



# International Institute for Primary Health Care- Ethiopia

## PRIMARY HEALTH CARE DIGEST

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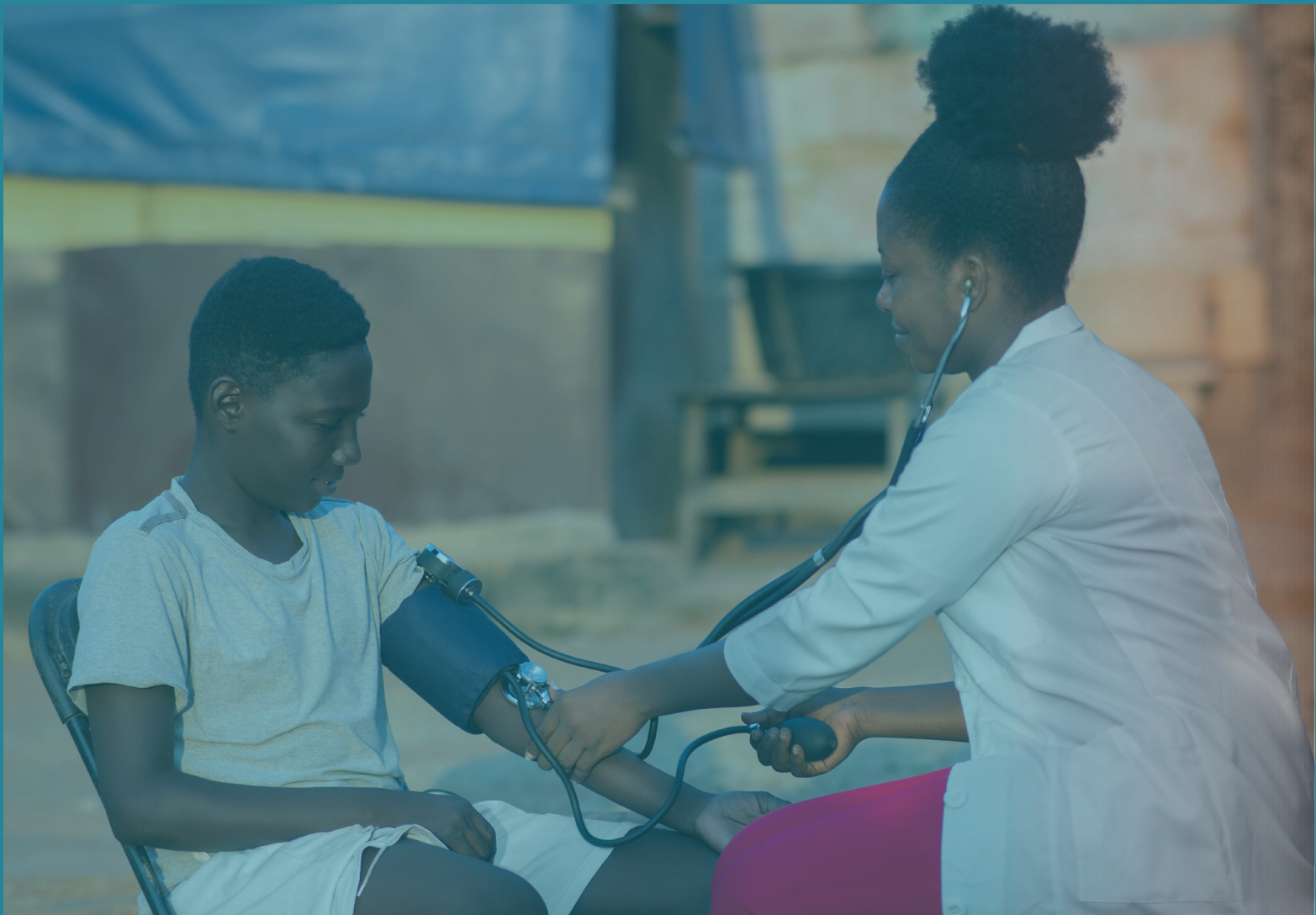
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# INTERNATIONAL INSTITUTE FOR PRIMARY HEALTH CARE - ETHIOPIA

## PRIMARY HEALTH CARE DIGEST

Welcome to the second volume of the International Institute for Primary Health Care-Ethiopia's (IPHC-E) Primary Health Care Digest! The purpose of the Digest is to share the latest news and research on primary health care from Ethiopia.

The Digest covers topics on the role of community health workers in prevention and control of COVID-19, attrition and turnover among community health workers, breast-self-examination practice, mental health in early childhood, and implementation of Workload Indicators of Staffing Need (WISN) method to measure community health worker's workload.



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# ROLE OF COMMUNITY HEALTH WORKERS IN PREVENTION AND CONTROL OF COVID-19 IN ETHIOPIA

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## Introduction

Pandemics historically have been more devastating than any other sort of disaster due to their worldwide spread causing significant morbidity and mortality. In the past few decades, the world has experienced severe acute respiratory syndrome (SARS) (2003), H1N1 influenza (2009), Middle East respiratory syndrome (MERS) (2012), Ebola (1976), Zika virus (1952) and the most recent pandemic, COVID-19 (2019). To maximize community well-being and lessen pain in facing pandemics, disasters preparedness and response are necessary (1).

The first cases of COVID-19 were reported in Ethiopia on 13 March 2020. In order to limit the potential risk of COVID-19 the government implemented a number of strategies including public health emergency response and declaring a state of emergency. It has set up well-organized national preparedness and response coordination bodies through the emergency operation center (EOC) and others including the National Disaster Risk Management council led by the Deputy Prime Minister's Office, Public Health Emergency Management (PHEM) led by MOH, the PHEM Technical Taskforce led by the Director General of EPHI and PHEM Technical Working Group led by the national incident manager. These structures were cascaded to the regions depending on their context. The structures incorporated multi sectorial national task forces and technical experts for supporting and guiding implementation of the response (2). The Ethiopian Public Health Institute (EPHI) has conducted rapid risk assessments, produced national COVID-19 guidelines, and aided in improving early warning and monitoring systems. In addition to this, in collaboration with the Federal Ministry of Health, UN agencies, World Health Organization (WHO) and implementing partners, EPHI created a scenario-based national COVID-19 emergency preparedness and response plan (EPRP) (3). During this time community health workers (CHWs) have been in the frontline for intensifying the response at community level and continued to provide vital health services to communities while many healthcare facilities were burdened (4).

## Role of community health workers (CHWs)

As part of a well-functioning health system, CHWs who are equipped, trained, and supported can help prevent a pandemic. During the COVID-19 pandemic, multiple public health responses have been incorporated into the prevention and control program. Despite the increased burden, CHWs continued to provide routine services in addition to undertaking additional responsibilities with regards to COVID-19. In low-income countries CHWs played a major role in fighting COVID-19 by participating in creating awareness among communities on disease prevention measures such as hand-washing and use of personal protective equipment (PPE), risk communication, community

engagement, contact tracing and monitoring, supporting referral surveillance for early case detection, vaccination and providing home based care for those in quarantine (5) (6).

In Ethiopia, risk communication and community engagement (RCCE) are two of the most critical modalities to reduce the effect and spread of COVID-19 (2). The main strategy of RCCE development in Ethiopia is to enable each person, families, and communities to adopt preventative and health-seeking behaviors that will stop the spread of COVID-19 (7). In addition to home visits, an important element of the routine work of community health workers, CHWs in Ethiopia played a major role to mitigate COVID-19 effects by providing services such as health education and promotion that mainly on awareness creation and promotion of the “new normal habits”. They maintain essential health services, educate the public about COVID-19 measures, prevention mechanisms and PPE, encourage the community to be vaccinated, and advocate regular medical check-ups and immunizations. CHWs also assist with community-based surveillance for early case detection by temperature checks and contact tracing (2) (8). This underscores that community health workers are vital in ensuring appropriate access to the services mentioned above if they are provided with consistent training and supervision, essential commodities, and PPE (9).

## Community health program in Ethiopia

Ethiopia’s main health initiative, the health extension program (HEP), has practically provided basic health care to the country’s largely rural population. The program has been delivering a wide spectrum of preventive and therapeutic services to meet the increasing demand for services through enhancing access to basic health services at the grass root level. This program employed more than 40,000 CHWs called health extension workers (HEWs) across the country, the majority of which were women (10). CHWs are essential for involving communities and improving the community’s ability to control the spread of disease during pandemics. The community health program is supported by other groups of CHWs including the women development army (WDA). During previous emergencies, CHWs functioned as a link between the community and health services, as well as facilitators of community health engagement (11) (12). In addition to this, CHWs offer a variety of services and information related to reproductive, maternal, child, and basic health care (13).

## Challenges of CHWs

In pandemics like COVID-19, CHWs function under difficult conditions, such as having inadequate supervision and support and potential antagonism from communities and/or facility-based providers (14). Furthermore, the safety of CHWs and their families may be jeopardized without training on ways to limit exposure to the virus SARS-COV-2, as well as with inadequate supply of PPE (15). Another issue that CHWs are confronted with during pandemics is stigma and discrimination since people fear that they may contract the virus from CHWs (15)(16).

## Lessons learned

After a few months of the pandemic it was observed that the health workforce in Sub-Saharan Africa had been insufficiently prepared (17), underscoring the importance of CHWs and the program.



Studies have shown that it was difficult to put immunization programs into action in 60% of countries in Africa due to shortage of health care workers (18).

Recognizing that health emergencies affect the entire society, including its socioeconomic system, prioritizing known capacity gaps among countries, leveraging health information for immediate action, recognizing the interconnectedness of the health system and emergency preparedness, investing in healthcare infrastructure and workforce, providing improved training and material support for community health workers and other frontline health workers are among the major lessons learned from COVID-19 experience (19).

In conclusion, our previous experience reminded us that CHWs play a crucial role in bridging the health system and the community's health needs. Therefore, it is recommended that Ministry of health, EPHI and other stakeholders work towards building the capacity of CHWs by providing adequate training and supervision to ensure that their skills are updated and the challenges are addressed.

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# WHAT FACTORS AFFECT MOTIVATION, TURNOVER INTENTION, AND ATTRITION AMONG CHWS' IN ETHIOPIA?

David Codington

## Introduction

Turnover intention is defined as “an employee’s expressed intention of leaving their current job in the near future” (1). Labor market research supports the finding that intention predicts behavior, which has important implications for policymakers and professionals working in human resources for health (HRH) (2). Additionally, turnover intention can manifest as lateness or absenteeism, affecting performance (1). While the literature suggests that annual attrition rate of health extension workers (HEWs) in Ethiopia is low, around 3% (3,4), turnover intention is 39.5% nationally (2) and as high as 52% in parts of Oromia (1), and the attrition rate is increasing (4, 5). This article reviews why this might be the case.

## Methods

A concept-building search technique was used to identify research articles in PubMed (MEDLINE, PubMed Central). A search including four key concepts (Ethiopia, community health workers, turnover intention or retention/attrition, and determinants) yielded 87 articles, of which 13 were relevant. The 74 excluded articles were excluded because they were primarily about job satisfaction (n=5), because they focused on a cadre other than community health workers (n=13), or because the topic was not relevant (n=56). None of the 87 articles were systematic reviews. The articles referenced were all published since 2010. Most (n=11) were published between 2015 and 2022. Sidama, Afar, Somali, the South West Ethiopia Peoples’ Region, Harari, Gambela, and Benishangul-Gumuz were the regions least represented in the research. This may be due to the recent establishment of some of these regions, namely Sidama in June 2020 and the South West Ethiopia Peoples’ Region in November 2021.

## Key Findings

Studies repeatedly identified both material and non-material, intrinsic and extrinsic, financial and non-financial factors as important determinants of motivation and turnover intention among HEWs (6, 4). Different categories have been used to discuss these factors, such as psychosocial, administrative or organizational, incentive- and career-related, aspects of the working environment, and systemic factors (2, 7). This article divides factors broadly into material and non-material.



## Material factors

Material factors affecting turnover intention and motivation include salaries, resources (equipment, tools, and supplies), the condition of health facilities, means of transportation, difficult “topographical conditions”, and other incentives (5,6, 3, 8, 1, 2). A study on indicators of motivation found that satisfaction with financial incentives and facility resources was persistently low in the 2000s (6).

## Nonmaterial factors

The nonmaterial factors driving turnover intention and demotivation include a lack of support and validation from supervisors, poor rapport with the community, burdensome distance between the workplace and their families, burdensome workload, unreasonable expectations of community members, lack of career advancement opportunities, and lack of educational opportunities (4, 5, 9, 8). One study found social factors to be more important for retaining HEWs than material or financial factors (4). These social factors are complex and dynamic, requiring careful attention to understand how these impact HEWs. For example, some HEWs have reported that their supervisors have a fault-finding attitude and micromanage them, indicating a need for supportive supervision and possibly changes in governance (9). Another dynamic is that HEWs may be asked by government officials to be involved in activities beyond their scope of work, such as politics, with the potential consequence of burdening HEWs and creating mistrust between the community and HEWs (9). Social identity is incredibly important to HEWs, involving interpersonal relationships and group membership, and has great potential to impact the rising rate of attrition (4).

One study looking at motivation among close-to-community health workers (CTC providers) in six countries, including Ethiopia, identified community commitment, organizational commitment, job satisfaction (including things like the quality of supervision, logistical support, resources and remuneration), and work conscientiousness as common and reliable indicators of motivation among CTC providers (10).

There is also literature assessing the factors that affect motivation of members of the volunteer CHW network in Ethiopia. Rapport with the community, a sense of having made an impact, personal growth and development opportunities, and opportunities for training and continuing education have been shown to improve motivation. Lack of support and validation from supervisors tend to demotivate (7, 11).

## Support for the influence of material and non-material factors

- A discrete choice experiment (DCE) study published in 2021 enlisted 198 HEWs and found that annual training opportunities, a supportive management style, and good facility quality were the most preferred job attributes, while salary, management style, and workload had the greatest potential to demotivate HEWs (3).
- A study among 245 HEWs in Oromia found that opportunities for greater educational achievement, higher salaries, and career advancement were pull factors driving turnover intention. Push

factors included a high workload as well as lack of incentives, resources, career opportunities, and motivation (1).

## Characteristics of HEWs predicting turnover intention and attrition

A study among 245 HEWs in Oromia found that 52% had turnover intention, associated with level of education, marital status, age, and length of service. Turnover intention was higher for those with level III education (69.5%) compared to those with level IV education (30.5%); higher for those married (61.7%) compared with singles (14.8%); higher among 26–30-year-olds (40.6%) compared with other age groups; and highest among those with 10+ years of service (34.3%) (1).

A national study that measured attrition rate over the course of the health extension program (HEP) (2004-2019) found that average attrition rate was highest among 25–29-year-olds (22.5%), diploma/degree holders (33.5%), those married (21.7%), those with a family size of 1–3 (21.9%), those without a certificate of competency (COC) (32.4%), those in pastoralist woredas (31.9%), and those who had not taken annual leave since hiring (21.5%) (2).

## Priority actions and interventions

- Policymakers and practitioners can adopt a variety of non-financial, pro-social policy interventions to address dynamics of social identity that impact attrition, including (4):
  - Providing supportive supervision and mentorship to improve HEW motivation and credibility. Validate and acknowledge HEWs in their skills, position, and role, providing actionable feedback where needed.
  - Identify causes of lack of trust in or low community acceptance of CHWs. Address these causes. For example, some communities may prefer CHWs who are female. Some may prefer CHWs who are from the community (though this varies due to concerns about confidentiality). Recognition through IDs and uniforms may encourage trust, as well. Additionally, if HEWs can deliver quality and timely services—dependent on the availability of trainings, equipment and tools, supplies, quality of health infrastructure, and transportation—rapport and trust with the community is also likely to increase.
  - Allow HEWs (particularly those with families) to be placed in or near their communities to be able to see their families or consider providing opportunities to transfer from one health post to another.
- Provide routine opportunities for training and education.
- Provide opportunities for career advancement for HEWs and remove barriers to existing advancement opportunities, such as overly difficult exams and exams only in English (4 9).
- Consider ways to lighten the workload for HEWs where they report feeling overworked. If this is not possible, consider changing the incentive mechanisms, such as by providing overtime pay (1), but do so only if economically and socially advisable. Assessing whether HEWs are, in fact, overworked, is important before introducing new or altered incentive mechanisms.

- Provide equipment, tools, and means of transport to facilitate the work.
- Renovate health infrastructure so that HEWs can achieve their work and feel motivated.
- Where salaries are difficult to maintain for HEWs, consider alternate monetary incentives such as tax cuts and land donation (3).
- Identify non-financial incentives that can be used to improve retention of volunteers (7).
- Note that there is little or mixed evidence that quality improvement programs impact HEW motivation (12).

## Program implications

- Several scales have been validated for use in measuring motivation among HEWs, including the CTC Provider Motivational Indicator Scale (10) and the Health Extension Workers Job Motivation Scale (13). These may be used in programs seeking to measure and address motivation and job satisfaction among HEWs.

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# PRACTICE OF BREAST SELF-EXAMINATION IN ETHIOPIA – A NEGLECTED SCREENING TECHNIQUE

**Mohammed Abseno (MD, MPH)**

Breast Self-Examination (BSE) is the regular checkup of both breasts by the woman herself at the time of ovulation of each menstrual cycle after the age of 20 years (1). Reports showed that breast cancer is a leading cause of morbidity and mortality in women around the globe (2). According to the estimates by Global Cancer Incidence, Mortality and Prevalence (GLOBOCAN), about 18.1 million new cancer cases and 9.6 million cancer deaths occurred in 2018. Breast cancer is the leading cause of cancer deaths for females (3). In Ethiopia, although it is reported that data was not encountered regarding nationwide population-based study on cancer except for Addis Ababa, it is estimated that cancer accounts for 5.8% of the total national mortality with the annual incidence of about 60,690 cases and the annual mortality of over 44,000. Regarding cancer specific prevalence rates among the adult population in Ethiopia, breast cancer (30.2%), cervical cancer (13.4%), and colorectal cancer (5.7%) are the most prevalent cancers (4).

This article is intended to show the gaps in knowledge and practice among women in Ethiopia and the importance of BSE for early detection of breast cancer. BSE when performed regularly is a simple and free method in which women's confidentiality is protected and which can be performed alone at home for the screening of breast cancer. Therefore, it is recommended that women aged  $\geq 20$  years should practice BSE. However, although the benefits of regularly performed BSE are well explained, few women are interested in this practice (5).

In Ethiopia, a lot of studies on BSE that have been encountered by searching the web focused mostly at university students, health facilities and at a community level. Several of the studies used cross-sectional design and mainly assessed knowledge and practice of BSE among women. The impressions left in mind are summarized here although detailed data descriptions are left for the reader by searching and referring the manuscripts from the citations.

An interesting finding in some articles among health care providers indicated that there is a gap in BSE practice although the level of knowledge was found to be good. For example, a study done by Aragaw et al. among female health care workers at Debre Tabor Comprehensive Specialized Hospital indicated that although 79.7% of the participants had good knowledge about breast cancer early detection methods, only 42.1% of them practiced BSE regularly (6). Other studies among female health care workers also showed that only a small proportion of females practice BSE regularly. In some facilities, they experience BSE at an irregular basis. Regarding knowledge, female health care workers have good knowledge compared to other community members (7, 8). A good number of studies were also done among different female university students which also revealed that most of the study participants do not have good knowledge and BSE practices (9, 10). Factors associated with BSE in collective terms from some of the references included personal or family history of breast cancer, having perceived good confidence to do BSE, having good perceived susceptibility

to develop breast cancer, urban residency, having knowledge of BSE, positive attitude, and ever taught or provided awareness creation about BSE to a client (9, 11, 12)

In conclusion, breast cancer is one of the most important diseases both globally and in Ethiopia. Among the three screening methods (BSE, regular clinical checkup by physician, and mammography), BSE has no cost, keeps confidentiality, and is an effective method of early detection of breast cancer. However, BSE is a neglected practice even among female health care providers. Hence, awareness creation activities using different communication tools should be implemented in order to create good acceptance.

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# MENTAL HEALTH IN EARLY CHILDHOOD PSYCHOSOCIAL DEVELOPMENT

**Hanna Wendatir (MPH)**

Health is more than just the absence of disease (1); it is an ever-evolving human resource that supports children's and adults' ability to successfully engage with their environment, adjust to the stresses of daily life, and fight off infections and other illnesses. Children's health, in other words, is a nation's wealth since it increases children's potential to acquire a variety of skills needed to succeed as productive members of society (2). Early childhood is defined as the period from prenatal development to eight years of age. What a child experiences during the early years sets a critical foundation for the entire life course (3).

Like physical health, positive mental health promotes success in life. As defined by the Centers for Disease Control and Prevention (CDC), "Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood" (4). Early childhood is a period of rapid brain growth as well as the development of various biological systems of the body that are essential for good health. A child's experiences and surroundings have a significant impact on both their immediate growth and eventual functionality when these systems are developing early in life. These effects may start to show up early and become more pronounced as kids become older and grow into adolescence and adulthood (2).

Positive early childhood experiences not only impact the architecture of the developing brain, but create the groundwork for good mental health across the life course (5). Disruptions to this developmental process during childhood can have long-term consequences on an individual's ability to learn and relate to others, and go onto live healthy, well and empowered lives. By strengthening children's early connections and experiences, countries can effectively mitigate and address many costly downstream problems, such as incarceration, homelessness, and failure to complete high school (6). Therefore, it's critical to address mental health issues in young children in the context of their families, homes, and communities.

The functioning of their caregivers and the families in which they reside has a direct impact on the emotional well-being of young children. Poor connections are a powerful risk factor for the development of early mental health disorders among children when they are in environments that are abusive, threatening, chronically negligent, or otherwise psychologically destructive (7). When relationships are consistently responsive and supportive, on the other hand, they can actually protect young children from the negative consequences of other stressors. As a result, lowering the stressors that children face necessitates tackling the stressors that their families face (8).

A study in US shows one in five children and teenagers has a diagnosable emotional, behavioral, or mental health condition, and one in ten young people has a mental health challenge severe enough to affect their ability to function at home, school, or in the community, addressing mental health needs at school is vital. Despite the fact that mental illness affects one-half of our children aged 6 to 17, several estimates suggest that as many as 80 percent of them do not receive the mental health care they require (9,10).

Schools are the best place to find, manage, and help kids with mental health issues progress (11). An increasing body of research shows that integrating mental health supports and services into the classroom is a successful method of delivering child mental health programs. There are many advantages to providing mental health treatments in schools, including increased access to care for many more kids (11), increased treatment adherence and participation, early problem identification, reduced effects of mental health conditions (12), decreased stigma among kids and their families, and favorable effects on academic and psychosocial functioning (13).

Prior to the COVID-19 pandemic, 13–22% of school-aged youth experienced a mental health challenge at a level associated with formal diagnoses (14). Researchers estimate that 80% of those children and youth have unmet treatment needs (15). Unmet needs may result in social, emotional, or behavioral challenges. In the absence of effective support, these children and students may experience reactive and exclusionary discipline practices (e.g., suspensions, expulsions) that further exacerbate mental health concerns, interrupt access to and participation in learning, limit opportunities, and negatively affect outcomes. The COVID-19 pandemic exacerbated this mental health crisis, accelerating the need to provide school mental health support at an even larger scale to meet the needs of our nation's youth. Research on the effects of prior pandemics and disasters clearly indicates that there will be both immediate and long-term adverse consequences for many children (16).

There is a desperate need for developed countries and non-governmental organizations based in those countries to help developing countries train personnel such as child psychiatrists, psychologists, and psychiatric nurses who are interested in treating psychologically and mentally handicapped children (17). Children in Africa have been exposed to even higher hazards with school closures, increasing exposure to violent conflicts, and a lack of opportunity to play and socialize with their peers. Long-term lockdowns during COVID-19 are said to have increased early marriage, teen pregnancies, and sexual and domestic abuse against youngsters, particularly females (18).

Up to 23% of Ethiopian children are reported to have mental health issues, and while mental health services for adults are sparse in Ethiopia, similar programs for children are essentially non-existent (19). It is typical to observe a dearth of precise information about Ethiopia's systems of assessment and intervention for mental health illnesses in a number of mental health status reports. Cultural variables play a role in the difficulty of accurately assessing the incidence of mental health issues and offering professional services (20). The difficulty stems specifically from the widespread belief among Ethiopians that serious mental illnesses like schizophrenia and mood disorders have spiritual roots.

There are difficulties for mental health practitioners in their counseling practice as a result of the

study's assertion that "culture misconceptions" about mental illness' origin as a curse exist (21). Additionally, informal interactions and spiritually-oriented care are frequently used to manage mental health conditions including depression and anxiety. People frequently opt for spiritual healers and religious authorities over professional assistance. This has reduced the chances for early detection of depression symptoms that could have led to supporting people who had suicide thoughts (20). Furthermore, the lack of mental health professionals at primary health care facilities adds to the difficulty of obtaining accurate early identified symptoms.

To promote child mental health, public health practitioners must develop linkages with the mental health and primary care populations. Furthermore, increased relationships must encompass schools, juvenile justice systems, youth development programs, and, most crucially, families' roles (22). In addition, children—as well as their parents and families—need a network of support. They require a support structure and broader sociopolitical setting that promotes healthy parent-child relationships and attachments, high-quality care and educational opportunities in all settings, and prompt, appropriate, and efficient assistance when issues arise (14). If we as a society are to really value children, we must all work together to guarantee that their social and economic environments especially during pregnancy and the early years of childhood do not damage their health and wellbeing and restrict who they are and what they can become.

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# IMPLEMENTATION OF THE WORKLOAD INDICATORS OF STAFFING NEED (WISN) METHOD TO MEASURE COMMUNITY HEALTH WORKER'S WORKLOAD

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Health workforce is critical for health systems to function optimally towards equity and universal health coverage. Effective service coverage is also dependent on health workers' availability, accessibility, acceptability and quality (1). For this, the global strategy on human resources for health focuses on substantive and strategic investment in the global health workforce (1). Workload Indicators of Staffing Need (WISN) is one of the recommended methods to be used while implementing the global strategy.

The WISN method is a human resource management tool that assess the workload pressure on the health workers in a facility, and determines how many health workers of a particular type are required to cope with the workload of a given health facility. The method provides guidance for health managers on how to analyze and calculate the health workers' workload to derive health worker requirements in health care facilities (2).

Implementation of the WISN method follows eight steps (2):

1. Determining priority cadre(s) and health facility type(s);
2. Estimating available working time;
3. Defining workload component, including health service activities, supportive activities, and additional activities;
4. Setting activity standards: This is the time necessary for a well-trained, skilled

and motivated worker to perform an activity to professional standards in the local circumstances;

5. Establishing standard workloads: A standard workload is the amount of work within a health service workload component that one health worker can do in a year;

6. Calculating allowance factors: This takes into account supportive and additional activities for which routine data are not collected unlike the health service activities;

7. Determining staff requirements based on WISN: This is done considering health service activities, supportive activities, and additional activities;

8. Analyzing and interpreting WISN results: The results are analyzed in two ways:

- **Difference:** Comparing the difference between current and required staffing levels. This will identify the health facilities that are relatively understaffed or overstaffed.
- **Ratio:** Using the WISN ratio as a proxy measure. This will assess the work pressure that health workers experience in their daily work in a health facility.

The WISN method is simple to operate and leverages existing service statistics (2, 3). The difference between the actual and calculated number of health workers shows the level of staff shortage or surplus for the particular staff category and health facility type for which WISN



have been developed (2). Although the WISN method is applicable to staffing decisions at all health service levels and to any type of health worker, so far, the WISN method has been used mainly for medical doctors, nurses, pharmacists and midwives in hospital settings; and the implementation of this tool for community health workers appears very limited (3, 4).

The workload of CHWs has been a concern for health managers as it affects their productivity and service quality (5). Although workload can be assessed in terms of perceived workload as reported by CHWs themselves, an objective measure of workload pressure in terms of number of staff required for a given task would be more informative for program decisions. Given the ideal number of tasks that can be implemented by a CHW is still unknown (5), implementing WISN method to measure CHWs' workload could give an insight to solve this gap. In addition, when the method is implemented in primary health care units that encompasses different type of health workers, it could inform health program managers whether task shifting strategy would be required or the task shifting strategy is increasing a workload for the other category of health workers within the units.

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