthcare service delivery responsibilities. Among these are providing health education and promotion services, advocating for, and mobilising the community, and providing preventative and clinical services [7, 9-14].

In addition, they are deployed to provide assistance during disease outbreaks [15-18], and, recently, controlling COVID-19 pandemics [20-27], and administering vaccines [28]. However, in India and Ethiopia, CHWs promoted COVID-19 vaccination awareness and adoption [29, 30]. In Brazil, Bangladesh, Iran, Ethiopia, Nepal, and Malawi, the significant responsibilities of community health workers are widely recognised and supported [31-36]. Consequently, it is essential to assess the roles of CHWs, address the challenges associated with the optimal performance of their designated tasks and responsibilities, and integrate them into the health system using contextual models applicable in a variety of settings. This is significant for

two reasons. Firstly, their contributions will accelerate the advancement of the SDG agenda of ensuring health for all. Additionally, supporting CHWs will enhance the health of marginalised rural communities, thereby reducing the disease burden, especially in developing nations with already overburdened health systems.

The findings indicate that CHWs play an essential role in health education and counselling pertaining to a variety of health topics, including teen pregnancy, substance abuse, alcohol abuse, sexually transmitted diseases, and HIV/AIDS. The aforementioned health issues are prevalent in South Africa context [8, 49-53]. The CHWs engaged the community on these health topics, empowering them to assume responsibility for their own health [8]. Furthermore, their efforts to provide health education on a variety of public health-related issues emphasise the importance of CHWs as educators in their communities [54]. They understand the health needs of the community's members and serve as gatekeepers between healthcare systems and local families, especially in underserved areas [54]. In addition, through home visits, health education sessions, and referrals to healthcare services, CHWs ensure that clients receive timely and appropriate care. Furthermore, if the community's health behaviour improves because of the CHW's health advice, they can be considered as agents of change in the community. These roles were acknowledged by the community, and the CHWs feel valued and content because the people and community they served appreciate them.

The CHWs connect with the community by constant engagement through health discussions/talks platform concerning their various health issues in the community, despite the insecurity in the community. CHWs affirmed engaging with the community on treatment defaulters, which is a common problem in the community, and, in the process, the clients are advised and encouraged to take their medications. They believed their in-depth health interaction with the clients and the community is productive, as those clients on chronic medications, after health engagement discussion, then access the clinics for their medications. This suggests a positive health behaviour of pursuing medical solution. However, the concerning and worrisome issue was the state of insecurity because of the high rate of crime in the community. Worried by this phenomenon in the community, CHWs reported feeling insecure and hesitant to move freely and interact with the community, which impacts their work. As part of their effort to mitigate the insecurity issue, CHWs move in groups or peers for their safety. There are salient aspects to reflect on regarding the above findings. First, the CHWs constant interface with the community they served is a pointer to the level of commitment and dedication to their duties. They recognised the need and significance of serving their communities, and, in turn, community members also valued their roles and contribution. Valued services delivery by the community and by the CHWs, can increase the utilisation of these services as well as the CHW’s legitimacy and motivation [5]. This symbolic relationship should be sustained by providing adequate security in the community through inter-sectoral stakeholder approach involving the government, police, the community representatives, and relevant organisations/agencies/bodies to minimise or curb crimes in the community. The security of the community is imperative for everyone, especially for CHWs who routinely move around in the community supporting the health needs of the community.

Community health workers (CHWs) identified several drawbacks that have an impact on their ability to perform their jobs and responsibilities effectively. These include discrimination, community attack vulnerability, training and skill, local dialect, and distrust. CHWs may lack the necessary training and skills to carry out their responsibilities and roles. The CHWs require training to carry out their tasks of preventative and promotional health services to communities. The rationale for CHW training stems from the fact that the personal life and job of CHW's in South Africa and other contexts are shaped by the same vulnerability dynamics at work in their communities [55]. Notably, many community health workers (CHWs) in South Africa are impoverished and come from rural Black areas and are largely female; they also have inadequate or informal training. According to Alonso *et al*. [56] despite living in poverty and being exposed to the same health risks as other users of the health system, CHWs are responsible for managing these vulnerabilities for their clients. Several studies have shown that CHWs lacked the appropriate education and abilities to provide various types of community health care [42, 44, 57, 58]. This scenario, when combined with overwork, may result in burnout, stress, and other psychological and physical health conditions [59]. The CHWs in this study acknowledged experiencing a high workload due to the additional activities assigned to them by nurses, which exceeded their regular responsibilities in clinic settings. Typically, they are tasked with organising admission documents and folders, dispensing chronic medications to patients, and recording vital signs. Despite lacking proper training, CHWs are seen performing these responsibilities, even without any extra compensation. CHWs, on the other hand, are proud of their work and happy to be able to help their communities. Efforts to empower and reward CHWs are required to motivate them to achieve far beyond what they currently do in the community.

Local dialect was cited as a peculiar factor that facilitates interactions between community health workers and their clients. The capacity to speak the local language (isiXhosa) of the community was an added benefit that helped build trust with the community; however, not everyone spoke the local language. Nevertheless, given that most of the community health workers could communicate healthcare services delivery in the local language of the community enhances trust between them and the community. A prior study in the Eastern Cape found that CHWs used the local language of the community to convey messages so as to accommodate the clients' experiences and thereby instigate cooperation and

trust [38]. In a related study conducted in India, CHWs built trust with their communities by choosing to communicate health issues in a careful and appropriate manner; they use simple health terms or language as opposed to clinical health terminology [60]. The ability to communicate a health issue to a community in their native tongue facilitates effective health service delivery because it promotes “cooperative relationships and collective action” [61]. This aspect of communicating health messages and needs in the community's language is crucial to consider in the training or workshop for community health worker program.

The CHWs reported that some clients lacked confidence and trust in their ability to provide healthcare services and, as a result, basically drove them away. They linked this to politics such as government pledges that were not fulfilled and a failure to provide communities with adequate services. Consequently, CHWs may encounter challenges in obtaining accurate contact information due to a lack of trust. These circumstances subsequently hinder the process of tracing defaulting clients, leading to difficulties and frustrations. Previous studies have reported similar findings of clients having limited respect and distrust of CHWs [55, 62], including research conducted in South Africa [38, 40, 63]. Poor communities' lack of trust in government services is common in South Africa, causing people to ignore the deteriorating and low-quality services provided by primary healthcare health facilities in the rural communities [64]. There are several incidents of violent behaviour from the community because of lack of essential services and concerns over poor working conditions for CHWs, which has ultimately halted engagements between CHWs and some communities [42]. This kind of scenario is undesirable for preventative and promotive health care in the community because it may not only ruin the credibility of community health workers who are seen as government agents or employees, but it may also affect clients' decisions regarding the use of health services, adherence to advice, and adherence to care or treatment. In a previous situation in the Eastern Cape, CHWs questioned the government's lack of concern towards their clients' health care service provision and other basic social and economic necessities, which have an impact on their health [38].

Another challenge that CHWs encounter in performing their duties was safety while performing their job in the community. Physical violence and other criminal activities such as theft and robbery are common in some of the rural populations they serve. Worryingly, sexual violence is a phenomenon that is increasing in South Africa [65-67], with women disproportionately affected. Notably, the majority of CHWs in our sample, and in South Africa, are women. Due to the lack of safety, the CHWs develop a simple strategy of working in groups or pairs [68]. stated, similarly to ours, that due to safety concerns, CHWs worked in pairs and generally delivered house medications on foot during the COVID-19 pandemic, and that some CHWs were robbed, verbally assaulted and attacked by dogs, or entangled in community protests. Other studies have reported safety concerns emphasised by CHWs as an impediment to scaling up community health care delivery in South Africa [8, 40, 42] and elsewhere [55, 69, 70]. According to a recent study in Brazil, 80% of community health workers were exposed to acts of violence in the communities they served.73 The prevalent insecurity in the communities renders CHWs vulnerable to attacks and criminal acts; despite this, they were motivated to continue their work. This scenario suggests that community health workers approached their duties with anxiety and fear. Relatedly, the Community Health Workers (CHWs) were tasked with fulfilling certain responsibilities within the COVID-19 epidemic, namely encompassing screenings and contact tracing [71], as well as the delivery of medication to individuals' homes [68-73]. Considering their limited resources, their safety issues are crucial and concerning [71]. The CHWs proposed that they be provided with transportation to reduce the risks and fear of being attacked by gangsters and criminals in the community. The violence in the community causes fear and anxiety, impacting the health and daily work routines of community health workers. The government, non-governmental organisations, and other stakeholders, in collaboration with health workers, should devise measures for addressing violence in communities to allow CHWs operate freely and safely while serving the community.

The CHWs perceived their services as relevant to the communities they served--the programme is beneficial and useful to the community. The support they received from the community's leadership exemplifies this. Despite some initial resistance from some clients in the community, they are eventually persuaded to listen to them. According to Glenton, Javadi and Perry [5], the most prevalent role of CHWs is health promotion, where the information and counselling is centred on behavioural change and health service utilisation. In the present study, CHWs emphasised these responsibilities. It is worth noting that the ultimate result of all these health engagement efforts with the community is the development of trust between the community and the CHWs themselves, as exemplified by the case of accredited social health activist (ASHA) workers in India [60]. CHWs fulfil a social function within the community. Indeed, there exist instances wherein CHWs have assumed additional remarkable responsibilities that extend beyond their prescribed functions, thereby assuming the role of advocates for societal change. In South Africa, female CHWs participated in a participatory action research study aimed at addressing gender inequities related to violence against women in the community [74]. In Tanzania, grassroots volunteers felt the concerns of their clients and approached an NGO, their employer, to become involved in the food distribution scheme, so as to assist their clients without food to improve their adherence to treatment due to food insecurity [75].

The CHWs viewed their duties as being relevant to community health issues, such as educating youth about the dangers of risky health behaviours and the importance of abstaining from them. Youth risky health behaviours are a developing health issue in South Africa [64, 76]. In addition, CHWs assisted in referring clients to social workers for additional intervention. Glenton, Javadi, and Perry [5] have

emphasised this specific function by emphasising that CHWs initiate treatment and make appropriate referrals. The CHWs in our study also assist clients who are unable to access the clinic due to age, financial constraints, or treatment noncompliance with the collection of their routine medications. One study found that community health workers (CHWs) in South Africa administer medications to patients who are unable to travel to a health facility, in addition to cooking and gathering water for their community members [63]. This further emphasises an additional aspect of the social function that CHWs provide for the community.

Such acts of assistance and kindness offered by CHWs during moments of crisis have been reported in Nepal (2015 earthquake) [77] and Brazil (disasters). The primary function of the CHW programme is to serve the community. Nevertheless, according to Perry *et al*. [32] in order to strengthen CHW programmes to ensure it can meaningfully contribute to the achievement of the desired health goals, they should be accorded serious attention regarding their fundamental needs of limited financial and material resources, poor enumeration, and insufficient supervision. In addition, community health workers need training that is tailored to their requirements and the community's health needs. It is time for the government to recognise and formalise CHWs within the health system to better serve and support the community. In addition, it is imperative to take the bull by the horns by demonstrating decisive political will or action in response to the program's various challenges. Such a stance would have greater effects on the community's health. The roles performed by CHWs are essential and unique to the community's needs. Thus, CHWs deserve attention, not neglect.

The CHWs indicated tremendous job satisfaction. They affirmed CHW program was beneficial, enhances healthy living, improves access to medical care, and promotes health education. The overall program assessment also revealed a high confirmation of the importance and value of the CHW program in improving health care in the community. These findings suggest that despite the challenges (lack of training, inadequate supervision, insufficient resources, low enumeration, distrust, discriminatory treatment, safety concerns, *etc*.) impeding the ability of CHWs to perform their work effectively; seemingly, because of neglect and non-recognition of their immense roles to the community and the larger health system goals, CHWs are resilient and satisfied with their jobs. CHWs' positive perspective towards their work demonstrates that they are drawn to the role for intrinsic reasons, such as a desire to help the community and improve its health, or a sense of pride in being community health workers. Thus, it is necessary to maintain this type of intrinsic motivation to serve the community. A similar study in Mopani district in South Africa reports that notwithstanding, the low stipend, CHWs were content with their employment because of the positive impacts they had in their communities [63]. As stated by Perry *et al*. [32] “CHWs are among the most-cost-effective and the most rapidly implementable approaches to improve the health of underserved populations. Our task now is to provide national CHW programmes with the resources and technical support to enable them to reach their full potential”. In accordance with this recommendation, policymakers and the government must refocus attention on the role of CHWs by addressing the numerous obstacles highlighted by the CHWs in this study. A recent study recommended redefining CHWs' scope of practise in South Africa to reflect their capacity, resources, and time [68].

5. LIMITATIONS OF THE STUDY

There are some limitations to this study. First, the purposeful sampling strategy employed to select participants; second, restricting the study to one specific sub-district and limited sample size hinders generalisation of the findings to other geographical contexts where CHWs serve, future research therefore, would draw from various regions of South Africa to enhance the robustness of the results and to account for regional differences in CHW roles and challenges.

We also did not interview the additional category of health workers in charge of supervising the CHWs to explore their perspectives; therefore, future research should endeavour explore the views of health system administrators or community members to provide to provide a more comprehensive picture of the CHW program’s impact and further identify key areas for improvement. Nonetheless, the findings highlight salient issues unique to CHWs in low-resource settings, which may inform a contextual approach to strengthening CHW programs. Second, we conducted the interviews in English, which may be difficult for some people to express themselves fluently. However, the utilisation of both individual and focus group discussions were beneficial in both broadening the interpretation of the findings and improving the credibility of the findings.

CONCLUSION

The study's findings demonstrate that CHWs are aware of their tasks, carry them out in tandem with CHW programme modelling, and are thus valued and appreciated by the communities they serve. Despite the numerous problems related to clients and communities, which ultimately impact their efforts to serve them effectively, CHWs remain committed to assisting their clients and communities. Given the significant contributions of this important but undervalued cadre of health workers, it is necessary to incorporate their function into the larger healthcare system. As mitigating factors to enhance the responsibilities of CHWs within the communities that they live and serve, it is necessary to provide them with adequate resources, training, recognition, and address safety concerns. Our findings have implications for improving the practise of community health worker (CHW) programmes and policies.

AUTHOR'S CONTRIBUTION

It is hereby acknowledged that all authors have accepted responsibility for the manuscript's content and consented to its submission. They have meticulously reviewed all results and unanimously approved the final version of the manuscript.

LIST OF ABBREVIATIONS

ART	=	Antiretroviral Therapy
CHW	=	Community Health workers
COVID19	=	Coronavirus
HIV	=	Human immunodeficiency virus
LMICs	=	Low and middle-income countries

ETHIC APPROVAL AND CONSENT TO PARTICIPATE

The study was approved by the Health Research Ethics Committee of the University of Fort Hare, South Africa (Ethical Approval Number: Ref#2020=10=10=GoonD=ObasanjoI). The participant's information was concealed and anonymized.

HUMAN AND ANIMAL RIGHTS

All procedures performed in studies involving human participants were in accordance with the ethical standards of institutional and/or research committee and with the 1975 Declaration of Helsinki, as revised in 2013.

CONSENT FOR PUBLICATION

Consent was obtained from all the participants of this study.

STANDARDS OF REPORTING

COREQ guidelines were followed.

AVAILABILITY OF DATA AND MATERIALS

The datasets used and/or analyzed during the current study are available from the corresponding author [U.B.O] upon reasonable request.

FUNDING

This study was funded by William and Mary, Reves Center for International Studies, Faculty Fellowship 2022.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

ACKNOWLEDGEMENTS

Reves Center for International Studies at the College of William and Mary, Faculty Fellowship 2022 for research support. We express our gratitude to the study participants for their involvement and to the Eastern Cape Department of Health for permitting us to conduct research at designated health institutions within the Buffalo City Metropolitan Municipality District.

REFERENCES

[1] Raven J, Akweongo P, Baba A, *et al*. Using a human resource management approach to support community health workers: experiences from five African countries. Hum Resour Health 2015; 13(1): 45. http://dx.doi.org/10.1186/s12960-015-0034-2 PMID: 26324423

[2] Olaniran A, Smith H, Unkels R, Bar-Zeev S, van den Broek N. Who is a community health worker? – a systematic review of definitions. Glob Health Action 2017; 10(1): 1272223. http://dx.doi.org/10.1080/16549716.2017.1272223 PMID: 28222653

[3] South J, Meah A, Bagnall AM, Jones R. Dimensions of lay health worker programmes: Results of a scoping study and production of a descriptive framework. Glob Health Promot 2013; 20(1): 5-15. http://dx.doi.org/10.1177/1757975912464248 PMID: 23563775

[4] WHO guideline on health policy and system support to optimize community health worker programmes. 2018. Available from:https://www.who.int/publications/i/item/9789241550369(accessed on 9-9-2024)

[5] Hodgins S, Kok M, Musoke D, *et al*. Community health workers at the dawn of a new era: 1. Introduction: tensions confronting large-scale CHW programmes. Health Res Policy Syst 2021; 19(S3) (Suppl. 3): 109. http://dx.doi.org/10.1186/s12961-021-00752-8 PMID: 34641886

[6] Pallas SW, Minhas D, Pérez-Escamilla R, Taylor L, Curry L, Bradley EH. Community health workers in low- and middle-income countries: what do we know about scaling up and sustainability? Am J Public Health 2013; 103(7): e74-82. http://dx.doi.org/10.2105/AJPH.2012.301102 PMID: 23678926

[7] Perry HB. A comprehensive description of three national community health worker programs and their contributions to maternal and child health and primary health care: Case studies from latin america (Brazil), Africa (Ethiopia) and Asia (Nepal). 2016. Available from: https://www.exemplars.health/-/media/files/egh/resources/community-health-workers/ethiopia/perrychwprogramsinbrazilethiopiaandnepal2016.pdf(accessed on 9-9-2024)

[8] Ramukumba MM. Exploration of community health workers' views about in their role and support in Primary Health Care in Northern Cape, South Africa. J Community Health 2020; 45(1): 55-62. http://dx.doi.org/10.1007/s10900-019-00711-z PMID: 31392601

[9] Schleiff MJ, Peters DH, Surkan PJ. Comparative case analysis of the role of community health workers in rural and low-income populations of West Virginia and the United States. J Ambul Care Manage 2020; 43(3): 205-20. http://dx.doi.org/10.1097/JAC.0000000000000335 PMID: 32467434

[10] Westgard CM, Llatance MA, Calderón LF. The creation of a field manual for community health workers to teach child health and development during home visits: a case study of participatory content creation. J Com Heal 2023; 2023: 1-7.

[11] Dunn M, Peterson Johnson E, Smith B, Cooper M, Bhakta N. Perspectives on workforce development needs for community health workers (CHWs): Results from a statewide survey of chw employers. J Community Health 2021; 46(5): 1020-8. http://dx.doi.org/10.1007/s10900-021-00986-1 PMID: 33847869

[12] Sugarman M, Ezouah P, Haywood C, Wennerstrom A. Promoting community health worker leadership in policy development: Results from a louisiana workforce *Study*. J Community Health 2021; 46(1): 64-74. http://dx.doi.org/10.1007/s10900-020-00843-7 PMID: 32448981

[13] Brownstein JN, Allen C. Addressing chronic disease through community health workers: A policy and systems-level approach. 2015. Available from:https://www.cdc.gov/dhdsp/docs/chw_brief.pdf(accessed on 9-9-2024)

[14] McCloskey J. Promotores as partners in a community-based diabetes intervention program targeting Hispanics. Fam Community Health 2009; 32(1): 48-57. http://dx.doi.org/10.1097/01.FCH.0000342816.87767.e6 PMID: 19092434

[15] Amara PS, M'Cormack-Hale FA, Kanu M, Bash-Taqi R, Kanu A. The effectiveness of the Sierra Leone health sector response to health shocks: Evidence from the COVID-19 perception survey. Oxford: OPM 2021.

[16] Miller NP, Milsom P, Johnson G, *et al*. Community health workers during the Ebola outbreak in Guinea, Liberia, and Sierra Leone. J Glob Health 2018; 8(2): 020601. http://dx.doi.org/10.7189/jogh.10.020601 PMID: 30023054

[17] Johnson G, Bedford J, Miller N. Community health workers during the ebola outbreak in Liberia. New York, NY: UNICEF 2017.
[18] Gautier L, Houngbedji KA, Uwamaliya J, Coffee M. Use of a community-led prevention strategy to enhance behavioral changes towards Ebola virus disease prevention: a qualitative case study in Western Côte d'Ivoire. Glob Health Res Policy 2017; 2(1): 35. http://dx.doi.org/10.1186/s41256-017-0055-6 PMID: 29299536
[19] National community health worker policy. 2016. Available from:https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/sl_national_chw_policy_2016-2020_508.pdf(accessed on 9-9-2024)
[20] Bhaumik S, Moola S, Tyagi J, Nambiar D, Kakoti M. Community health workers for pandemic response: a rapid evidence synthesis. BMJ Glob Health 2020; 5(6): e002769. http://dx.doi.org/10.1136/bmjgh-2020-002769 PMID: 32522738
[21] Dhaliwal BK, Singh S, Sullivan L, *et al*. Love, labor and loss on the frontlines: India's community health workers straddle life and the COVID-19 pandemic. J Glob Health 2021; 11: 03107. http://dx.doi.org/10.7189/jogh.11.03107 PMID: 35003708
[22] Bezbaruah S, Wallace P, Zakoji M, Padmini Perera WLS, Kato M. Roles of community health workers in advancing health security and resilient health systems: emerging lessons from the COVID-19 response in the South-East Asia Region. WHO South-East Asia J Public Health 2021; 10(3) (Suppl. 1): 41. http://dx.doi.org/10.4103/2224-3151.309872
[23] Olateju Z, Olufunlayo T, MacArthur C, Leung C, Taylor B. Community health workers experiences and perceptions of working during the COVID-19 pandemic in Lagos, Nigeria—A qualitative study. PLoS One 2022; 17(3): e0265092. http://dx.doi.org/10.1371/journal.pone.0265092 PMID: 35259204
[24] Tune SNBK, Islam BZ, Islam MR, Tasnim Z, Ahmed SM. Exploring the knowledge, attitudes, practices and lived experiences of frontline health workers in the times of COVID-19 : a qualitative study from Bangladesh. BMJ Open 2022; 12(1): e051893. http://dx.doi.org/10.1136/bmjopen-2021-051893 PMID: 35017240
[25] Chemali S, Mari-Sáez A, El Bcheraoui C, Weishaar H. Health care workers' experiences during the COVID-19 pandemic: a scoping review. Hum Resour Health 2022; 20(1): 27. http://dx.doi.org/10.1186/s12960-022-00724-1 PMID: 35331261
[26] Salve S, Raven J, Das P, *et al*. Community health workers and Covid-19: Cross-country evidence on their roles, experiences, challenges and adaptive strategies. PLOS Global Public Health 2023; 3(1): e0001447. http://dx.doi.org/10.1371/journal.pgph.0001447 PMID: 36962877
[27] Yahemba D, Chowdhury S, Olorunfemi T, *et al*. Exploring the impact of COVID-19 on frontline health workers through a photovoice study in Kaduna, Kwara and Ogun States, Nigeria. Int Health 2023; 15 (Suppl. 1): i110-25. http://dx.doi.org/10.1093/inthealth/ihad005 PMID: 36960811
[28] Gibson E, Zameer M, Alban R, Kouwanou LM. Community health workers as vaccinators: a rapid review of the global landscape, 2000–2021. Glob Health Sci Pract 2023; 11(1): e2200307. http://dx.doi.org/10.9745/GHSP-D-22-00307 PMID: 36853637
[29] Gooding K, Webster J, Wiafe N, Kumar V. Real time assessment (RTA) of UNICEF's ongoing response to COVID-19 in eastern and southern Africa: COVID-19 vaccine supply and rollout Key insights from qualitative research in Ethiopia, Rwanda, South Africa and South Sudan. New York: United Nations Children's Fund 2021.
[30] Srinivasan S. Making community health worker supervision supportive: - Insights from an implementation research pilot. 2022. Available from:https://policycommons.net/artifacts/3329214/making-community-health-worker-supervision-supportive/4128025/(accessed on 9-9-2024)
[31] Kok MC, Ormel H, Broerse JEW, *et al*. Optimising the benefits of community health workers' unique position between communities and the health sector: A comparative analysis of factors shaping relationships in four countries. Glob Public Health 2017; 12(11): 1404-32. http://dx.doi.org/10.1080/17441692.2016.1174722 PMID: 27133127
[32] Perry HB, Zulliger R, Rogers MM. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annu Rev Public Health 2014; 35(1): 399-421. http://dx.doi.org/10.1146/annurev-publhealth-032013-182354 PMID: 24387091
[33] Joardar T, Javadi D, Gergen J, Perry H. the government family welfare assistants, and community health care providers in Bangladesh. In: Perry H, Ed. National Community Health Programs: Descriptions from Afghanistan to Zimbabwe. Washington, DC: USAID/Jhpiego/Maternal and Child Survival Program 2020.
[34] Ban B, Shrestha A, Khanal L. Nepal's community health worker system. In: Perry H, Ed. National Community Health Programs: Descriptions from Afghanistan to Zimbabwe. Washington, DC: USAID/Jhpiego/Maternal and Child Survival Program 2020.
[35] Rahbar M, Raeisi A, Chowdhury Z. Iran's community health worker program. In: Perry H, Ed. National Community Health Programs: Descriptions from Afghanistan to Zimbabwe. Washington, DC: USAID/Jhpiego/Maternal and Child Survival Program 2020.
[36] Liu A, Sullivan S, Khan M, Sachs S, Singh P. Community health workers in global health: scale and scalability. Mt Sinai J Med 2011; 78(3): 419-35. http://dx.doi.org/10.1002/msj.20260 PMID: 21598268
[37] Austin-Evelyn K, Rabkin M, Macheka T, *et al*. Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa. PLoS One 2017; 12(3): e0173863. http://dx.doi.org/10.1371/journal.pone.0173863 PMID: 28301609
[38] Nxumalo N, Goudge J, Manderson L. Community health workers, recipients' experiences and constraints to care in South Africa–a pathway to trust. AIDS Care 2016; 28(sup4): 61-71 2016; 28(S4): 61-71.
[39] Horwood C, Butler L, Barker P, *et al*. A continuous quality improvement intervention to improve the effectiveness of community health workers providing care to mothers and children: a cluster randomised controlled trial in South Africa. Hum Resour Health 2017; 15(1): 39. http://dx.doi.org/10.1186/s12960-017-0210-7 PMID: 28610590
[40] Murphy JP, Moolla A, Kgowedi S, *et al*. Community health worker models in South Africa: a qualitative study on policy implementation of the 2018/19 revised framework. Health Policy Plan 2021; 36(4): 384-96. http://dx.doi.org/10.1093/heapol/czaa172 PMID: 33367608
[41] Provincial Guidelines for the Implementation of the three streams of PHC Re-engineering. 2011.
[42] Malatji H, Griffiths F, Goudge J. Community-orientated primary health care: Exploring the interface between community health worker programmes, the health system and communities in South Africa. PLOS Global Public Health 2023; 3(2): e0000881. http://dx.doi.org/10.1371/journal.pgph.0000881 PMID: 36962793
[43] le Roux KW, Almirol E, Rezvan PH, *et al*. Community health workers impact on maternal and child health outcomes in rural South Africa – a non-randomized two-group comparison study. BMC Public Health 2020; 20(1): 1404. http://dx.doi.org/10.1186/s12889-020-09468-w PMID: 32943043
[44] Wilford A, Phakathi S, Haskins L, Jama NA, Mntambo N, Horwood C. Exploring the care provided to mothers and children by community health workers in South Africa: missed opportunities to provide comprehensive care. BMC Public Health 2018; 18(1): 171. http://dx.doi.org/10.1186/s12889-018-5056-y PMID: 29361926
[45] van Heerden EM, Jenkins LS. The role of community health workers in palliative care in a rural subdistrict in South Africa. Afr J Prim Health Care Fam Med 2022; 14(1): e1-9. http://dx.doi.org/10.4102/phcfm.v14i1.3657 PMID: 36453807
[46] Statistics South Africa. 2011. Available from: statssa.gov.za(accessed on 9-9-2024)
[47] Gill P, Baillie J. Interviews and focus groups in qualitative research: an update for the digital age. Br Dent J 2018; 225(7):

668-72.
http://dx.doi.org/10.1038/sj.bdj.2018.815 PMID: 30287965
[48] Braun V, Clarke V. Using thematic analysis in psychology. *Quali*. Res Psy 2006; 3(2): 77-101.
[49] Simbayi LC, Zuma K, Zungu N, *et al*. South African national HIV prevalence, incidence, behaviour and Communication Survey, 2017. Cape Town: HSRC Press 2019.
[50] South Africa Demographic and Health Survey 2016. Pretoria: National Department of Health 2019.
[51] Gouda HN, Charlson F, Sorsdahl K, *et al*. Burden of non-communicable diseases in sub-Saharan Africa, 1990–2017: results from the Global Burden of Disease Study 2017. Lancet Glob Health 2019; 7(10): e1375-87.
http://dx.doi.org/10.1016/S2214-109X(19)30374-2 PMID: 31537368
[52] Ajayi AI, Ezegbe HC. Association between sexual violence and unintended pregnancy among adolescent girls and young women in South Africa. BMC Public Health 2020; 20(1): 1370.
http://dx.doi.org/10.1186/s12889-020-09488-6 PMID: 32894130
[53] Francis SC, Mthiyane TN, Baisley K, *et al*. Prevalence of sexually transmitted infections among young people in South Africa: A nested survey in a health and demographic surveillance site. PLoS Med 2018; 15(2): e1002512.
http://dx.doi.org/10.1371/journal.pmed.1002512 PMID: 29485985
[54] Westgard C, Alnasser Y. Developmental delay in the Amazon: The social determinants and prevalence among rural communities in Peru. PLoS One 2017; 12(10): e0186263.
http://dx.doi.org/10.1371/journal.pone.0186263 PMID: 29023517
[55] Lotta G, Nunes J, Fernandez M, Garcia Correa M. The impact of the COVID-19 pandemic in the frontline health workforce: Perceptions of vulnerability of Brazil's community health workers. Health Policy OPEN 2022; 3: 100065.
http://dx.doi.org/10.1016/j.hpopen.2021.100065 PMID: 35036911
[56] Alonso CMC, Béguin PD, Duarte FJCM. Work of community health agents in the Family Health Strategy: meta-synthesis. Rev Saude Publica 2018; 52: 14.
http://dx.doi.org/10.11606/S1518-8787.2018052000395 PMID: 29489997
[57] Brieger W, Orji B. Nigeria's paths to primary health care. In: Perry H, Ed. National Community Health Programs: Descriptions from Afghanistan to Zimbabwe. Washington, DC, USA: USAID/Jhpiego/Maternal and Child Survival Program 2020.
[58] Smith S, Deveridge A, Berman J, *et al*. Task-shifting and prioritization: a situational analysis examining the role and experiences of community health workers in Malawi. Hum Resour Health 2014; 12(1): 24.
http://dx.doi.org/10.1186/1478-4491-12-24 PMID: 24885454
[59] Telles SH, Pimenta AMC. Burnout syndrome in community health agents and coping strategies. Saude Soc 2009; 18(3): 467-78.
http://dx.doi.org/10.1590/S0104-12902009000300011
[60] Mishra A. 'Trust and teamwork matter': Community health workers' experiences in integrated service delivery in India. Glob Public Health 2014; 9(8): 960-74.
http://dx.doi.org/10.1080/17441692.2014.934877 PMID: 25025872
[61] Gilson L. Trust and the development of health care as a social institution. Soc Sci Med 2003; 56(7): 1453-68.
http://dx.doi.org/10.1016/S0277-9536(02)00142-9 PMID: 12614697
[62] Shaw B, Amouzou A, Miller NP, Tafesse M, Bryce J, Surkan PJ. Access to integrated community case management of childhood illnesses services in rural Ethiopia: a qualitative study of the perspectives and experiences of caregivers. Health Policy Plan 2016; 31(5): 656-66.
http://dx.doi.org/10.1093/heapol/czv115 PMID: 26608585
[63] Naidoo N, Zuma N, Khosa NS, *et al*. Qualitative assessment of facilitators and barriers to HIV programme implementation by community health workers in Mopani district, South Africa. PLoS One 2018; 13(8): e0203081.
http://dx.doi.org/10.1371/journal.pone.0203081 PMID: 30161208
[64] Francis JM, Myers B, Nkosi S, *et al*. The prevalence of religiosity and association between religiosity and alcohol use, other drug use, and risky sexual behaviours among grade 8-10 learners in Western Cape, South Africa. PLoS One 2019; 14(2): e0211322.
http://dx.doi.org/10.1371/journal.pone.0211322 PMID: 30759112
[65] Ajayi AI, Mudefi E, Owolabi EO. Prevalence and correlates of sexual violence among adolescent girls and young women: findings from a cross-sectional study in a South African university. BMC Womens Health 2021; 21(1): 299.
http://dx.doi.org/10.1186/s12905-021-01445-8 PMID: 34399751
[66] Steele SJ, Abrahams N, Duncan K, *et al*. The epidemiology of rape and sexual violence in the platinum mining district of Rustenburg, South Africa: Prevalence, and factors associated with sexual violence. PLoS One 2019; 14(7): e0216449.
http://dx.doi.org/10.1371/journal.pone.0216449 PMID: 31365536
[67] Gibbs A, Jewkes R, Willan S, Washington L. Associations between poverty, mental health and substance use, gender power, and intimate partner violence amongst young (18-30) women and men in urban informal settlements in South Africa: A cross-sectional study and structural equation model. PLoS One 2018; 13(10): e0204956.
http://dx.doi.org/10.1371/journal.pone.0204956 PMID: 30281677
[68] Mash RJ, Schouw D, Daviaud E, Besada D, Roman D. Evaluating the implementation of home delivery of medication by community health workers during the COVID-19 pandemic in Cape Town, South Africa: a convergent mixed methods study. BMC Health Serv Res 2022; 22(1): 98.
http://dx.doi.org/10.1186/s12913-022-07464-x PMID: 35073888
[69] Vieira-Meyer APGF, Ferreira RGLA, Albuquerque G. Gender and violence in the daily routine of community health workers in Fortaleza, Brazil. J Comm Heal 2023; 48: 810-8.
http://dx.doi.org/10.1007/s10900-023-01221-9
[70] van Dyk J. Pandemic politics: Community health workers gear up to fight COVID-19 with little protection, less pay. 2020. Available from:https://bhekisisa.org/features/2020-03-31-pandemic-politics-community-health-workers-gear-up-to-fight-covid19-with-little-protection-less-pay/(accessed on 9-9-2024)
[71] Brey Z, Mash R, Goliath C, Roman D. Home delivery of medication during Coronavirus disease 2019, Cape Town, South Africa: Short report. Afr J Prim Health Care Fam Med 2020; 12(1): e1-4.
http://dx.doi.org/10.4102/phcfm.v12i1.2449 PMID: 32501022
[72] Gilson L, Erasmus E. Improve health service delivery through building trust: Trust and accountability in health service delivery in South Africa. Johannesburg: Centre for Health Policy 2007.
[73] de Lange N, Mitchell C. Community health workers as cultural producers in addressing gender-based violence in rural South Africa. Glob Public Health 2016; 11(5-6): 783-98.
http://dx.doi.org/10.1080/17441692.2016.1170867 PMID: 27080871
[74] Corbin JH, Mittelmark MB, Lie GT. Grassroots volunteers in context: rewarding and adverse experiences of local women working on HIV and AIDS in Kilimanjaro, Tanzania. Glob Health Promot 2016; 23(3): 72-81.
http://dx.doi.org/10.1177/1757975915569514 PMID: 25802302
[75] Odimegwu CO, Ugwu NH. A multilevel mixed effect analysis of neighbourhood and individual level determinants of risky sexual behaviour among young people in South Africa. Reprod Health 2022; 19(1): 119.
http://dx.doi.org/10.1186/s12978-022-01407-9 PMID: 35549967
[76] Fredricks K, Dinh H, Kusi M, *et al*. Community health workers and disasters: lessons learned from the 2015 earthquake in Nepal. Prehosp Disaster Med 2017; 32(6): 604-9.
http://dx.doi.org/10.1017/S1049023X1700680X PMID: 28786371
[77] Santos P, Dias J, Alves R. Permanent education on psychosocial care in disaster situations for community health agents: an experience report. Saúde em Debate, 43(SPE3), 200–208. Saúde Debate 2019; 43: 200-8.
http://dx.doi.org/10.1590/0103-11042019s315