Received: 13 May 2020 | Revised: 24 July 2020 | Accepted: 12 August 2020

DOI: 10.1111/hsc.13153

ORIGINAL ARTICLE

Health and Social Care in the community | WILEY

Balancing roles and blurring boundaries: Community health workers' experiences of navigating the crossroads between personal and professional life in rural South Africa

Christina A. Laurenzi Msc[1,2] | Sarah Skeen PhD[1] | Stephan Rabie PhD[1] | Bronwynè J. Coetzee PhD[2] | Vuyolwethu Notholi[1] | Julia Bishop LLM[3] | Emma Chademana PhD[3] | Mark Tomlinson PhD[1,4]

[1]Institute for Life Course Health Research, Department of Global Health, Stellenbosch University, Stellenbosch, South Africa

[2]Department of Psychology, Stellenbosch University, Stellenbosch, South Africa

[3]One to One Africa, Cape Town, South Africa

[4]School of Nursing and Midwifery, Queens University Belfast, Belfast, United Kingdom

Correspondence
Christina A. Laurenzi, 4009 Education Building, Faculty of Medicine and Health Sciences, Francie van Zijl Drive, Stellenbosch University, Tygerberg, South Africa, 7505.
Email: christina.a.laurenzi@gmail.com

Funding information
This work was funded by the One to One Children's Fund, through a grant from the UBS Optimus Fund.

Abstract

As demand for health services grows, task-shifting to lay health workers has become an attractive solution to address shortages in human resources. Community health workers (CHWs), particularly in low-resource settings, play critical roles in promoting equitable healthcare among underserved populations. However, CHWs often shoulder additional burdens as members of the same communities in which they work. We examined the experiences of a group of CHWs called Mentor Mothers (MMs) working in a maternal and child health programme, navigating the crossroads between personal and professional life in the rural Eastern Cape, South Africa. Semi-structured qualitative interviews ($n = 10$) were conducted by an experienced isiXhosa research assistant, asking MMs questions about their experiences working in their own communities, and documenting benefits and challenges. Interviews were transcribed and translated into English and thematically coded. Emergent themes include balancing roles (positive, affirming aspects of the role) and blurring boundaries (challenges navigating between professional and personal obligations). While many MMs described empowering clients to seek care and drawing strength from being seen as a respected health worker, others spoke about difficulties in adequately addressing clients' needs, and additional burdens they adopted in their personal lives related to the role. We discuss the implications of these findings, on an immediate level (equipping CHWs with self-care and boundary-setting skills), and an intermediate level (introducing opportunities for structured debriefings and emphasising supportive supervision). We also argue that, at a conceptual level, CHW programmes should provide avenues for professionalisation and invest more up-front in their workforce selection, training and support.

KEYWORDS

Carers' Needs, Community Health, Healthcare in Developing Countries, Professional Roles and Responsibilities, Qualitative Research, Rural Healthcare, Work–Life Balance Issues

1 | INTRODUCTION

Recent estimates indicate that by 2030, there will be a global shortfall of 18 million health workers, primarily in low- and middle-income countries (LMICs) (World Health Organization, 2016). As demand for health services grows, task-shifting to lay health workers has become an attractive solution to attempt to close these gaps (Fulton et al., 2011; Okyere, Mwanri, & Ward, 2017). A well-developed evidence base supports the effectiveness of lay and community health workers (CHWs) in addressing areas of maternal and newborn health (Rotheram-Borus et al., 2011), HIV/AIDS support (Mwai et al., 2013), psychosocial support (Nyatsanza, Schneider, Davies, & Lund, 2016) and child nutrition (le Roux, Rotheram-Borus, Stein, & Tomlinson, 2014; Yousafzai, Rasheed, Rizvi, Armstrong, & Bhutta, 2014), among other domains. Furthermore, research has documented the potential fiscal benefits of task-shifting (Seidman & Atun, 2017), promoted modes of strengthening existing community-based programmes to deliver quality interventions at scale (Perry et al., 2017) and raised key considerations and challenges for policy makers (Deller et al., 2015).

Much of the literature about CHWs describes a generally motivated workforce (Greenspan et al., 2013), buoyed by a sense of purpose and dignity (Swartz & Colvin, 2015) and an opportunity to earn an income while helping their peers (Singh, Negin, Otim, Orach, & Cumming, 2015). Qualitative accounts of CHW programmes indicate that CHWs readily take on additional roles, and are mobilised by a sense of service and deeper connection to their clients (Busza, Dauya, Makamba, & Ferrand, 2018). Particularly in LMICs, CHWs have emerged as critical in promoting equitable care, serving families in regions that are typically underserved by formal health systems (Sommanustweechai et al., 2016). Most CHWs work in their own communities, making them well-suited to connect to their peers; this proximity also facilitates broader acceptance of CHW initiatives (Scott et al., 2018). The majority of CHWs, an estimated 70% globally, are women (Lehmann & Sanders, 2007).

The CHW role also requires individuals to shoulder specific responsibilities and expectations (Mundeva, Snyder, Ngilangwa, & Kaida, 2018). While CHWs are often selected based on demonstrated interpersonal competencies, previous experience and/or geographic location, they typically undergo limited pre-service training (Lehmann & Sanders, 2007), and as a result may lack the requisite professional skills and support to navigate the complexities of their roles (Pandey & Singh, 2015). In transitioning from a community member to a trained paraprofessional, CHWs may be unprepared to negotiate local power dynamics and how this may shape clients' healthcare access (Lehmann & Gilson, 2012). Many CHW programmes are also situated in resource-constrained settings, with poor health infrastructure, which may complicate their experiences of supervision, or demand more from them personally to attain programme goals (Rotheram-Borus et al., 2017; Satti et al., 2012). CHWs may underestimate the challenges of addressing the health needs of their peers, and the additional emotional toll this may take.

What is known about this topic?

- Community health workers are critical members of the healthcare workforce, and can face additional responsibilities as they provide care for their own communities.
- These challenges and the complexity of these workers' experiences are not well understood or documented, especially in resource-limited settings.

What does this paper add?

- Community health workers found purpose in their roles; they also described additional burdens related to providing care in a resource-limited setting.
- Boundary-setting and communicating expectations were two areas where community health workers struggled.
- Community health workers could benefit from more structured opportunities for self-care, debriefing and professional development as they navigate challenging work environments.

These realities challenge many healthcare workers in demanding circumstances; however, they can be more pronounced for CHWs, especially in LMICs. These circumstances also call into question the idea of CHWs as a 'tool' to solve entrenched problems, which has been the de facto response in global health policy (Perry, Zulliger, & Rogers, 2014). Considerations about how CHWs navigate community spaces are essential for implementation research that aims to track the effectiveness, long-term sustainability and scalability of community-based health interventions (Pallas et al., 2013). Although most CHWs are embedded within the communities they serve, there is limited research on how their performance is linked to, and interacts with, the context in which they work (Kok et al., 2015). Furthermore, the voices of CHWs themselves have been largely absent from this body of literature (Maes, Closser, & Kalofonos, 2014; Swartz, 2013). Some researchers have begun to explore CHWs' perspectives on their roles and their motivators (Swartz & Colvin, 2015), and how they navigate the dual imperatives of working within their own communities while providing services as paraprofessionals (Pandey & Singh, 2015). These studies suggest that CHWs' experiences require careful, nuanced consideration. More evidence is needed describing the individual perspectives of CHWs in low-resource settings, especially as relates to the benefits and demands of the role, and their competencies for managing their own self-care as well as their clients' care. Some of these considerations may be particularly relevant for women who manage households while working as CHWs. This understanding is vitally important as this cadre increasingly assumes the burden of primary healthcare in under-resourced communities.

The South African context is especially relevant for exploring these dynamics further. In the nearly three decades since the country's transition to democracy, government-funded CHWs have only

more recently become integrated into national policies for improving quality and access to health services, through what are known as ward-based outreach teams (Schneider & Nxumalo, 2017). In response to prior shortcomings across a highly inequitable social and health landscape, however, parallel non-governmental organisations (NGOs) have implemented and expanded CHW programmes (le Roux et al., 2014). While this arrangement is not uncommon (Lehmann & Sanders, 2007), it also may create additional challenges for programmes and their staff operating as a supplement to formal health systems.

This paper examines the experiences of a group of CHWs navigating the crossroads between personal and professional life in an NGO-based maternal and child health home visiting programme, the Enable Mentor Mother Programme, in the rural Eastern Cape Province of South Africa.

2 | METHODS

2.1 | Design

This study employed a qualitative exploratory design. The Health Research Ethics Committee at Stellenbosch University granted ethical approval (N16/05/062).

2.2 | The Enable Programme

The Enable Mentor Mother (MM) Programme (further referred to as Enable) was established to improve maternal and infant mortality and morbidity in South Africa's O.R. Tambo District, one of the country's worst-performing health districts, located in the Eastern Cape Province (District Health Barometer, 2019). Enable utilises a programme model originally developed by Philani Nutrition Centres Trust in the peri-urban settlement of Khayelitsha, South Africa (Rotheram-Borus et al., 2011). Enable, established in 2016 as the first 'social franchise' of this model—taking it to a new, rural location, under new management—recruits women to work as MMs in their own communities to improve maternal and child health outcomes. Enable is operated by the One to One Children's Fund, a non-profit organisation, and throughout the course of the social franchise agreement has continued to be guided by strategic and supervisory support from the Philani Nutrition Centres Trust. While MMs work in tandem with existing governmental health infrastructure, the programme and organisation they represent are separate from the formal health system.

This model employs a 'positive deviance' approach, seeking to identify mothers who—despite sharing common adversities with their peers—practice behaviours that enable them to raise healthy children (Marsh, Schroeder, Dearden, Sternin, & Sternin, 2004). Local community leaders hold informational meetings and help programme managers identify these mothers, who are invited to submit curricula vitae. Candidates are interviewed and undergo a 6-week training run by experienced trainers sent by Philani. Trainees are subsequently evaluated through practical and paper-based examinations, and one MM per area is selected to work in the community where she resides. MMs enroll pregnant women and underweight-for-age children through home-based visits—providing education, support and advice about nutrition, perinatal health, HIV/AIDS and infant care and linking these clients to necessary care (Tomlinson et al., 2016). They are expected to work 25 hr weekly (from 9:00 until 14:00) and to travel to each client's home on foot.

2.3 | Study setting

The area where Enable operates consists of families living in predominantly traditional rural homesteads—which tend to be clusters of several houses and an attached enclosure for livestock, occupied by an extended family—that lack on-site running water and electricity. Approximately 89% of households served by Enable receive monthly government-issued, means-tested child support grants (nearly all households in the area are eligible). Furthermore, a large majority of adults are either unemployed, or migrate circularly or permanently to urban centres for work (Hall & Posel, 2019). Although the South African government provides free primary healthcare, the quality of care is uneven across a significant rural–urban divide, and is inconsistent in the O.R. Tambo District. The region has a widely dispersed population, and resource limitations, as well as long distances to health facilities, make health-seeking challenging for Enable's clients.

2.4 | Sample

At Enable's inception, 14 MMs were selected to work in their respective areas. One MM was later promoted to the supervisory team. Each of the remaining 13 MMs were invited, and agreed, to be interviewed by an experienced, isiXhosa-speaking research assistant employed by [blinded for review] the University (VN), with whom they were acquainted through prior external capacity-building trainings. All MMs were led through an informed consent process before the interview in their home language, isiXhosa.

2.5 | Data collection procedure

CL drafted a semi-structured interview guide. The interview schedule covered topics including, working in one's own community, negotiating entry into homes and the process of relationship-building and developing trust with clients. Questions also asked about peer support, supervisory roles and how MMs viewed their responsibilities as lay health workers. The interview guide was revised together with VN. Three preliminary interviews were conducted in November 2017 to gather a first round of data and help refine the interview guide. From February–March 2018, the remaining 10 interviews were completed; these interviews lasted between 1 and 2 hr.

All interviews were audio-recorded with participant consent, and each recording was securely transferred to a cloud-based platform for data storage and backup. After all interviews were completed, three experienced transcribers translated and transcribed each recording simultaneously from isiXhosa into English, discussing any challenges as a team. The interviewer (VN) checked approximately 30% of transcripts for clarity and accuracy. The senior transcriber checked those transcripts completed by two more junior transcribers.

2.6 | Data analysis

The 10 main interviews completed in 2018 comprised the final analytic sample; transcript data from these interviews were systematically analysed. CL read each transcript twice and used inductive coding to identify emergent themes, resulting in 49 codes, 29 of which were present across a majority of transcripts. SR read and coded two interviews for quality control purposes (20%). CL and SR discussed key themes during multiple meetings and addressed small discrepancies in interpretation or framing. Salient themes emerging across interviews were grouped into two overarching themes—balancing roles and blurring boundaries—with seven sub-themes.

3 | RESULTS

Mentor Mothers were, on average, 36.9 years old at the time of the interview (range 24.6–51.8 years, *SD* = 7.85). Six had completed high school, with the remaining four completing Grade 10 or Grade 11. At the time of the interviews, they had each been employed as MMs for approximately 18 months, and had accumulated caseloads that included an average of 30 maternal clients. One of the 10 MMs had undergone health service provision training prior to being recruited by Enable.

3.1 | Balancing roles: finding purpose as a paraprofessional

MMs described a sense of being recognised by the community and pride that came from their job. Leveraging their identities as community members, they stated that they connected to clients easily and felt motivated by serving their community; they also utilised professional skills to empower clients and counsel them confidentially.

3.1.1 | A feeling of recognition and sense of dignity

MMs spoke about the sense of dignity that was a benefit of their role. They reported feeling valued, as individuals who were seen to be able to make a difference, as well as feeling pride in earning a salary and working in their own communities. One MM pointed to '*that thing of being called nurses*' as a motivator, and a way of feeling respected by the community—'*that means there is a big role you play*'(MM6). As many residents seeking formal employment are forced to migrate and live away from their families, the ability to work within their own community was described as an added benefit and convenience. '*What is nice is that you wake up at home and go to work and you do not rent. You will bath and go to the field to people that you know*'(MM3). She continued, '*even if the money is little, that hope of having money at month-end, it can make you feel confident even when you walk on the road*'.

3.1.2 | An ability to form connections with clients

Underpinning themes of dignity and empowerment was a deeper sense of connection. Some MMs repeated lessons from training when characterising their approaches to relationship-building, reiterating humility, respect and approachability to gain acceptance and build clients' self-esteem. Many approaches were tied to MMs' embeddedness in their own communities. The idea of 'being known' often reduced barriers to entry and facilitated connection; MMs often noted that their actions on the job reflected their individual characters. As one MM said, trust was essential in the job, '*especially when they know you are also from the same place, you live here, and what kind of a person you are*'(MM2). Similarly, another MM explained, *'I feel very happy because I work with people that I know most of the time, that also know me, trust me and know that I am so-and-so's child and what my home is like because people are able to be open'*(MM7). This MM contrasted what it might look like if her interviewer were to go house-to-house, citing difficulties because clients would not know her history and might not open up with her. Another MM spoke about being the only one who graduated high school in her village, and noted, '*I never got scared [people] might judge me [as a MM]…people used to come to me because I have always been that person*'(MM5). Being 'that person' enabled her to feel comfortable taking on an advising, supporting role, albeit with new parameters and training.

3.1.3 | Using context to build professional relationships

Many MMs linked their success to a specific 'community member' advantage. On another level, this embeddedness also gave MMs access to insider knowledge, allowing them to use creative ways to engage potential clients—harnessing what might be considered village gossip to enroll new clients. As one MM explained:

> You will hear someone saying hey sis, you must go to so-and-so's home…When I get there, I do not say, hey [this person] says that you are pregnant, no, I would just say 'I saw you girl on some other day when I was passing, and you were hanging clothes

> on the line, I said to myself by the look of things you must be pregnant'…they would laugh and give me the truth that I wanted, and I would open a folder. You see if I was in a village that I do not know, there is no one that would come and whisper to me about that(MM3).

Using this closer understanding of appropriate approaches, MMs described gaining their clients' trust. MMs reported that this kind of approach seemed to reduce feelings of shame or judgment of one's situation, especially as many of these clients were living in difficult circumstances. Another MM spoke about the importance of compliments:

> You get in and chat in general, maybe about something that will make them happy, maybe say, "your beans look nice" or maybe compliment even the dress she is wearing…by that you are trying to build that relationship(MM2).

Choosing the right words, and being able to connect with clients in small yet important ways, was described as central to MMs' roles.

3.1.4 | Empowering clients through the intervention

MMs spoke about empowering others as they were trained to do through home visit interactions, especially through emphasising confidentiality and autonomous decision-making. Just as closeness might foster connection, the interviewer noted that it might invite mistrust:

> Interviewer: How do you [reassure] people…maybe people would say, 'no, I know [her], she grew up in this village and I would never tell her this thing because I do not want this thing to be known by people in the community'?
>
> MM7: I would promise them that I would never talk about that thing, if they talk about it to me and to me only, they will never hear another person talk about it…I was taught a lot about that.

Echoing this theme of client respect, MMs explained the importance of a client making decisions about her own health: '*I do not force the person. Everything is up to her*'(MM7). Another emphasised:

> I don't wear my client's shoes…all I do is I give advice to my client about that situation she is facing at that moment so, I sit down with her and talk about how what I think about that situation, but I don't make decisions for her and also ask her what she thinks(MM10).

This approach reflected a delicate balance between engaging the personal with the professional, prioritising a client's right to privacy within a tight-knit community, alongside a right to autonomy.

3.2 | Blurring boundaries: encountering challenges in the job

As MMs emphasised their ways of capitalising on their community embeddedness, they also acknowledged the ways that it might demand more of their professional and personal selves. Being recognised also meant bearing the weight of expectation; MMs had to navigate both sides of this role, with less control over where boundaries might be drawn.

3.2.1 | 'No one asked me [to do this]'

MMs spoke about being available for their clients at all times—even when this conflicted with their personal lives or professional training. For many MMs, having to restrict their working hours to between 9:00 and 14:00 was unrealistic if clients had additional needs. One MM described 'leaving the pots on' after she had started making dinner to put on her uniform and go help a client who had called with an emergency. She noted:

> You don't ever think that you supposed to tell the manager that today, I left work at five, the only thing you think is that I have to help this person, [it] doesn't matter what time I knock off, I'm not supposed to say I'm rushing for 14:00, rather this person die because you want to knock off at 14:00(MM6).

She noted this was part of the job for which she was grateful: '*if I pushed and managed to help a person, I see that as an achievement even though it was difficult*'. Often, MMs did not seek credit or pay for this additional work, recognising it as essential for the client but something they were not necessarily supposed to be doing. While MMs described this practice as fulfilling their responsibilities to their clients, they simultaneously blurred the lines of what might be seen as professional.

Most MMs portrayed these tendencies to help after hours as self-prompted, rather than based on their proximity, on community members' expectations or a sense of guilt. Some MMs discussed the need to apply principles of fairness across clients, especially in challenging cases:

> [Later] I would be thinking of a plan to use in order for things to get better there…Because of the way that I am so eager to make a change in the community, so that thing makes me feel guilt, it would seem like I am not attending their problem because of a reason(MM4).

This sense of commitment often embodied more instrumental forms of support. MMs spoke about bringing food from their own gardens to certain clients so that they could digest their antiretroviral medication, and sending sick children to the clinic on public transport using their own funds—yet described these acts as routine. Even if

this extra effort sometimes felt like a burden, MMs seemed willing to shoulder that responsibility: as one MM explained, '*I would say, I made myself tired, because no one asked me [to do this]*'(MM1).

This ambivalence between choice and constraint also related to how situations could be reflected back to the MM. One MM noted that being close to clients also invited the possibility that any gossip about someone's health information could be pinned back on the MM, even if she was not to blame(MM3). Others described an internalised imperative to 'live' the role, reiterating: '*I must do what I tell people to do. They must see me doing it*'(MM1). For many of the MMs, testing for HIV and being open about their status was one example of this, especially in a region with high prevalence rates but similarly high stigma. One MM spoke about how she used to run an informal tavern, and she realised she had to choose between being a MM or keeping her business open to reflect her own integrity. Using personal examples with their clients, MMs reiterated the importance of taking their own advice, revealing reverence for, and perhaps bounds set by the role they had taken on.

3.2.2 | Struggling to practice self-care

While most MMs recognised the need for self-care to do their jobs well, some MMs struggled to keep home and work separate. One MM described her after-work routine: '*we were taught that we must not take people's things and make them ours, so I would get home, drink water and be at peace*'(MM8). Another noted, '*[you can] lose your situation over problems that are not yours*'(MM9) if you start to reflect on clients' problems. By not promising clients more than they could give, MMs found ways to erect boundaries:

> We do not promise things that we do not have, we tell them that we bring nothing, we just came in to change the situations in homes, with things like, what must one do when they are pregnant, what must they do with the baby is underweight, there is nothing else that we bring(MM10).

In these ways, MMs articulated their capacities to make distinctions between clients' problems and their own lives, especially where they were experiencing similar deprivation.

Nevertheless, some MMs struggled to manage these burdens, particularly those who described being emotionally connected to clients. One MM described coming home to rest after difficult days and having to explain her tiredness to her daughter:

> At home they now know, I just go to sleep when there is something troubling me. My daughter would ask me, 'mom, what happened in the field? why do you come home troubled?' I would tell her that, 'no, stop, I just need to sleep first,' I would then sleep. When I wake up, [I] tell them that it is because we work with people and sometimes the problems would be too much in the community, so sometimes you must just leave me(MM4).

Often, problems might re-emerge after the working day had ended, and unresolved issues could weigh on MMs' consciences as they cooked dinner, engaged with their families or lay awake at night.

> MM7: You have a big challenge every time you arrive [home] and your mind is still on that thing, even though sister said in the training that you must not carry someone's burden. But it is not easy to not carry that person's burden, because you want to help that person, sometimes you would feel that there are difficulties.
> Interviewer: Okay…what do you think it is that causes that?
> MM7: I think that it is caused…I would say, sis, it is caring, caring for that person, you wish to see them past that problem

Despite professing an understanding of self-care and boundary-setting, the blurring of boundaries and closeness to clients in practice complicated this logic.

3.2.3 | Disrupting dynamics at home

Lastly, even as MMs discussed being able to empower clients to seek care and make decisions, they sometimes encountered resistance to their own empowerment as MMs in their personal lives. Being an employed person in a community with extremely low rates of formal employment engendered a different burden, inviting accompanying jealousy from this status change.

> People are alright now, but when we started, yoh, it was hard because we were many when we went to the training, and we were not all hired. So when you enter a home you would have to explain why so-and-so was not hired and why were you hired, and you don't even know why you were hired at that time(MM8).

In addition to facing scrutiny from community members, some MMs described a disrupted home dynamic due to shifts in cultural expectations. One of the MMs who was married spoke about her newfound financial independence as something that her husband both appreciated, and felt threatened by.

> MM7: He would feel like that, when he was not working he was happy that I was working, but he was worried that he was supported by his wife at the end of the day.
> Interviewer: What are the things that he would say, or express himself with, to show that he does not like being supported by his wife?
> MM7: For example, my husband is someone that drinks, he would come home drunk and say, 'hey, this thing of being supported by a wife, having your children raised by the wife, with food

> I am looking at this wife, with everything, even at school she has to take care of the children.' He would look down on himself, you see?

As this MM articulated some of the tensions that had entered her marriage and home, she was simultaneously able to recognise these challenges and contextualise them. Another MM shared tensions that had arisen in her household, where she as a young wife (*makoti*) was expected to plan meals and clean. After accompanying a client to an emergency clinic visit, she recalled, '*I arrived at home past eight and when I got home, I saw the mood had changed, but I told myself that what matters is I helped the baby*'(MM6). Despite the apparent irritation from other female household members, she said her husband and family had come to acknowledge and accept her new role.

4 | DISCUSSION

In this article, we have described the complexity Mentor Mothers face—as women trained and employed to deliver a maternal and child health intervention in their own communities—in navigating the crossroads between their professional roles and their personal lives. This process of engaging in a relatively new role within a familiar context was described by many as empowering, pushing them to 'live' their role with a deep sense of personal integrity. In bridging personal and professional domains, MMs identified ways of forging personal connections while also using their professional role to establish credibility. They drew strength from being recognised and respected in their communities and internalised the importance of their roles as they described working extra hours and being available for clients. In other literature, CHWs often self-identify as advocates and connectors, employing flexibility and creativity to meet their clients' needs (Ingram et al., 2012).

However, this role also exposed them to community and familial expectations of selflessness, equitably applied care, maintaining domestic responsibilities at home and a tacit understanding that extra work did not amount to extra pay. As such, the advantages they experienced were also tempered by conflicting situations they faced. Not all challenges described were specific to community health work; they included finding a balance between home and work spheres, adapting new strategies to reach job-related goals and employing personal qualities and acquired skills to perform well (Buykx, Humphreys, Wakerman, & Pashen, 2010). However, other experiences echoed the burdens facing other South African health personnel in rural settings (Braathen, Vergunst, Mji, Mannan, & Swartz, 2013; Engelbrecht, Bester, Van den Berg, & Van Rensburg, 2008), and also reiterated the distinct challenges that CHWs navigate (Razee, Whittaker, Jayasuriya, Yap, & Brentnall, 2012; Roman, Lindsay, Moore, & Shoemaker, 1999; Scott et al., 2018). As CHWs' work and home spheres overlap more than usual, they may face expectations (or create them) about when boundary-setting is acceptable, and when it is not. For example, feeling obligated out of a sense of loyalty or care to provide a hot meal, or a transport fare, to a struggling client was not atypical; yet it posed challenges for MMs who were not necessarily always in a financial position to provide this mode of support.

While recognising the value that individual MMs place on their roles, it is also necessary to think critically about what these challenges mean for CHWs, who are often pitched as a 'solution' workforce for countries struggling to meet population health needs, (Colvin & Swartz, 2015). The substantial public health literature on CHWs in LMICs, and the daily challenges they face, tend to focus on performance improvement—citing barriers around community acceptance, equipment needs and training needs more specifically (Ballard & Montgomery, 2017). Fewer studies investigate the role of occupational, CHW-specific challenges of working within their own communities (Trafford, Swartz, & Colvin, 2017). For the MMs in this study, employed by a non-profit organisation to expand care to maternal and child clients in areas far from health facilities, these roles may be even more community-centric when compared to South African government-funded CHWs who are primarily based in clinics and are expected to conduct outreach work (Schneider, Sanders, Rohde, Besada, & Daviaud, 2018). These considerations are also largely absent from larger-scale research and advocacy work that advocates task-shifting key health roles to CHWs (WHO, 2018). The advantages of CHWs, such as their comparably low cost (McCord, Liu, & Singh, 2013), cultural affinity with clients (Kok et al., 2017) and logistical flexibility as a workforce (Herman, 2011), are often posited as critical determining factors in national strategic plans and global guidelines promoting CHWs—at the expense of more personalised, nuanced examinations of their experiences and capabilities. Our research attempts to address this gap, and we consider three potential 'levels' to consider how to interpret and operationalise these findings in other community health programme contexts. We believe these implications are relevant for both NGO-based community programmes such as Enable, as well as nationally implemented programmes.

4.1 | Implications of these findings: immediate, intermediate and conceptual

At the most immediate level, these findings highlight a need for programme leadership to equip CHWs with self-care and boundary-setting skills. Pre-service and in-service training should be framed to equip CHWs with opportunities for growth and skill-building, and should consider integrating this skillset with sessions on soft skills such as interpersonal engagement or relationship building. These skills can include evidence-based techniques for self-care and stress relief—identifying stressors, journaling, support networking and/or relaxing techniques. They may also harness locally derived strategies that CHWs are already effectively employing in their daily work. Just as some MMs shared strategies to detach from their clients' needs when arriving home, other research has echoed the need for health workers to engage in client relationships without becoming too invested. Accredited Social Health Activists (ASHAs)

in India performed better and were found to be better protected against stress and burnout when they practised 'surface-level' emotional labour that enabled them to connect to clients outwardly. ASHAs engaging in 'deep-level' emotional labour, conversely, took on more clients' burdens and suffered from this closeness (Pandey & Singh, 2015). Similar research with Brazilian community-based health agents and South African community-based volunteer caregivers has also identified high levels of stress and burnout, stemming from lack of support, depersonalisation and emotional exhaustion (Akintola, Hlengwa, & Dageid, 2013; Silva & Menezes, 2008). However, additional work from LMICs is needed in order to frame successful strategies for mitigating these factors and better supporting staff to erect necessary boundaries.

Secondly, many CHW models would benefit from more routine opportunities for supportive supervision to reduce occupational burdens. Programme leadership should carefully consider these provisions at the inception stages of programme implementation and at any subsequent stage of expansion. While MMs shared their personal ways of coping, they spoke less about routine, structured opportunities for sharing emotional burdens with peers and supervisors. Supportive supervision, which extends beyond managerial oversight to encompass a more multi-faceted 'humanised' type of support, has been found to be linked with improved CHW performance and motivation (Kok et al., 2018). Such comprehensive supervision can be challenging to implement consistently, however, facing the same geographic and resource limitations that programmes themselves encounter (Bailey et al., 2016; Ndima et al., 2015). Additional psychosocial support strategies—such as routine debriefing, a strategy commonly used with registered counsellors and mental health professionals, as well as peer-to-peer support—could further benefit and support CHWs (Deahl, 2000). Shifting the supervisory focus from observing clinical challenges, monitoring performance and providing informal support (Hernández, Hurtig, Dahlblom, & San Sebastián, 2014) to providing structured opportunities for debriefing, case sharing and team problem-solving (Rabin, Saffer, Weisberg, & Kornitzer-Enav, 2000; Tseng et al., 2019) is an important step in constructing a more supportive, responsive programme. There is further scope for research on supervisory mechanisms and practices to understand how to mitigate challenges within community settings and ensure quality in programme implementation (Rotheram-Borus et al., 2017).

On a broader conceptual level, these findings also highlight ways that existing models and assumptions about CHWs may disadvantage these workers. Lay and community health workers are overwhelmingly women, seen to fit nurturing roles as 'care workers', who tend to be remunerated poorly, if at all (Daniels, Clarke, & Ringsberg, 2012; George, 2008). CHWs are often seen as an indispensable solution to health system failings from policy makers' perspectives, able to operate within'lean' models of care and mobilise in the face of considerable resource constraints. On the other hand, they take up the mantle of work that a functioning health system should be conducting, and do so in ways that are often undervalued and overlooked (Di Paola & Vale, 2019). How can CHW models be strengthened to fit these needs and plays supporting roles, without placing undue burdens on CHWs?

One response is a clearer division between personal and professional domains, comprising a more intensive, up-front investment in training and professionalising the CHW workforce. This approach moves beyond the 'positive deviance' model, which has been found to be a promising way to identify motivated, gifted CHWs, but may also blur the boundaries between personal and professional to create a greater burden. By living and working within the same community, CHWs may engage more intensively with beneficiaries than formal health sector interventions could (Smith et al., 2014). However, there are ways to establish divisions more concretely. Training CHWs on how to provide 'synthetic social support' —characterised by targeted (not organic) social networks, and non-reciprocal, time-limited client interactions—is one such approach to creating these boundaries from a programmatic perspective (Gale, Kenyon, MacArthur, Jolly, & Hope, 2018). This approach might also entail more centralised, standardised recruitment criteria and training curricula, and higher standards of accountability in care. For example, in Kazakhstan, all pregnant women and families with children under age 5 are visited at home by patronage nurses and social workers as part of a universal progressive model for primary care (Sukhanberdiyev & Tikhonova, 2019). This approach represents a cross-sectoral, sustainable effort; community health teams have begun to undergo comprehensive training, and training modules have been incorporated into medical and nursing curricula to ensure widespread uptake and impact.

A second response is to provide CHWs with a clearer path to professional development, as a similar way to embed CHWs within the larger health workforce. As CHWs implement interventions on the front lines, they face decisions about how to flexibly adapt strategies to meet unanticipated community needs or adjust to contextual changes (Ingram et al., 2012). From a practical perspective, understanding CHWs' personal goals and prioritising opportunities for professional development can help promote their growth and longevity both individually and collectively (Abdel-All et al., 2019; Pallas et al., 2013). It also positions CHWs to develop within and beyond their roles, as evidence shows that many CHWs use the role as a stepping stone to further career opportunities (Lloyd & Thomas-Henkel, 2017; Schneider, Hlophe, & van Rensburg, 2008; WHO, 2018).

Both of these approaches involve a clearer, more defined role, and would also require adequate pay and resources for CHWs to operate at a high level. These suggestions, however, may also inherently lead into a sort of tension surrounding the definition of CHWs' roles, as too 'professional' a framing may distance them from the very communities and individuals with whom they aim to connect and serve. Consequently, CHW models must continue to work alongside clients to establish appropriate expectations from an early stage, and ensure that both CHWs and clients feel supported and respected. Importantly, these recommendations extend to diverse types of CHW workforces. Ward-based outreach teams, the most recent iteration of South African policies promoting government-employed

CHWs, have been implemented slowly and unevenly, yet would similarly benefit from incorporating support and role definition for CHWs as they continue to be rolled out (Schneider et al., 2018).

In addition to considering practical responses to challenges inherent within CHW models, a more fundamental rights-based framing is needed (Trafford et al., 2017). As CHWs are embedded within complex environments and larger systems, their motivations and experiences are multi-dimensional and diverse (Swartz, 2013). While continuing to incorporate local community networks and knowledge is critical, shifting towards a more professionalised community health system would also acknowledge the pivotal, preventative roles played by CHWs, and could allocate resources for them to effectively serve vulnerable communities.

4.2 | Limitations

This study has a number of limitations. All interviews were conducted with the first cohort of MMs from the Enable programme, who were recruited to establish the programme in Nyandeni and therefore may have experienced the added burdens of reflecting the programme's values and goals in their daily work. This challenge may have been somewhat diminished for later cohorts of MMs who joined after the programme was well-established in the area. Furthermore, the interviewer (VN) was known to the participants previously, through her visits as an external trainer from Stellenbosch University. While we believe this prior contact was an overall advantage, it is possible that certain participants withheld certain perspectives or information with the understanding that it might be shared with their supervisors. However, we are confident that the informed consent process and existing relationships acted as protective factors against this limitation.

5 | CONCLUSIONS

Our findings add to ongoing dialogue about how to sustain and expand CHW programmes to reduce the burden of health for LMICs. Interview data from CHWs highlight the conflicting nature of their roles, and the tangible challenges that they face in working in their own communities. We emphasise the need to reconsider the assumptions that underpin community health programmes and suggest responses that might help elevate and professionalise these individuals. Future research on CHW performance, and implementation research focused on evaluating and expanding CHW programmes, should incorporate a more nuanced understanding of CHWs' diverse roles and the ways in which they navigate their own lives and identities in the context of their work.

ACKNOWLEDGEMENTS

The authors would like to thank the Mentor Mothers of the Enable programme who enthusiastically agreed to participate in this research, as well as the transcription team (Athenkosi Mangele, Nezisa Ntante and Akhona Sambudla) for their essential contributions to this work.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

AUTHORS CONTRIBUTION

All authors contributed to the study conceptualisation and design. Material preparation and data collection were performed by CAL and VN, with support from SS, BJC, and MT. Data were coded by CAL and SR. The first draft of the manuscript was written by CL and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript as submitted.

ORCID

Christina A. Laurenzi https://orcid.org/0000-0001-9648-4473
Sarah Skeen https://orcid.org/0000-0002-7464-2861
Stephan Rabie https://orcid.org/0000-0002-5464-0746
Bronwynè J. Coetzee https://orcid.org/0000-0003-1545-418X
Mark Tomlinson https://orcid.org/0000-0001-5846-3444

REFERENCES

Abdel-All, M., Angell, B., Jan, S., Howell, M., Howard, K., Abimbola, S., & Joshi, R. (2019). What do community health workers want? Findings of a discrete choice experiment among Accredited Social Health Activists (ASHAs) in India. *BMJ Global Health*, *4*(3), e001509. https://doi.org/10.1136/bmjgh-2019-001509

Akintola, O., Hlengwa, W. M., & Dageid, W. (2013). Perceived stress and burnout among volunteer caregivers working in AIDS care in South Africa. *Journal of Advanced Nursing*, *69*(12), 2738–2749. https://doi.org/10.1111/jan.12166

Bailey, C., Blake, C., Schriver, M., Cubaka, V. K., Thomas, T., & Martin Hilber, A. (2016). A systematic review of supportive supervision as a strategy to improve primary healthcare services in Sub-Saharan Africa. *International Journal of Gynecology & Obstetrics*, *132*(1), 117–125. https://doi.org/10.1016/j.ijgo.2015.10.004

Ballard, M., & Montgomery, P. (2017). Systematic review of interventions for improving the performance of community health workers in low-income and middle-income countries. *British Medical Journal Open*, *7*(10), e014216. https://doi.org/10.1136/bmjopen-2016-014216

Braathen, S. H., Vergunst, R., Mji, G., Mannan, H., & Swartz, L. (2013). Understanding the local context for the application of global mental health: A rural South African experience. *International Health*, *5*(1), 38–42. https://doi.org/10.1093/inthealth/ihs016

Busza, J., Dauya, E., Makamba, M., & Ferrand, R. A. (2018). "I will not stop visiting!" a qualitative study of community health workers' reluctance to withdraw household support following the end of a community-based intervention in Zimbabwe. *BMC Health Services Research*, *18*(1), 718. https://doi.org/10.1186/s12913-018-3531-x

Buykx, P., Humphreys, J., Wakerman, J., & Pashen, D. (2010). Systematic review of effective retention incentives for health workers in rural and remote areas: Towards evidence-based policy. *Australian Journal of Rural Health*, *18*(3), 102–109. https://doi.org/10.1111/j.1440-1584.2010.01139.x

Colvin, C. J., & Swartz, A. (2015). Extension agents or agents of change? *Annals of Anthropological Practice*, *39*(1), 29–41. https://doi.org/10.1111/napa.12062

Daniels, K., Clarke, M., & Ringsberg, K. C. (2012). Developing lay health worker policy in South Africa: A qualitative study. *Health Research Policy and Systems*, *10*(1), 8. https://doi.org/10.1186/1478-4505-10-8

Deahl, M. (2000). Psychological Debriefing: Controversy and Challenge. *Australian & New Zealand Journal of Psychiatry*, *34*(6), 929–939. https://doi.org/10.1080/000486700267

Deller, B., Tripathi, V., Stender, S., Otolorin, E., Johnson, P., & Carr, C. (2015). Task shifting in maternal and newborn health care: Key components from policy to implementation. *International Journal of Gynecology & Obstetrics*, *130*, S25–S31. https://doi.org/https://doi.org/10.1016/j.ijgo.2015.03.005 . https://doi.org/10.1016/j.ijgo.2015.03.005

Di Paola, M., & Vale, B. (2019). Knowledge, Power and the Role of Frontline Health Workers for South Africa's Epidemic Preparedness. In Z. Mazibuko (Ed.), *Epidemics and the Health of African Nations* (pp. 229). Mapungubwe Institute for Strategic Reflection (MISTRA).

District Health Barometer (2019).

Engelbrecht, M. C., Bester, C. L., Van den Berg, H., & Van Rensburg, H. C. J. (2008). A study of predictors and levels of burnout: the case of professional nurses in primary health care facilities in the free state 1. *South African Journal of Economics*, *76*, S15–S27.

Fulton, B. D., Scheffler, R. M., Sparkes, S. P., Auh, E. Y., Vujicic, M., & Soucat, A. (2011). Health workforce skill mix and task shifting in low income countries: A review of recent evidence. *Human Resources for Health*, *9*(1), 1. https://doi.org/10.1186/1478-4491-9-1

Gale, N. K., Kenyon, S., MacArthur, C., Jolly, K., & Hope, L. (2018). Synthetic social support: Theorizing lay health worker interventions. *Social Science & Medicine*, *196*, 96–105. https://doi.org/10.1016/j.socscimed.2017.11.012

George, A. (2008). Nurses, community health workers, and home carers: Gendered human resources compensating for skewed health systems. *Global Public Health*, *3*(Suppl 1), 75–89. https://doi.org/10.1080/17441690801892240

Greenspan, J. A., McMahon, S. A., Chebet, J. J., Mpunga, M., Urassa, D. P., & Winch, P. J. (2013). Sources of community health worker motivation: A qualitative study in Morogoro Region, Tanzania. *Human Resources for Health*, *11*, 52–52. https://doi.org/10.1186/1478-4491-11-52

Hall, K., & Posel, D. (2019). Fragmenting the Family? The complexity of household migration strategies in post-apartheid South Africa. *IZA Journal of Development and Migration*, *10*(2). https://doi.org/10.2478/izajodm-2019-0004

Herman, A. A. (2011). Community Health Workers and Integrated Primary Health Care Teams in the 21st Century. *The Journal of Ambulatory Care Management*, *34*(4), https://journals.lww.com/ambulatorycaremanagement/Fulltext/2011/10000/Community_Health_Workers_and_Integrated_Primary.5.aspx. https://doi.org/10.1097/JAC.0b013e31822cbcd0

Hernández, A. R., Hurtig, A.-K., Dahlblom, K., & San Sebastián, M. (2014). More than a checklist: A realist evaluation of supervision of mid-level health workers in rural Guatemala. *BMC Health Services Research*, *14*(1), 112. https://doi.org/10.1186/1472-6963-14-112

Ingram, M., Reinschmidt, K. M., Schachter, K. A., Davidson, C. L., Sabo, S. J., De Zapien, J. G., & Carvajal, S. C. (2012). Establishing a professional profile of community health workers: Results from a National study of roles, activities and training. *Journal of Community Health*, *37*(2), 529–537. https://doi.org/10.1007/s10900-011-9475-2

Kok, M. C., Kane, S. S., Tulloch, O., Ormel, H., Theobald, S., Dieleman, M., … de Koning, K. A. (2015). How does context influence performance of community health workers in low- and middle-income countries? Evidence from the literature [journal article]. *Health Research Policy and Systems*, *13*(1), 13. https://doi.org/10.1186/s12961-015-0001-3

Kok, M. C., Ormel, H., Broerse, J. E. W., Kane, S., Namakhoma, I., Otiso, L., … Dieleman, M. (2017). 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. *Global Public Health*, *12*(11), 1404–1432. https://doi.org/10.1080/17441692.2016.1174722

Kok, M. C., Vallières, F., Tulloch, O., Kumar, M. B., Kea, A. Z., Karuga, R., … Taegtmeyer, M. (2018). Does supportive supervision enhance community health worker motivation? A mixed-methods study in four African countries. *Health Policy and Planning*, *33*(9), 988–998. https://doi.org/10.1093/heapol/czy082

le Roux, I. M., Rotheram-Borus, M. J., Stein, J., & Tomlinson, M. (2014). The impact of paraprofessional home visitors on infants' growth and health at 18 months. *Vulnerable Children and Youth Studies*, *9*(4), 291–304. https://doi.org/10.1080/17450128.2014.940413

Lehmann, U., & Gilson, L. (2012). Actor interfaces and practices of power in a community health worker programme: A South African study of unintended policy outcomes. *Health Policy and Planning*, *28*(4), 358–366. https://doi.org/10.1093/heapol/czs066

Lehmann, U., & Sanders, D. (2007). *Community health workers: What do we know about them.* The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers (pp. 1–42). Geneva: World Health Organization.

Lloyd, J., & Thomas-Henkel, C. (2017). Integrating Community Health Workers into Complex Care Teams: Key Considerations. Center for Health Care Strategies. May.

Maes, K., Closser, S., & Kalofonos, I. (2014). Listening to community health workers: How ethnographic research can inform positive relationships among community health workers, health institutions, and communities. *American Journal of Public Health*, *104*(5), e5–e9. https://doi.org/10.2105/AJPH.2014.301907

Marsh, D. R., Schroeder, D. G., Dearden, K. A., Sternin, J., & Sternin, M. (2004). The power of positive deviance. *BMJ*, *329*(7475), 1177–1179.

McCord, G. C., Liu, A., & Singh, P. (2013). Deployment of community health workers across rural sub-Saharan Africa: Financial considerations and operational assumptions. *Bulletin of the World Health Organization*, *91*, 244–253b.

Mundeva, H., Snyder, J., Ngilangwa, D. P., & Kaida, A. (2018). Ethics of task shifting in the health workforce: Exploring the role of community health workers in HIV service delivery in low- and middle-income countries. *BMC Medical Ethics*, *19*(1), 71. https://doi.org/10.1186/s12910-018-0312-3

Mwai, G. W., Mburu, G., Torpey, K., Frost, P., Ford, N., & Seeley, J. (2013). Role and outcomes of community health workers in HIV care in sub-Saharan Africa: A systematic review. *Journal of the International AIDS Society*, *16*, 18586. https://doi.org/10.7448/IAS.16.1.18586

Ndima, S. D., Sidat, M., Give, C., Ormel, H., Kok, M. C., & Taegtmeyer, M. (2015). Supervision of community health workers in Mozambique: A qualitative study of factors influencing motivation and programme implementation. *Human Resources for Health*, *13*(1), 63. https://doi.org/10.1186/s12960-015-0063-x

Nyatsanza, M., Schneider, M., Davies, T., & Lund, C. (2016). Filling the treatment gap: Developing a task sharing counselling intervention for perinatal depression in Khayelitsha, South Africa. *BMC Psychiatry*, *16*(1), 164. https://doi.org/10.1186/s12888-016-0873-y

Okyere, E., Mwanri, L., & Ward, P. (2017). Is task-shifting a solution to the health workers' shortage in Northern Ghana? *PLoS One*, *12*(3), e0174631. https://doi.org/10.1371/journal.pone.0174631

Pallas, S. W., Minhas, D., Pérez-Escamilla, R., Taylor, L., Curry, L., & Bradley, E. H. (2013). Community health workers in low- and middle-income countries: What do we know about scaling up and sustainability? *American Journal of Public Health*, *103*(7), e74–e82. https://doi.org/10.2105/AJPH.2012.301102

Pandey, J., & Singh, M. (2015). Donning the mask: Effects of emotional labour strategies on burnout and job satisfaction in community healthcare. *Health Policy and Planning*, *31*(5), 551–562. https://doi.org/10.1093/heapol/czv102

Perry, H., Crigler, L., Lewin, S., Glenton, C., LeBan, K., & Hodgins, S. (2017). A new resource for developing and strengthening large-scale community health worker programs. *Human Resources for Health*, *15*(1), 13. https://doi.org/10.1186/s12960-016-0178-8

Perry, H. B., Zulliger, R., & Rogers, M. M. (2014). Community health workers in low-, middle-, and high-income countries: An overview of their history, recent evolution, and current effectiveness. *Annual Review of Public Health*, *35*(1), 399–421. https://doi.org/10.1146/annurev-publhealth-032013-182354

Rabin, S., Saffer, M., Weisberg, E., & Kornitzer-Enav, T. (2000). A multifaceted mental health training program in reducing burnout among occupational social workers. *The Israel Journal of Psychiatry and Related Sciences*, *37*(1), 12.

Razee, H., Whittaker, M., Jayasuriya, R., Yap, L., & Brentnall, L. (2012). Listening to the rural health workers in Papua New Guinea – The social factors that influence their motivation to work. *Social Science & Medicine*, *75*(5), 828–835. https://doi.org/10.1016/j.socscimed.2012.04.013

Roman, L. A., Lindsay, J. K., Moore, J. S., & Shoemaker, A. L. (1999). Community Health Workers: Examining the Helper Therapy Principle. *Public Health Nursing*, *16*(2), 87–95. https://doi.org/10.1046/j.1525-1446.1999.00087.x

Rotheram-Borus, M. J., le Roux, I. M., Tomlinson, M., Mbewu, N., Comulada, W. S., le Roux, K., … Swendeman, D. (2011). Philani Plus (+): A Mentor Mother community health worker home visiting program to improve maternal and infants' outcomes. *Prevention Science*, *12*(4), 372–388. https://doi.org/10.1007/s11121-011-0238-1

Rotheram-Borus, M. J., Le Roux, K., Le Roux, I. M., Christodoulou, J., Laurenzi, C., Mbewu, N., & Tomlinson, M. (2017). To evaluate if increased supervision and support of South African Government health workers' home visits improves maternal and child outcomes: Study protocol for a randomized control trial. *Trials*, *18*(1), 368–368. https://doi.org/10.1186/s13063-017-2074-5

Satti, H., Motsamai, S., Chetane, P., Marumo, L., Barry, D. J., Riley, J., … Mukherjee, J. S. (2012). Comprehensive approach to improving maternal health and achieving MDG 5: Report from the mountains of Lesotho. *PLoS One*, *7*(8), e42700. https://doi.org/10.1371/journal.pone.0042700

Schneider, H., Hlophe, H., & van Rensburg, D. (2008). Community health workers and the response to HIV/AIDS in South Africa: Tensions and prospects. *Health Policy and Planning*, *23*(3), 179–187. https://doi.org/10.1093/heapol/czn006

Schneider, H., & Nxumalo, N. (2017). Leadership and governance of community health worker programmes at scale: A cross case analysis of provincial implementation in South Africa. *International Journal for Equity in Health*, *16*(1), 72. https://doi.org/10.1186/s12939-017-0565-3

Schneider, H., Sanders, D., Rohde, S., Besada, D., & Daviaud, E. (2018). Ward-based primary health care outreach teams in South Africa : Developments, challenges and future directions. *South African Health Review*, *2018*(1), 59–65.

Scott, K., Beckham, S. W., Gross, M., Pariyo, G., Rao, K. D., Cometto, G., & Perry, H. B. (2018). What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Human Resources for Health*, *16*(1), 39. https://doi.org/10.1186/s12960-018-0304-x

Seidman, G., & Atun, R. (2017). Does task shifting yield cost savings and improve efficiency for health systems? A systematic review of evidence from low-income and middle-income countries. *Human Resources for Health*, *15*(1), 29. https://doi.org/10.1186/s12960-017-0200-9

Silva, A. T. C., &Menezes, P. R. (2008). Burnout syndrome and common mental disorders among community-based health agents. *Revista De Saúde Pública*, *42*, 921–929.

Singh, D., Negin, J., Otim, M., Orach, C. G., & Cumming, R. (2015). The effect of payment and incentives on motivation and focus of community health workers: Five case studies from low- and middle-income countries. *Human Resources for Health*, *13*(1), 58. https://doi.org/10.1186/s12960-015-0051-1

Smith, S., Deveridge, A., Berman, J., Negin, J., Mwambene, N., Chingaipe, E., … Martiniuk, A. (2014). Task-shifting and prioritization: A situational analysis examining the role and experiences of community health workers in Malawi. *Human Resources for Health*, *12*(1), 24. https://doi.org/10.1186/1478-4491-12-24

Sommanustweechai, A., Putthasri, W., Nwe, M. L., Aung, S. T., Theint, M. M., Tangcharoensathien, V., & Wynn, S. S. (2016). Community health worker in hard-to-reach rural areas of Myanmar: Filling primary health care service gaps. *Human Resources for Health*, *14*(1), 64. https://doi.org/10.1186/s12960-016-0161-4

Sukhanberdiyev, K., & Tikhonova, L. (2019). Kazakhstan: Cooperation between sectors: Nurturing care for early childhood development. https://nurturing-care.org/resources/kazakhstan

Swartz, A. (2013). Legacy, legitimacy, and possibility: An exploration of community health worker experience across the generations in Khayelitsha, South Africa. *Medical Anthropology Quarterly*, *27*(2), 139–154. https://doi.org/10.1111/maq.12020

Swartz, A., & Colvin, C. J. (2015). 'It's in our veins': Caring natures and material motivations of community health workers in contexts of economic marginalisation. *Critical Public Health*, *25*(2), 139–152. https://doi.org/10.1080/09581596.2014.941281

Tomlinson, M., Rotheram-Borus, M. J., le Roux, I. M., Youssef, M., Nelson, S. H., Scheffler, A., … Worthman, C. M. (2016). Thirty-Six-month outcomes of a generalist paraprofessional perinatal home visiting intervention in south africa on maternal health and child health and development. *Prevention Science*, *17*(8), 937–948. https://doi.org/10.1007/s11121-016-0676-x

Trafford, Z., Swartz, A., & Colvin, C. J. (2017). "Contract to Volunteer": South African community health worker mobilization for better labor protection. *NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy*, *27*(4), 648–666. https://doi.org/10.1177/1048291117739529

Tseng, Y.-H., Griffiths, F., de Kadt, J., Nxumalo, N., Rwafa, T., Malatji, H., & Goudge, J. (2019). Integrating community health workers into the formal health system to improve performance: A qualitative study on the role of on-site supervision in the South African programme. *British Medical Journal Open*, *9*(2), e022186. https://doi.org/10.1136/bmjopen-2018-022186

WHO (2018). WHO guideline on health policy and system support to optimize community health worker programmes. World Health Organization.

World Health Organization. (2016). Working for health and growth: investing in the health workforce.

Yousafzai, A. K., Rasheed, M. A., Rizvi, A., Armstrong, R., & Bhutta, Z. A. (2014). Effect of integrated responsive stimulation and nutrition interventions in the Lady Health Worker programme in Pakistan on child development, growth, and health outcomes: A cluster-randomised factorial effectiveness trial. *The Lancet*, *384*(9950), 1282–1293. https://doi.org/10.1016/S0140-6736(14)60455-4

How to cite this article: Laurenzi CA, Skeen S, Rabie S, et al. Balancing roles and blurring boundaries: Community health workers' experiences of navigating the crossroads between personal and professional life in rural South Africa. *Health Soc Care Community*. 2021;29:1249–1259. https://doi.org/10.1111/hsc.13153