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FACTORS INFLUENCING PROVIDER PERCEPTION OF WORKLOAD AND IMPACT ON INTEGRATED HEALTH CARE

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CONTENTS

EXECUTIVE SUMMARY **I**
METHODOLOGY I
KEY FINDINGS I
KEY RECOMMENDATIONS 3

INTRODUCTION **5**
HEALTH SERVICES INTEGRATION 5
CONCEPTUAL FRAMEWORK 6
STUDY QUESTIONS 7

METHODOLOGY **8**
STUDY AREA 8
STUDY DESIGN AND TARGET POPULATION 8
SAMPLE SIZE AND SAMPLING 8
DATA COLLECTION PROCEDURE 9
DATA ANALYSIS 9
QUALITATIVE ASSESSMENT 9
STRUCTURED DOCUMENT REVIEW 11
ETHICAL CONSIDERATIONS 11
LIMITATIONS 11

RESULTS AND DISCUSSION **12**
RESPONSE RATE 12
BACKGROUND CHARACTERISTICS OF HSPS 12
HSP KNOWLEDGE, ATTITUDES, AND PRACTICES 14
HSP TRAINING 15
HSP CAPACITY TO PROVIDE INTEGRATED SERVICES 17
HSP MOTIVATION TO PROVIDE INTEGRATED SERVICES 18
PROVISION OF MALARIA, NUTRITION, AND FP SERVICES AT RCH AND CTC CLINICS 19
TASKS PERFORMED DAILY BY HSPS 20
DRIVERS OF WORK ALLOCATION 21
TASK-SHIFTING AND TASK-SHARING PRACTICES 21
HSPS' PERCEIVED WORKLOAD AND ASSOCIATED REASONS 24
REASONS CITED FOR HEALTH SERVICE PROVIDERS' OVERLOAD 26
FACTORS AFFECTING HSP PERCEIVED WORKLOAD 27

RECOMMENDATIONS **28**

BIBLIOGRAPHY **30**

ANNEXES **31**
ANNEX 1: RESULTS TABLES 31
ANNEX 2: QUESTIONNAIRE FOR HEALTH CARE PROVIDERS (QUANTITATIVE) 52
ANNEX 3: IN-DEPTH INTERVIEW GUIDE FOR HEALTH CARE PROVIDERS 64

ANNEX 4: KEY INFORMANT INTERVIEW GUIDE FOR CHMT MEMBERS 68
ANNEX 5: CASE MANAGEMENT FORM 73

FIGURES AND TABLES

FIGURES

FIGURE 1: CONCEPTUAL FRAMEWORK 7
FIGURE 2: SERVICE OUTLETS AND LEVELS OF HEALTH FACILITIES AT WHICH HSPS WORK 14
FIGURE 3: AWARENESS AND EXPERIENCE IN INTEGRATED SERVICE 15
FIGURE 4: TRAINING RECEIVED BY THE HSPS 16
FIGURE 5: PROVISION OF INTEGRATED SERVICES AT CTC AND ANC/PNC OUTLETS 20
FIGURE 6: OVERALL PERCEIVED WORKLOAD BY HSPS 24
FIGURE 7: REASONS HSPS CONSIDER THEIR DAY AS LOADED 27

TABLES

TABLE 1: SAMPLING PROPORTIONAL TO THE NUMBER OF HSPS PER REGION 8
TABLE 2: SAMPLE SIZE (NUMBER OF STAKEHOLDERS) FOR THE QUALITATIVE COMPONENT 10
TABLE 3: BACKGROUND CHARACTERISTICS OF HSPS 12
TABLE 4: SERVICE OUTLETS AND LEVELS OF HEALTH FACILITIES AT WHICH HSPS WORK **ERROR! BOOKMARK NOT DEFINED.**
TABLE 5: AWARENESS AND EXPERIENCE IN INTEGRATED SERVICE PROVISION **ERROR! BOOKMARK NOT DEFINED.**
TABLE 6: TASK SHIFTING PRACTICES 22
TABLE 7: TASK SHIFTING OR SHARING 23
TABLE 8: PERCENTAGE OF HSP PERCEIVED WORKLOAD BY DAY OF THE WEEK 25
TABLE 9: PERCEIVED FACTORS AFFECTING HSP WORKLOAD 27
TABLE 10: SUMMARY FINDINGS AND RECOMMENDATIONS 28
TABLE 11: INTEGRATED SERVICES PROVIDED 31
TABLE 12: INTEGRATED SERVICES PROVIDED BY FACILITY LEVEL 32
TABLE 13: HSP'S PERCEIVED CAPACITY TO PROVIDE INTEGRATED SERVICES (N=426) 33
TABLE 14: HSP MOTIVATION TO PROVIDE INTEGRATED SERVICES (N=426) 35
TABLE 15: TASKS PERFORMED DAILY ON AVERAGE – ONE-MONTH RECALL (N=426) 38
TABLE 16: PERCEIVED HSP WORKLOAD BY SELECTED CHARACTERISTICS (N=426) 39
TABLE 17: AWARENESS ABOUT THE INTEGRATION OF SERVICES 40
TABLE 18: EVER LEARNED TO PROVIDE FP, MALARIA, AND NUTRITIONAL SERVICES AT ANC/PNC AND CTC PLATFORMS 41
TABLE 19: PROVIDE INTEGRATED SERVICES ON USUAL PRACTICE 43
TABLE 20: A DAILY GUIDE FOR TASK SCHEDULING BY HEALTH FACILITY LEVEL 44
TABLE 21: DISTRIBUTION OF REASONS FOR SAYING THE DAY IS LOADED BY FACILITY LEVEL 45

TABLE 22: A DAILY GUIDE FOR TASK SCHEDULING BY SERVICE OUTLET 46
TABLE 23: DISTRIBUTION OF REASONS FOR SAYING THE DAY IS LOADED BY SERVICE OUTLET 47
TABLE 24: TASK SHIFTING/SHARING BY SERVICE OUTLET 48
TABLE 25: HSP PERCEIVED WEEKLY WORKLOAD BY FACILITY LEVEL (N=426) 49
TABLE 26: HSP PERCEIVED WEEKLY WORKLOAD BY SERVICE OUTLET 50

ABBREVIATIONS

ANC	Antenatal Care
ART	Antiretroviral Therapy
BA	Boresha Afya
BEmONC	Basic Emergency Obstetric and Newborn Care
CECAP	Cervical Cancer Screening and Prevention
CHMT	Council Health Management Team
CIRCLE	Coordinating Implementation Research to Communicate Learning and Evidence project
CTC	Care and Treatment Clinic
DACC	District AIDS Control Coordinator
DE	Developmental Evaluation
DRCHCos	District Reproductive and Child Health Coordinators
FPGBV	Family PlanningGender-Based Violence
HIV	Human Immunodeficiency Virus
HSP	Health Service Provider
IDI	In-Depth Interview
IPD	In-Patient Department
KAP	Knowledge, Attitudes, and Practices
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
mRDT	Malaria Rapid Diagnostic Test
OPD	Outpatient Department
PNC	Postnatal Care
PORALG	President's Office for Regional and Local Government
RCH	Reproductive and Child Health

SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
USAID	U.S. Agency for International Development
WHO	World Health Organization

DEFINITION OF TERMS

The following terminologies have been adopted for this study.

- **Client waiting time**: Average time a client spends before being seen by a health service provider (HSP) after being seen at the registration desk. This study does not objectively measure this variable as it is well documented in a separate case study on Analysis of Client Waiting Time and Satisfaction.

- **Clinical vs non-clinical tasks**: Clinical tasks refer to activities such as client screening, history taking, counseling, providing prescriptions, and documentation of information after provision of health services, which require the exercise of clinical judgment concerning client care (direct client contacts). Non-clinical tasks include administrative tasks and others that do not involve direct client contact. This study assumes that if HSPs spend more time doing clinical vs. non-clinical tasks, consistency in the provision of integration services will likely improve.

- **Integration of services**: This study assesses integration of services with respect to the provision of family planning counseling and methods, malaria services (counseling/screening/mRDT), and nutrition services (weight/height measurement/nutrition supplements) into the primary services offered within care and treatment clinic (CTC), antenatal care (ANC), and postnatal care (PNC) outlets.

- **Perceived workload**: This refers to subjective and psychological workload experienced by HSPs. This study assesses HSP perceived workload in terms of a five-point scale: 5 will indicate much higher workload, 4 higher workloads, 3 is normal, 2 is lower workload, and 1 represents much lower or no workload.

- **Provider's day shift**: This is an official working day for HSPs, from 7:30 am to 3:30 pm, excluding break time.

- **Provision of integrated services**: This refers to the organization and management of health services to ensure that people get the care they need when they need it, achieving the desired results and providing value for money. For this study, the provision of integrated health services implies the provision of additional services (malaria services, nutrition, and family planning within the CTC and ANC-PNC clinic) beyond the primary one.

- **Task sharing**: This refers to an expansion of the roles of health providers who can appropriately deliver health services.

- **Task shifting**: This is a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers.

EXECUTIVE SUMMARY

The USAID Coordinating Implementation Research to Communicate Learning and Evidence (CIRCLE) project supports real-time collaborative learning and adaptation of the USAID Boresha Afya (BA) project in Tanzania through the implementation of a developmental evaluation. As part of the developmental evaluation, in 2021 CIRCLE studied perceived workload among health providers at 66 high-volume BA-supported facilities in Iringa, Dodoma, and Mara regions. The purpose was to explore how health service providers' (HSPs') perceived workload influences their provision of integrated health services. To isolate the influence of perceived workload on integrated health services provision, the study controlled for factors such as knowledge about integrated health services and HSP motivation. Results provide some indication of HSPs' needs and priorities for improving workload management and the provision of integrated health services. The study findings were contrasted with findings from an earlier case study on client satisfaction with respect to perceived wait times. The following questions guided the study design and data analysis:

- How much do HSPs know about the provision of integrated services?
- How do HSPs perceive workload as affecting the provision of integrated services?
- What are the operational, contextual, and behavioral "drivers" used by HSPs to allocate time for different time blocks in a day shift?
- How do task-shifting or task-sharing practices affect perceived workload?
- What are the providers' priorities and needs to improve service integration and workload moving forward?

METHODOLOGY

A knowledge, attitudes and practices (KAP) survey was administered to 416 HSPs working at care and treatment center (CTC) and reproductive and child health (RCH) service delivery points of the 66 high-volume Boresha Afya facilities. Additionally, key informant interviews (KIIs) were conducted with 36 service providers and six members of Council Health Management Team (CHMTs) from the three BA regions. Quantitative data were analyzed for descriptive statistics using STATA 15. KII data were transcribed, translated, coded, and analyzed using thematic framework analysis. Both quantitative and qualitative data were synthesized and triangulated to ensure robust findings and conclusions.

KEY FINDINGS

HSPs are aware of and knowledgeable about the provision of integrated health services

Most HSPs said that they were aware of and understood what was meant by integrated health services. About 80% of the HSPs in dispensaries and health centers (80.1% and 80.7%, respectively) claimed awareness and understanding of integrated health services, compared to 77.3% of hospital-based HSPs; and 82.1% of the nurses claimed awareness and understanding of integrated health services compared to approximately three-quarters (74.8%) of the clinicians.

Providers are self-motivated to carry out integrated services and it bolsters their self-esteem to do so. The Client Satisfaction Case Study indicates that clients receiving integrated services appreciate the additional attention and perceive the level of quality of care to be high.

HSPs' capacity to consistently provide integrated health services is limited by perceived high workload and several binding constraints which increase HSPs' workload.

HSPs considered their day as overloaded for two common reasons: having a high number of clients, and staff shortages/with an inadequate number of skilled HSPs. About 53% of HSPs working at CTC ANC and PNC outlets agreed that an "unexpectedly high number of clients limits HSPs' ability to offer integrated services." Similarly, 30% of both clinicians and nurses agreed that "unexpectedly high number of clients limits HSPs' ability to offer integrated services." Although 78% of the HSPs at CTCs are affected by an unexpectedly high number of clients in the provision of integrated services, 73% of them said that no matter what came along their way in the provision of integrated services, they can usually manage the situation. Additional reasons cited for overloaded clinics included offering more than one service per client (47.7%) and having so many reports to compile (31.2%) (non-clinical obligations). Overall, most of the HSPs perceived their workload to be medium (55.4%) or heavy (43.2%).

Standard operating procedures for integrated health services delivery, training and support, as well as for behavioral incentives (especially motivation), enable HSPs to better allocate time to more consistently provide integrated health services.

A leading motivator for HSPs to provide integrated health care is the availability of standard operating procedures (SOPs) for types of integrated services. However, as has been noted in other Boresha Afya Development Evaluation (DE) studies, defined SOPs for a menu of integrated services and how to provide them does not exist. HSPs did say that training and mentorship had helped improve their skills in the provision of multiple services, and had given them confidence in serving clients and allocating time to offer integrated health services. However, the trainings are fragmented among the types of services to be integrated. The data highlight that while the majority of HSPs received training on the provision of different aspects of (or services included in) integrated services, only 27.7% were able to identify that the training was specifically for "integrated services." Providers could not cite being trained on a spectrum of integrated services and what that comprised. Most had been trained on some of the services that are included in integrated services. The majority (96.4%) of the clinicians in this study affirmed that they could find the means and ways to deliver integrated services regardless of their work burden. Just over half (53.1%) felt they had adequate experience and skills to cope with unexpected facility challenges such as shortage of space, unstandardized intrafacility referrals, and commodity unavailability.

HSPs are positively inclined toward and motivated to provide integrated health services

Health service providers were generally inclined and motivated to provide integrated services. Over 80% of 426 HSPs in this study reported that malaria/malaria rapid diagnostic testing (mRDT), nutrition, and family planning (FP) services are integrated within ANC. HSPs also reported that FP services were integrated within CTC (76%), ANC, (81%), and PNC outlets (85%). Among the motivating factors cited for health service providers to continue offering integrated care is time efficiency when multiple services are offered in the same room; improved privacy and confidentiality as clients get multiple services in the same setting; and increased opportunities to expand their knowledge and skills to offer multiple services.

HSPs felt motivated to provide integrated services because it was their responsibility, and they were happy to serve clients and utilize their skills. Consistent provision of integrated health services was seen to be influenced by absenteeism, motivation and job satisfaction, obtaining knowledge, skills, and attitudes, accountability systems, and working conditions, all of which are interrelated. As reported in the case study on client satisfaction and wait times, successful client-provider interaction increased HSPs' self-efficacy to continue providing integrated services despite the challenges HSPs are facing.

HSPs use task sharing and task shifting as strategies to address workload and improve provision of integrated health services.

Health service providers used task shifting as a way to manage staff shortages in the health facilities. Most HSPs (90.8%) reported having been performing additional tasks beyond their normal daily schedule as a result of task shifting. Over three-quarters (78.4%) said task-shifting helps reduce the work burden among clinical staff in facilities with the scarcity of skilled HSPs as some non-clinical tasks are delegated to non-clinical staff. However, more than half of HSPs (52.1%) could not cite policy guidelines to guide task delegation in their facility. Most of those HSPs reported that they opted to skip offering some of the integrated services unless expressly requested by a client when staffing was limited and many clients were waiting.

Addressing operational, contextual, and social behavior constraints that hinder provision of integration were providers' priorities that need to be addressed to further enhance provision of integrated services

Health service providers cited several priorities to improve integrated service provision: (i) address operational drivers such as availability of guidelines and SOPs to guide them in provision of integrated health services, (ii) enhance training and supportive supervision with focus on more guidance of health services integration packages and expectations on their delivery, (iii) address challenges including staffing shortages, inadequate space, and interruptions in provision of supplies and commodities; and (iv) increase leadership, guidance, and supervision from district and regional teams, as well as recognition/incentives.

Similarly, the Client Satisfaction Study indicated that improved processes (e.g. organization of care, scheduling, staffing) for offering integrated services and improving client patient flow could optimize the provision of integrated services.

KEY RECOMMENDATIONS

- MOHCDGEC review/revise and roll out pre-service and in-service training interventions based on service integration demands to ensure all HSPs are trained. This will help simplify work and, over time as HSPs rotate positions, will expedite scale-up of integrated services throughout facilities. Implementing partners and CHMTs ensure that supportive supervision and onsite training includes space reorganization, work organization, and commodity and supply management.

- Address staffing shortages. While this is a larger systemic issue that cannot be addressed quickly, some measures that can be taken that can improve provision of integrated services immediately. Specifically, policy makers and health facility managers should support the scaling up of the following proven workload strategies: (i) MOHCDGEC develop and introduce SOPs for integrated services, (ii) CHMTs supportive supervision include mentorship of health service providers on proper work

organization and prioritization; (iii) MOHCDGEC develop task shifting facility SOPs to enable assignment of non-clinical and administrative tasks to non-medical staff; (iv) Health facility incharges reorganize space where possible to improve patient flow and consistent provision of integrated services; and (v) Implementing partners and CHMT supportive supervision to emphasize commodity management within the service room

- Motivate health providers and build a culture to routinely offer integrated services through; During supportive supervision, CHMT educate providers about benefits of offering integrated services including improved time efficiency; improved privacy and confidentiality for clients; and increased opportunities to expand provider knowledge and skills. MOHCDGEC and CHMTs revise HSP job descriptions to clearly state provision of integrated health services to ensure provider accountability.

- The Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) and the President's Office for Regional and Local Governance (PORALG) with support from USAID, should consider revising existing guidelines on task shifting/sharing to support provision of integrated FP, Malaria and Nutrition services within HIV clinics, ANC and PNC service delivery points. They should then distribute these new guidelines to all health facilities and encourage implementing partners and CHMTs to promote training and orienting all HSPs who provide integrated services.

INTRODUCTION

USAID supports the government of Tanzania through the five-year Boresha Afya project to establish and strengthen integrated primary health services. Boresha Afya is the agency's flagship health program in Tanzania and encompasses three separate awards to consortia of implementing partners in three geographical areas: Jhpiego in the Lake/Western Zone, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) in the North/Central Zone, and Deloitte in the Southern Zone. In addition to supporting health-specific programs, partners design and deploy integrated models that encompass HIV/AIDS; sexual and reproductive health; tuberculosis; malaria; and maternal, newborn, and child health.

USAID commissioned a Developmental Evaluation (DE) of Boresha Afya to strengthen implementation of integrated service delivery. on the DE-generated real-time evidence through a flexible, contextually tailored evaluation design, building and supporting adaptive management practices among the program stakeholders, and catalyzing rapid learning and decision-making to improve the quality, efficiency, utilization, and scalability of integrated health services in Tanzania. The Coordinating Implementation Research to Communicate Learning and Evidence (CIRCLE) project conducted the four-year DE in collaboration with Boresha Afya implementing partners and the Tanzanian government. The CIRCLE project is managed by Social Solutions International, Inc., headquartered in Rockville, MD, and the DE was implemented by its evaluation team in Tanzania. DE is distinguished from conventional evaluation approaches in that developmental evaluators are physically embedded with partners to support real-time evidence generation and continuous engagement with implementers and project stakeholders over the life of the project. DE also is participatory, with evaluators collaborating and co-designing the priorities and framework of the evaluation with stakeholders.

HEALTH SERVICES INTEGRATION

Health service integration is a broad concept that encompasses efforts to coordinate policies, systems, and services to optimize health care coverage, quality, and outcomes. Implicit in integration is the promotion of "people-centered" or "client-centered" care; ensuring that clients' needs and preferences are addressed comprehensively, respectfully and competently across the continuum of care (World Health Assembly, 69. (2016)). Integration at the service delivery level involves one or more of the following characteristics:

- Providing services from one or more types of programs within the context of another service that is traditionally managed and provided separately (e.g., tuberculosis screening within HIV testing and counseling).
- Co-locating an array of health services in the same physical site so clients can receive what they need during the same visit.
- Referring clients horizontally or vertically to other service points, such as between separate facilities or between facility and community or hospital.

Integrated health services are increasingly becoming the standard of care in low- and middle-income countries. Evidence demonstrates that integration in the appropriate conditions contributes to improving quality, efficiency, acceptability, and utilization of services (Armitage, et al., 2009) (Topp, et al., 2018) (World Health Assembly, 69. (2016).

Routine indicator data, collected quarterly by CIRCLE's DE among 66 high-volume facilities, showed that offering multiple health services at one location or service point under the Boresha Afya project has increased uptake of family planning (FP), malaria and nutrition assessment, counseling, and support within HIV care and treatment clinics (CTCs) and at antenatal and postnatal care (ANC-PNC) platforms across the country. However, integration was taking place in an environment in which public health facilities grapple with several policy and structural difficulties. Routine DE facilities assessments show that health providers often cited high workload as an obstacle to consistently providing integrated health services (Baine et al., 2018; Inegbedion et al., 2020; Mohr et al., 2013; Mutemwa et al., 2013; Sweeney et al., 2014).

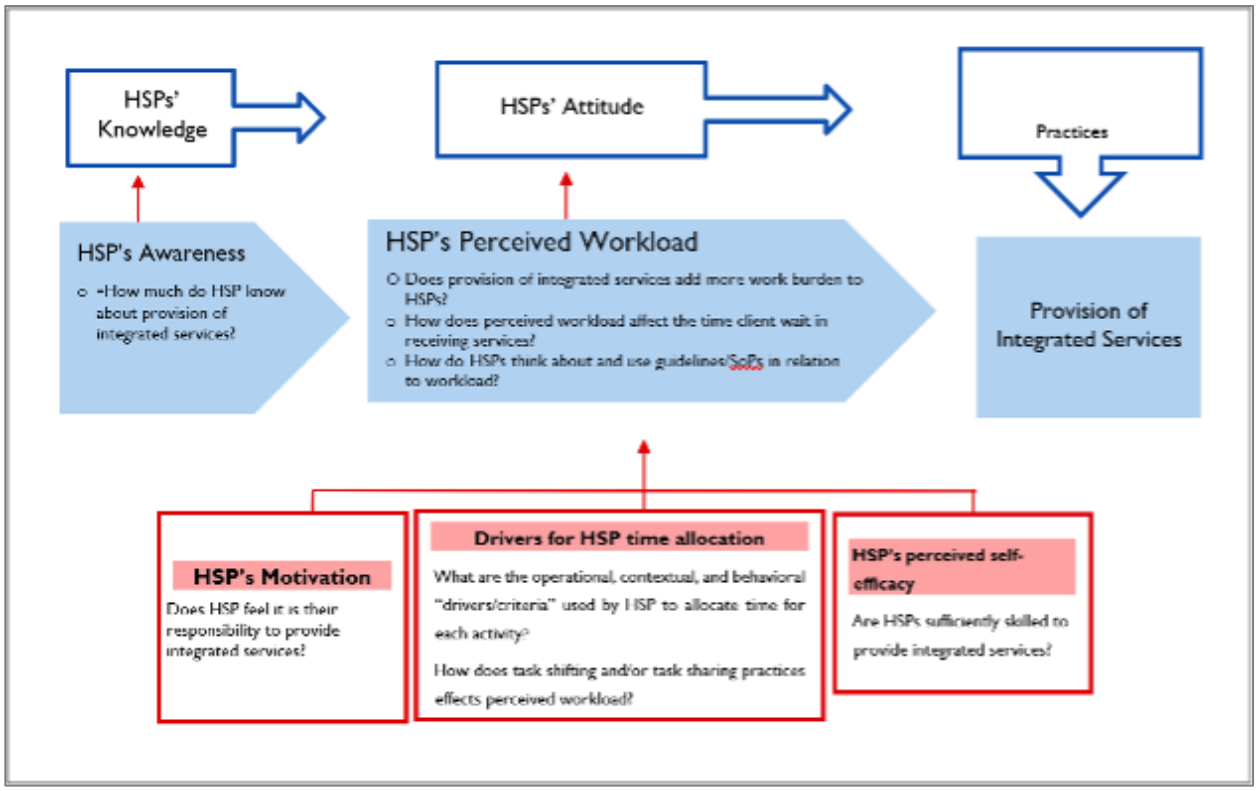
Although perceived workload has often been attributed to a shortage of health professionals, previous DE findings have found that the average staffing at health centers and dispensaries in Boresha Afya-supported facilities meet the recommended minimums by the government, and in some cases (in Mara), exceeds it. Nonetheless, staff shortages have been noted in dispensaries in Iringa; and hospitals in Tabora had the highest level of staff shortages among the three regions. In all regions, the shortage of skilled providers, coupled with high workload contributed to exclusion of family planning counseling, malaria screening, and nutritional assessment at CTCs. Additionally, when staff members were available, their performance was found to be influenced by absenteeism, motivation and job satisfaction, the extent to which they obtained new skills, accountability systems, and working conditions, all of which are interrelated. This study explores and describes the factors affecting health service providers' (HSPs') perceived workload and their understanding and provision of integrated health services, homing in on their priorities and needs to improve health service integration and workload.

CONCEPTUAL FRAMEWORK

The study assumes that several factors influence the provision of integrated services besides perceived workload. These include providers' and health system factors. These factors are described around providers' KAP around the provision of integrated health services (Figure 1). HSPs' awareness, knowledge, motivation, experience and self-efficacy are the perceptions that drive their time allocation and that influence perceived workload (Inegbedion et al., 2020; Mohr et al., 2013). KAP variables affect the provision of integrated health services. Task shifting or sharing, if well implemented, has been shown to facilitate the smooth provision of integrated health services (Naburi et al., 2017), as staff are expected to expand their roles to efficiently provide multiple services.

The study also considered other factors that influence the links from HSPs' knowledge into the provision of integrated services. For example, leadership support at the district and facility level, quality of supportive supervision, enabling environment in terms of infrastructure and logistics, teamwork, coordination, communication, and other Boresha Afya supports may improve providers' capacity to provide integrated services. The availability of health management information system tools (including digital documentation), staffing levels, and adequate commodity supply, space, and management in an integrated setting, may influence providers' perceived workload, which in turn influences their attitudes and practices toward the provision of integrated services (Inegbedion et al., 2020; Mohr et al., 2013; Mutemwa et al., 2013; Sweeney et al., 2014).

Figure 1: Conceptual framework



STUDY QUESTIONS

The following study questions were used to explore factors affecting perceived workload toward the provision of integrated health services and identify providers' priorities and needs to improve service integration at CTCs and RCH clinics in the Boresha Afya-supported health facilities in Iringa, Dodoma, and Mara regions.

1. How much do HSPs know about the provision of integrated services?
2. What are the operational, contextual, and behavioral drivers used by HSPs to allocate their time during a day shift?
3. How do task-shifting or task-sharing practices affect perceived workload?
4. How do HSPs' perceive workload as affecting the provision of integrated services?
5. What are the providers' priorities and needs to improve service integration and workload moving forward?

METHODOLOGY

STUDY AREA

The scope of this study was limited to the three regions of Iringa, Dodoma, and Mara. The study drew from 64 public and two private-owned facilities (33 dispensaries, 25 health centers, and eight hospitals) in 12 councils of the three Boresha Afya supported regions.

STUDY DESIGN AND TARGET POPULATION

The study used a mixed-methods, cross-sectional design, including a provider knowledge, attitude and practice (KAP) survey using a digitized questionnaire, document review, and key informant interviews (KIIs) using interview guides. The study triangulated the findings to ensure that the conclusions were robust and that the recommendations were sound.

The study population for the quantitative survey included randomly selected clinicians and nurses working at the 66 DE-supported health facilities in the three regions. Clinicians included physicians, medical officers, assistant medical officers, clinical officers, and clinical assistants, while nurses included registered nurses, enrolled nurses, nurse officers, and nurse midwives.

The study population for the KIIs included members of the Council Health Management Teams (CHMTs), including District AIDS Control Coordinators and/or District Reproductive and Child Health Coordinators (DRCHCos), and nurses and clinicians at the health facilities.

SAMPLE SIZE AND SAMPLING

The sample size was calculated using the single proportion formula. This calculation assumed that 50% of the HSPs were practicing service integration, with a 5% precision (margin of error), and a 1.96 standard normal value under a 95% level of confidence. Assuming a 5% non-response rate, the minimum required sample size was 404 providers. All Boresha Afya-supported health facilities where the DE operates participated in the study (24 facilities in Mara, 18 in Dodoma, and 22 in Iringa). The sampling unit for this study was health service providers (clinicians and nurses cadres) working within CTC and ANC-PNC service delivery points. From a sampling frame (list of all providers) with a total of 621 providers working in the 66 DE-supported health facilities, sampling was calculated proportionally to the size of each region (number of health service providers by cadres) to ensure representativeness and generalizability of findings. The sampling probability was calculated by taking the total sample size (404) divided by the total number of health service providers in the project's catchment area (621), giving 0.65. The obtained sampling probability of 0.65 was multiplied by the number of health service providers from each region to obtain the number of providers proportional to size, as shown in **Table 1**.

Table 1: Sampling proportional to the number of HSPs per region

REGION	NUMBER OF HEALTH FACILITIES IN A REGION	SAMPLED HSPS PER REGION			
		TOTAL	DISPENSARY	HEALTH CENTER	HOSPITAL
Mara	24	226	65	60	101
Iringa	22	81	37	40	4
Dodoma	18	119	34	71	14

REGION	NUMBER OF HEALTH FACILITIES IN A REGION	SAMPLED HSPS PER REGION			
		TOTAL	DISPENSARY	HEALTH CENTER	HOSPITAL
Total	**64**	**426**	**136**	**171**	**119**

A simple random sampling technique (using random numbers in Excel) was used to identify interview respondents from a list of all available HSPs.

DATA COLLECTION PROCEDURE

Quantitative data were collected via phone using a structured survey questionnaire. The questionnaire (Annex 2) had several sections that addressed the key questions regarding provider workload and health service integration. The questionnaire was uploaded into Kobo Toolbox in both English and Swahili. However, the interviews were administered in Swahili.

Before data collection, enumerators were trained over three days through Zoom. After the training, the questionnaire was pilot tested in a randomly selected facility in each region to validate and amend the quantitative survey as well as qualitative tools before embarking on data collection. A total of 20 trained enumerators collected the data, with each enumerator interviewing three participants per day.

Before the interview, the enumerator made a self-introduction while reading the information sheet and asked the provider whether he or she had understood the information and had any questions for clarification. If the provider agreed to be interviewed, the enumerator read the informed consent and proceeded with the interview. If the provider did not consent, the interview was canceled and considered as a non-response. On average, the interviews took about 45 minutes. Participants were asked to participate in the interview alone while in a quiet place with reliable network connectivity.

DATA ANALYSIS

Data were analyzed using STATA Version 15.1. Data cleaning was done before the analysis. Measures of central tendency and dispersion were used to summarize numeric variables and frequencies and percentages for categorical variables.

QUALITATIVE ASSESSMENT

In each region, two districts were purposively selected based on urban-rural criteria. The total sample for the qualitative component was exactly as planned (36 HSPs and six CHMTs). The reason for the selection was that 42 respondents were enough to saturate all the information needed to answer study questions. Two HSPs (one health service provider from CTC and one health service provider from ANC-PNC) from one hospital, one health center, and one dispensary in each of the two councils in a region were selected to participate in the study. In each region, two council health DRCHCos were purposively selected to participate in the study (**Table 2**).

Table 2: Sample size (number of stakeholders) for the qualitative component

REGIONS	HSPS	CHMTS	TOTAL
Mara	12	2	14
Iringa	12	2	14
Dodoma	12	2	14
Total	**36**	**6**	**42**

DATA COLLECTION PROCEDURE

Evaluators, using interview guides (see Annex 3 and 4), collected quantitative data through in-depth interviews (IDIs) with HSPs and key informant interviews (KIIs) with CHMT members. The IDIs for HSPs were conducted before the KII with the CHMT team. This was to allow for follow-up on issues observed in the IDIs that needed more clarification and to address information gaps. The interview guide was designed to explore respondents' views on perceived workload and related factors that hinder and or facilitate the provision of integrated services (family planning, nutrition, and malaria) among health service providers within CTC and ANC-PNC outlets.

Research assistants for the qualitative team were trained over three days. Tools were then pilot tested with two HSPs in each facility selected and given final adjustments before data collection. The tools were pilot tested with HSPs and CHMT members who did not participate in the actual data collection.

All interviews were conducted in Swahili at a time most convenient for the respondents. Each interview lasted between 45 and 60 minutes. All the interviews were conducted over the phone. All interviews were audio-recorded following the verbal consent of participants (to participate and be recorded). Participants were reminded to ensure their phones are adequately charged and position themselves in a quiet place with no background noise and charge their phones and indicate the time the enumerator could call back. The evaluators used the case management form (Annex 5) to track the number of times each participant was dialed

Audio files and interview transcripts were tagged alpha-numerically based on date, district identifier, and category of stakeholder—for example, 13/07/21-DOM-HSP25. Immediately after the interviews, audios were transcribed following the developed transcription guide (Annex 4). Later the transcripts were checked for quality and to ensure all details from the audio interview had been captured in the transcript before being translated.

DATA ANALYSIS

Interview transcripts were coded thematically in Dedoose[1] to produce a summary of recurrent themes that emerged for each topic. Code books (for HSPs and CHMTs) were developed. Sub-themes were identified in the data through an iterative process, and codes were refined as needed during the analysis. A thematic content analytical approach was adopted. The analytical framework was based on an

[1] Dedoose is a cross-platform app for analyzing qualitative and mixed methods research with text, photos, audio, videos, spreadsheet data and more: https://www.dedoose.com/

inductive coding frame, where a basic unit of an idea was defined as a code. Finally, the codes associated with a particular major theme were grouped into an overarching theme.

STRUCTURED DOCUMENT REVIEW

The assessment team collected documentation and reports related to the study from various sources, including: research databases, WHO, the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC), Boresha Afya, and USAID CIRCLE. These included previous DE research findings, Boresha Afya reports, related studies, and the WHO workload indicators of staffing needs.

ETHICAL CONSIDERATIONS

Ethical approval for the study was already sought for the CIRCLE project by Social Solutions International. Informed consent was sought from all the participants. The District Medical Officers, DACCs, and DRCHCos in all the participating regions and districts were informed about the study. Moreover, all respondents were fully briefed about the purpose, aims, and objectives of the study, and the expected duration of the interviews before their participation. They were also allowed to ask questions for clarification before consenting. All respondents had a right to decline to answer any question or to withdraw completely from the study at any time during the interview process. To assure anonymity, an alphanumeric coding system was used. Additionally, all personal identifying information was left out of the discussion and interview transcripts.

LIMITATIONS

- The key concepts of perceived workload and provision of integrated health services were self-reported by service providers, injecting a degree of subjectivity and bias.

- Due to constraints related to the COVID-19 pandemic, the team conducted telephone rather than in-person interviews, which is subject to limitations, especially on the bias and integrity of the HSPs' self-reported data. This limitation was mitigated by orienting and training recruited enumerators on how to develop good rapport and trust with the providers to further ensure reliability and credibility of findings and minimize biases. In addition, the team piloted and refined the tools to ensure consistency in data collection and responses to questions.

- During data collection, mobile network connectivity was occasionally limited, affecting the clarity of participants' responses during the interview process. In such situations, the interviewers and enumerators redialed the participant to ascertain that the interview could proceed. Where necessary, participants were asked to relocate to a place or location with better mobile network connectivity.

RESULTS AND DISCUSSION

RESPONSE RATE

Among 433 eligible HSPs, 426 consented to participate, giving a response rate of 98.4%.

BACKGROUND CHARACTERISTICS OF HSPS

Over half (53.1%) of the 426 HSPs were from Iringa region, followed by Dodoma (27.9%) and Mara (19.0%). Just over 70% (70.2%) of the HSPs were females. Most of the HSPs were nurses (64.3%) and clinicians (32.6%). The median age of the 426 HSPs was 34 years and interquartile range of 26 to 43 years. Most of the HSPs had a certificate (43.4%) or diploma (43.0%). The median working duration was eight years and interquartile range of 4 to 12 years, while 36.6% had worked for 6-10 years and 32.9% for over 10 years (**Table 3**).

Table 3: Background characteristics of HSPs

VARIABLE	FREQUENCY	PERCENTAGE
REGION		
Iringa	226	53.1
Mara	81	19.0
Dodoma	119	27.9
CADRE		
Clinician†	139	32.6
Nurse‡	274	64.3
Others**	13	3.1
AGE (YEARS)		
20-30	140	32.9
31-40	159	37.3
>40	127	29.8
SEX		
Male	127	29.8
Female	299	70.2

VARIABLE	FREQUENCY	PERCENTAGE
EDUCATION LEVEL		
Masters	2	0.5
Bachelor	36	8.5
Diploma	183	43.0
Certificate	185	43.4
Others	20	4.7
DURATION WORKING IN YEARS		
≤5	130	30.5
6-10	156	36.6
>10	140	32.9

†Clinicians included specialists, medical doctors, assistant medical officers, clinical officers and assistant clinical officers.

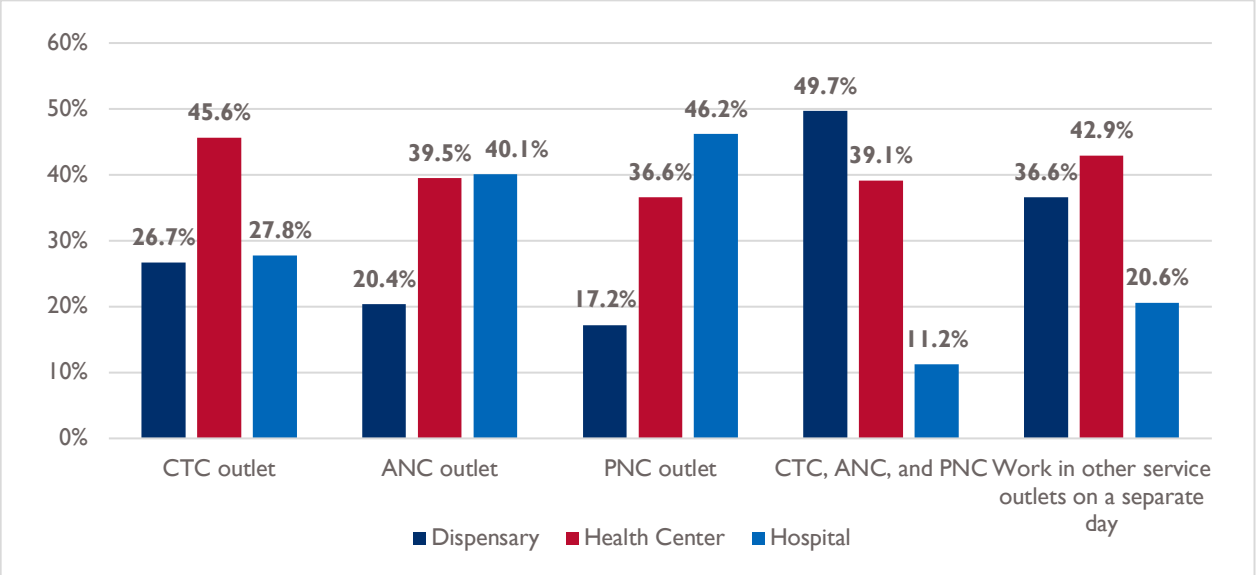
‡ Nurses included nursing officers, assistant nursing officers, enrolled nurses, and nurse-midwife.

**Other cadres included dentistry, pharmacy, data clerks, medical attendants and laboratory assistants.

Nearly 40% (37.8%) of the 426 HSPs reported working in CTC, ANC, and PNC outlets, while others reported only work at CTC (21.1%), ANC (34.5%), and PNC (34%) outlets. Only about 10% of providers work in CTC, ANC and PNC at Hospitals due to differentiation of services by provider type (specialization) compared to health centers and dispensaries where specialization is less often. More than half (56.8%) of all HSPs worked at CTC and ANC/PNC outlets for five years or less. Also, the majority (82.2%) worked in other service delivery points on a separate day. The other service delivery point where the HSPs also worked was, among others, outpatient department (OPD) (68.9%), labor and delivery (63.4%), FP outlet (43.4%), and in-patient department (IPD) (40.6%). Among HSPs working in other service outlets on separate days, 43% had five shifts per week while 31% had between one to four shifts per week. In addition, 31.9% work in dispensaries, 40.1% work in health centers, and 27.9% work in hospitals (**Figure 2**).

† Frequencies do not tally to the total due to missing values.

Figure 2: Service outlets and levels of health facilities at which HSPs work



† Frequencies do not tally to the total due to missing values.

HSP KNOWLEDGE, ATTITUDES, AND PRACTICES

The majority of HSPs in this study were aware of integrated services, with 80% saying they have heard about the concept; this was backed up by qualitative findings. Most of these HSPs worked in two of the three outlets (85.7%) compared to those working in one of the three outlets. HSPs from 81.1%, 77.6%, and 73.1% of the CTC, ANC, and PNC outlets, respectively, claimed to have been aware of the concept. About 80% of the HSPs in dispensary and health centers (80.1% and 80.7%, respectively) were aware of the integrated services concept compared to 77.3% of hospital-based HSPs, which signifies that integrated services are more practiced at dispensary and health centers than at the hospital level. Moreover, 82.1% of the nurses showed awareness of the provision of integrated services compared to almost three-quarters (74.8%) of the clinicians. Iringa and Mara regions recorded 82% compared to 74% of HSPs in Dodoma region **(Figure 3)**. HSPs defined integrated services as "when you provide all services in one outlet without letting the client move to another section." In terms of information sources about integrated services, there were variations among HSPs, with the majority mentioning that they had been sensitized through Boresha Afya. A few reported having learned about the concept through their studies and read the guidelines for different types of services (which comprise integrated services) made available at their health facilities.

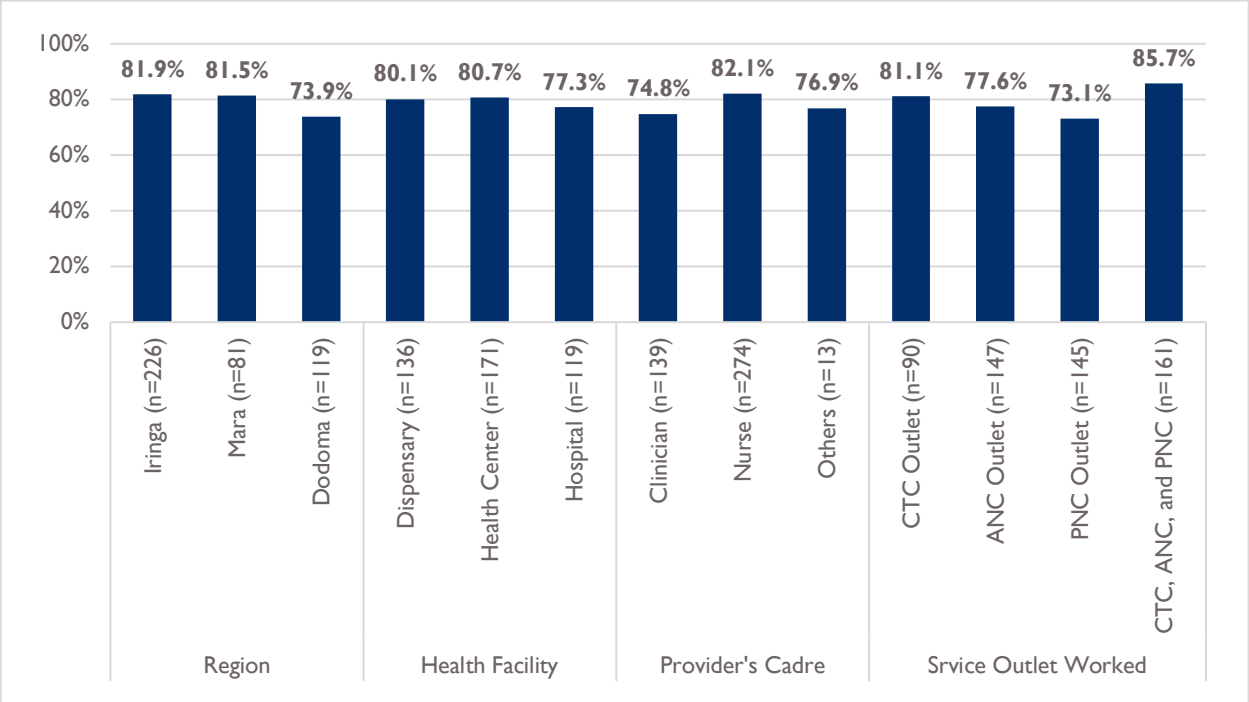
> *Integrated service means the customer is offered all the services such as family planning and malaria screening at the same unit. The client will get such services as general testing during ANC, family planning, HIV care, and malaria screening, all in one area.*
> *[Health Service Provider]*

The client satisfaction case study (previously conducted by CIRCLE) indicated that clients were willing to wait to receive integrated health services, and over 75% of clients assessed reported receiving more than one service. Data from this Provider Perception study show that: the integrated services commonly provided at CTCs are FP counseling (98%), FP methods (91.1%), and nutrition assessment (84.3%). At ANC outlets, the common integrated services provided are FP counseling (96.7%), malaria screening (85.9%), and nutrition assessment (83%), while the integrated services commonly provided at PNC outlets are FP counseling (98.7%), FP methods (96.4%), and nutrition assessment (78.9%) (**Annex 1, Table 11**). However, the qualitative findings demonstrated that nutritional services were mostly provided for children at all the health facility levels.

On the other hand, 44% and 42% of the HSPs said that integrated services provided at the CTCs are provided at the dispensary and health center levels, respectively, while 36% and 41% said those provided at ANC outlets are mostly provided at dispensary and health center levels, respectively. At PNC outlets, 35% and 38% (**Annex 1, Table 12**) of HSPs said that integrated services are provided at dispensary level and health center levels.

Among the motivating factors cited for health service providers to continue offering integrated care is time efficiency when multiple services are offered in the same room; improved privacy and confidentiality as clients get multiple services in the same setting; and increased opportunities to expand their knowledge and skills to offer multiple services. The client satisfaction study found that integrated health services were accessible and convenient to over 80% of clients interviewed in Mara and Iringa. Nevertheless, the HSPs said they felt overwhelmed when providing integrated services.

Figure 3: Awareness and experience in integrated service among service providers

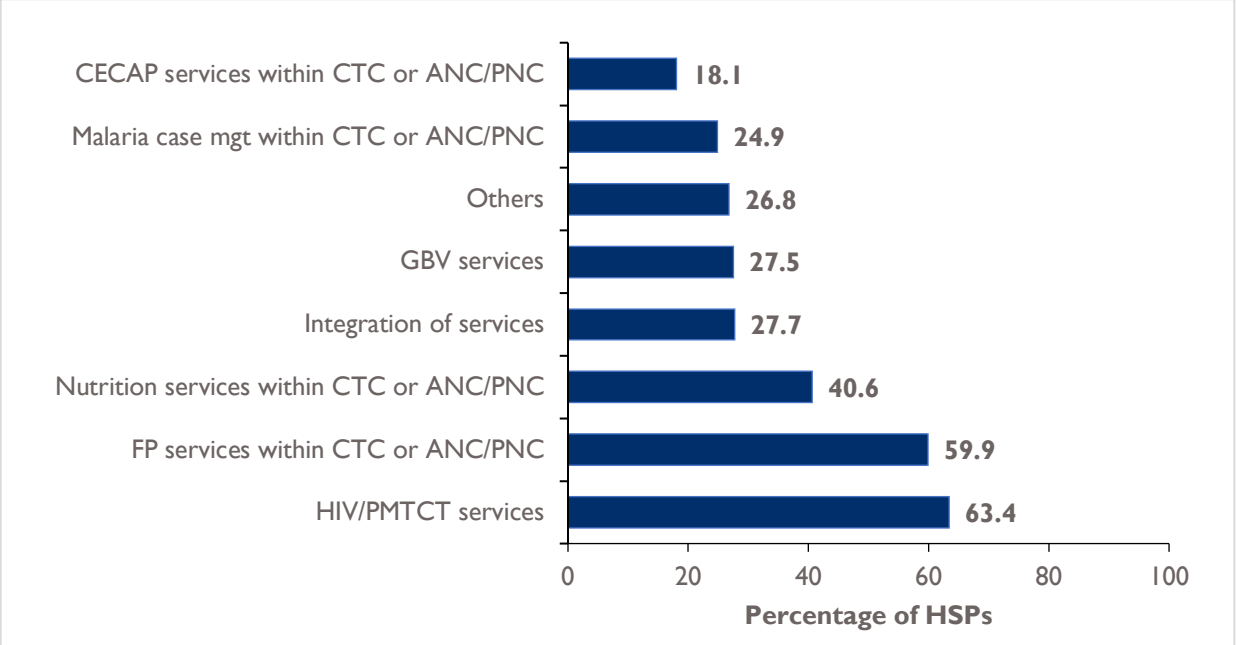


HSP TRAINING

HSPs reported receiving some training on selected services, as well as information from their colleagues about how to provide some integrated services. No specific training on what comprises an integrated service package was provided through training or guidelines. Most HSPs indicated that they received training on HIV/prevention of mother-to-child transmission (63.4%), family planning (60%), and nutritional services (40.6%) provision at CTC and ANC/PNC outlets. Qualitative findings showed that some HSPs also received training on provision of malaria services, cervical cancer and sexually transmitted infection (STI) screening, basic emergency obstetric and newborn care (BEmONC), and cervical cancer screening and prevention (CECAP) services. The HSPs said that training had helped to improve their confidence and skills in the provision of multiple services. A few HSPs attributed their awareness and knowledge to what they had learned through earlier education and the use of disease-specific guidelines which emphasize some additional services. The majority of the HSPs that had not received (Boresha Afya) training were recently employed (two years or less) or had been transferred from other outlets or units.

> *I received on-the-job training through Boresha Afya. I personally received family planning and nutrition training. Some others that I know of have taken cervical cancer and BEmONC services training. They have passed on their knowledge through in-house feedback sessions. This has helped to improve our skills; for example, there were previously no integrated services being offered, but that is not the case now at my facility. The skills have helped to revamp service provision and in advising clients effectively … [Health Service Provider]*

Figure 4: Training received by the HSPs



Note: Percentages do not tally to 100 because the question required multiple responses

Ironically, despite receiving training for provision of FP and nutritional services at CTC and ANC/PNC platforms, 60% of the HSPs indicated that they had never received formal training on how to provide integrated services, yet they are providing those services at their respective service outlets within the health facilities.

HSP CAPACITY TO PROVIDE INTEGRATED SERVICES

Overwhelmingly, providers felt that confident that they could deliver integrated services, and that the mentorship they received had bolstered their perceived abilities to do so. Regarding perceived self-efficacy, 96.4% of the clinicians and 91.1% of CTC staff affirmed that they could find the means and ways to deliver integrated services even if they experienced additional work burden. This is likely due to supportive supervision, coaching and mentorship provided jointly by BA and district health management teams. Just over half (53.1%) felt they had adequate experience and skills to cope with unexpected facility challenges such as lack of space, non-standardized intra-facility referrals, and lack of commodities.

Qualitative findings support the claim that HSP mentorship empowered them to offer integrated services. The skills HSPs gained increased their confidence when offering integrated services.

> *Neither was I aware of the integrated health services concept nor did I have the skills to offer such services…but I was empowered through on-job mentorship related to malaria screening and insertion of implants for family planning at the CTC. I now have the knowledge and skills…. I have the confidence to offer quality integrated services to clients. [Health Service Provider]*

About 53% of HSPs working at CTC ANC and PNC outlets agreed that an "unexpectedly high number of clients limits HSPs' ability to offer integrated services." Similarly, 30% of both clinicians and nurses agreed that "unexpectedly high number of clients limits HSPs' ability to offer integrated services." Although 78% of the HSPs at CTCs are affected by an unexpectedly high number of clients in the provision of integrated services, 73% of them said that no matter what came along their way in the provision of integrated services, they can usually manage the situation; however, only around 40% of PNC outlet staff said the same, while 57% of the HSPs at ANC outlets and those working in all outlets (CTC, ANC and PNC) affirmed this statement (Annex 1, Table 13). The discrepancy of responses among providers in CTC and ANC/PNC platforms are likely to be influenced by the fact that Recent integration efforts and support from development partners has been on integrating additional services within HIV clinics. The claims are confirmed by the qualitative data: the majority of the respondents mentioned that, despite the high-volume clinics and staff shortages, they managed to provide integrated services by using different tactics. One tactic cited was providing group counseling before offering services:

> *I convene clients in a group so that I can offer group counseling. I will talk about all those services available at RCH. From there, I'd offer education about pregnancy and explain danger signs. For PNC women, I will talk about family planning methods. After completing the group counseling, I will start attending to clients one by one. [Health Service Provider]*

A few HSPs responded differently when asked about their reaction to work overload, saying they would offer an appointment for a different day, refer a client to another unit, or not offer some of the services.

> *…but if she comes asking for injection as a family planning method when I have many clients, I will have no time for counseling her for other methods. I will just provide her what she has asked for… [Health Service Provider]*

Some HSPs were motivated to satisfy client needs without referring them, explaining that providing services without referrals increased clients' respect, trust, and confidence in them.

> *I don't have to refer my client to someplace else. I will take care of them here. This increases their trust in me and makes it easier for me to manage any paperwork by myself. I don't need to draft a referral for my clients to go to another clinic. I just provide the services at one location. [Health Service Provider]*

Some respondents mentioned that they would continue providing integrated services just because they were being paid for the job they are doing, and they had to do it.

> *…it is my job. I am paid a monthly salary. I am here for this job. [Health Service Provider]*

Successful client-provider interaction increased HSPs' self-efficacy to continue providing integrated services:

> *I get motivated when I counsel a client on the use of family planning, and they consent; it encourages me to do it even more. [Health Service Provider]*

HSP MOTIVATION TO PROVIDE INTEGRATED SERVICES

HSPs identified several factors that affected their motivation to provide integrated services including: availability of standard operating procedures (SOPs) (68%), supplies and commodities (50%), regional and facility-level leadership and management support (48%), guidelines, and training 48%, and availability of adequate space (40%).

Across service outlets, the availability of SOPs and guidelines was the principal motivating factor for the majority of HSPs (68.1%) to provide integrated services. Regionally, 71% of HSPs in Dodoma were motivated by the availability of SOPs and guidelines, followed by 69% in Mara and 66% in Iringa. Routine DE assessment findings indicate that SOPs and guidelines are more available to facilities in Dodoma compared to those in Iringa and Mara. By area of specialty, slightly more clinicians (72%) reported being influenced by the availability of SOPs and guidelines than nurses (67%). Nearly half (48%) of HSPs were

motivated by the leadership and management support they receive from regional, district, and facility leadership, and 48% were motivated by trainings received. About 40% of HSPs at CTCs are motivated to offer integrated services by infrastructure and space availability, with other outlets scoring below 40%. Nearly 50% of the HSPs at CTCs reported the availability of commodities and supplies as their motivating factor.

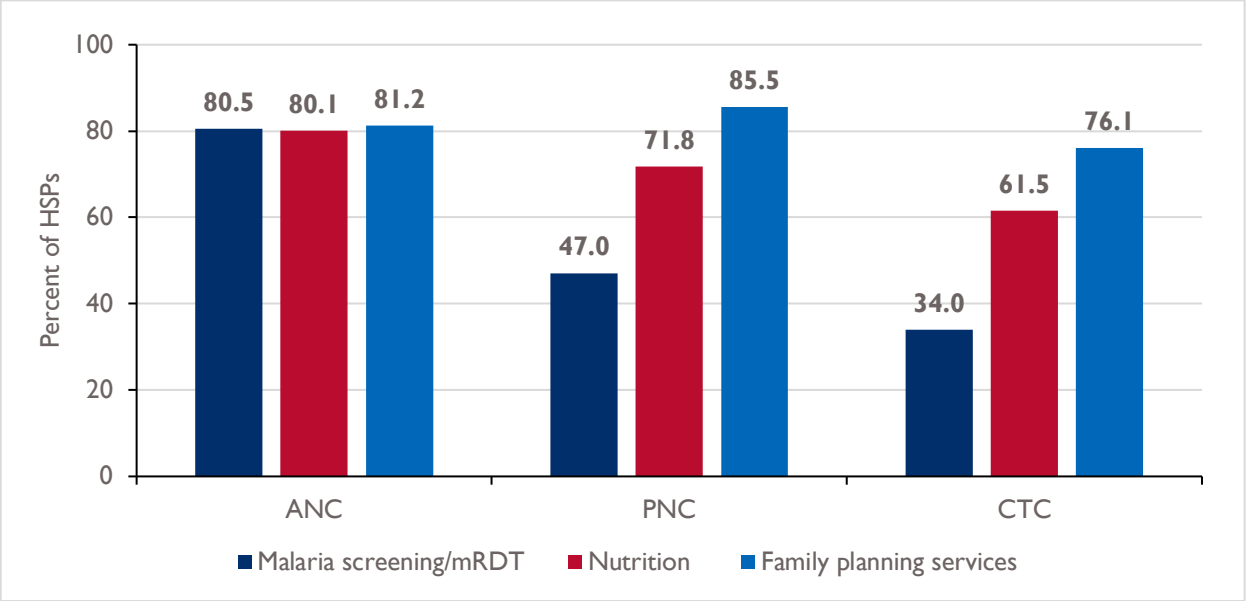
The qualitative data revealed that HSPs felt motivated to provide integrated services because it was their responsibility, they were happy to serve clients, and they wanted to apply their skills. HSPs were also motivated by incentives such as recognition from a higher authority, leadership and management support, and supervision.

Some activities that boost HSP motivation can be achieved cost-effectively include, building messages to encourage integration into routine supervision visits and skills training. Prioritization of commodity supply management at site, district and regional levels can contribute to a more enabling environment. Efforts to strengthen regional and district health management teams to provide such support can inspire HSPs to provide quality health care services, including integrated services. Factors motivating HSPs to provide integrated services are shown in **Annex 1, Table 14**.

PROVISION OF MALARIA, NUTRITION, AND FP SERVICES AT RCH AND CTC CLINICS

The majority of the HSPs reported that FP services were integrated within CTC (76%), ANC, (81%), and PNC outlets (85%). Nutrition services were the second most commonly available services integrated within CTC (62%), ANC (72%), and PNC (80%) outlets; see Figure 3 below. Only a small proportion of HSPs reported availability of integrated malaria services within CTCs (34%) and PNC outlets (47%), perhaps because Boresha Afya does not implement a malaria intervention in Iringa and Dodoma; additionally, there is less focus on malaria in Mara. Other integrated services offered included: cervical cancer screening, STI counseling and testing, and resources for those who have experienced gender-based violence (GBV). HSPs mentioned that they offered integrated services because it was their responsibility, and doing so increased their capacity to provide and deliver services. Despite feeling overwhelmed by the increased workload to provide integrated services, HSPs strongly with the need to expand the menu of service offerings. Opinions on what should be added varied, depending on what was offered at the facility or service outlet. Providers identified as priorities: screening for STIs, tuberculosis (TB), GBV services, cervical cancer screening, mental health services, non-communicable disease care, and youth-friendly services. Nevertheless, other HSPs felt that adding these would add a huge burden to the HSPs' workload. While the integration of services could increase patient care and satisfaction, additional services may have negative implications, especially where there is a shortage of skilled providers (*Winestone et al.*, 2012).

Figure 5: Provision of integrated services at CTC and ANC/PNC outlets



Note: Percentages do not tally to 100 because the question required multiple responses

While HSPs felt motivated to provide integrated services, they cited several barriers to their ability to do this well, including a high number of clients, staffing shortages, and inadequate space, which compromises privacy and confidentiality for clients to receive multiple services in the same setting. As consequence, HSPs skip or shorten essential screening and counseling services such as malaria screening and long-term FP methods provision. Curtailing services in this way helps to manage client load but ultimately increases client safety risks and reduces the quality of care.

On the days that we are overloaded with work and clients, we only provide FP counseling, but you cannot be able to provide a long-term family planning method, so you make an appointment with her to come the next day. [Health Service Provider]

TASKS PERFORMED DAILY BY HSPS

To understand how HSPs plan their time during a day, they were asked to reflect on the tasks they normally perform early morning (7-10 am), late morning (10 am-noon), and afternoon (noon-3pm) within the past one month. On average, the study found that the commonly performed tasks in the early morning hours were health education (56.3%), meetings (44.1%), and administrative tasks (29.3%). HSPs allocated late morning hours on providing of family planning services (47.7%) and health education (41.1%). In the afternoon hours, HSPs mostly reported dedicating time on documentation (61.3%), administrative tasks (35.2%), and provision of family planning services (30.5%) (**Annex 1, Table 15**).

However, it was noted that ANC and PNC consultation services were performed throughout the day: early morning (34% and 33% respectively), late morning (49% and 50% respectively), and afternoon (38

and 37 respectively). ART refill services are offered throughout the day (13.4% early morning, 18.8 mid-late morning and 14.3% afternoon hours).

DRIVERS OF WORK ALLOCATION

HSPs cited different drivers that influence task scheduling. Work allocation is driven by emergency needs (84.3%), client traffic (82.9%), and scheduled appointments (52.8%). Availability of guidelines and administrative norms (58%) and HSPs' preference (22.8%) are other drivers that influence HSP work schedules (**Annex 1, Tables 20 & 22**). Both clinicians and nurses are driven by the same factors. For example, 83% of the clinicians and 82.5% of the nurses use the number of clients waiting for services to schedule their tasks, while 53% of both nurses and clinicians use the available client appointment system. Over 80% of both nurses and clinicians say that the client emergencies influence their scheduling of regular tasks the most. to schedule their tasks. Qualitative findings showed that work allocation is influenced by the number of service providers available on a given clinic day, availability of space, and the number of waiting clients.

> *There is a shortage of HSPs at the CTC. Consequently, one can't offer services at one point alone. As we know, sometimes you find yourself playing all roles, as a doctor, as a nurse, and as laboratory personnel. If I decide to stick to my job description, there are tasks that I would not perform. [Health Service Provider]*

> *I know the guidelines are there but due to a shortage of staff, we don't follow them. So, you plan the timetable depending on the available HSPs on the day. [Health Service Provider]*

The Client satisfaction survey indicated that clients do not mind waiting for services, though providers adjust services when they see many clients waiting. This discourages providers from offering fully integrated services.

TASK-SHIFTING AND TASK-SHARING PRACTICES

The findings suggest that task shifting or sharing was not yet well established in the evaluated facilities. Where it was applicable, task shifting was informally used as a coping mechanism for existing staff shortages in the health facilities. Multitasking was especially common in some facilities with only one health provider. HSPs reported practicing the four models of task shifting (Extending Scopes of Practice at Senior Level, Extending Scopes of Practice across Different Professional Cadres, Extending Auxiliary Scopes of Practice, Improving Patient/Client Skills in Self-Management) described by the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC). However, less than half of the providers (47.9%) confirmed having guidelines to define these models of practice. See Table 6 below for examples of task shifting practices.

Table 4: Task shifting practices

TYPE OF TASK SHIFTING	ORIGINAL SCOPE	SHIFTED TO
Extending scopes of practice at senior level	senior-level practitioners	junior-level practitioners of the same cadre for clinicians/nurses/pharmacists/ laboratory practitioners
Extending scopes of practice across different professional cadres	clinicians/pharmacists	nurses and midwives
Extending auxiliary scopes of practice	clinicians/pharmacists	nurses and midwives
Improving patient/client skills in self-management	health care workers	patient

Because guidelines, SOPs, and protocols are an important motivator to provide integrated services (as noted above), it stands to reason that lack of such guidelines could translate into less emphasis on the use of task shifting. This was mentioned in all three regions.

> *…If you are overloaded with work in a clinic and you are alone, you request your colleague to help for the service to continue and to avoid long waiting time for the patients…at times you find that you're the doctor, you are the nurse… If there is no doctor, you might find you become a doctor, you also do the lab tests. Those are the challenges.*
> *[Health Service Provider]*

Most HSPs (90.8%) reported performing tasks not included in their daily schedule, with primary health facilities reporting high levels of task-shifting (dispensary 94.9%, health centers 90.6%) compared to hospitals, though they also reported high levels of task-shifting (86.6%). **See Annex 1, Table 24**. Task shifting in dispensaries and health centers was more common due to staff shortages. Almost half (47.9%) of all HSPs indicated that policy or legal guidelines are available to guide task delegation in the facility. Among those who did not know policy and legal guidelines are available to guide task delegation, their ability to engage in task shifting was guided by providers' willingness to do it (62.2%), work experience (54.5%), good working relationship among providers (42%), and direction from management (25%). Ability to engage in task shifting was also influenced by HSP skills, perceived responsibility to provide integrated services, coaching and mentorship, supportive supervision, and conducive infrastructure (see Table 7 below). Across the facility levels, the majority of HSPs (78.4%) said task shifting helps reduce the work burden in understaffed facilities. Other perceived benefits of task shifting among HSPs included reduced overcrowding in the facility, reduced client waiting time, improved continuity of services, improved provider work relationship and opportunity to learn.

Similar findings emerged during the qualitative assessment of this study.

Task delegation helps to save time. For instance, the Community Health Workers help with contacting clients on our behalf. At the RCH clinic, we ask them to assess the nutritional status of the children by measuring the mid-upper arm circumference (MUAC). They reduce one's workload. [Health Service Provider]

A few HSPs cited perceived increase in workload (25.8%), lack of confidence (12.9%), and inadequate equipment to perform assigned tasks (4.7%) as obstacles to task-shifting practices. Some HSPs were concerned that task shifting would create an increased workload for them without corresponding remuneration. Assistant nurses, nurses, and clinicians are three cadres assuming a greater diversity of functions as a result of task-shifting, but some perform those tasks without formal training. CHMTs mentioned that all cadres were involved in task shifting or sharing and stressed that through adaptation of task shifting policy and guidelines, medical attendants perform more tasks as a result of task shifting including documentation, dispensing, preparing files, and in some instances, providing health education.

There are so many tasks I perform which I am not trained in…especially, in the dispensary, you do almost all duties. [Health Service Provider]

Table 5: Task shifting or sharing

VARIABLE	FREQUENCY	PERCENTAGE
WHAT GUIDES HSPS TO PERFORM TASK DELEGATION OR EXPANSION OF ROLES IN THE FACILITY (N=143)*		
Willingness/interest of HSPs to perform tasks	89	62.2
Work experience	78	54.5
Good relationship and cooperation among staff	60	42.0
Obeying order from top management	36	25.2
Perception of self-efficacy (HSP feels skilled to take on more tasks)	33	23.1
Because of the provision of integrated services	25	17.5
On the job the training and mentorship/coaching received	25	17.5
Supportive supervision	25	17.5
Facility infrastructure	24	16.8
Other	18	12.6

VARIABLE	FREQUENCY	PERCENTAGE
PERCEIVED BENEFITS OF TASK DELEGATION OR EXPANSION OF ROLES		
Reduces overcrowding of clients	304	71.4
Reduces client waiting time	290	68.1
Ensures continuity of health service provision	201	47.2
Is a learning opportunity for HSP	188	44.1
Improves HSP's working relationships	176	41.3

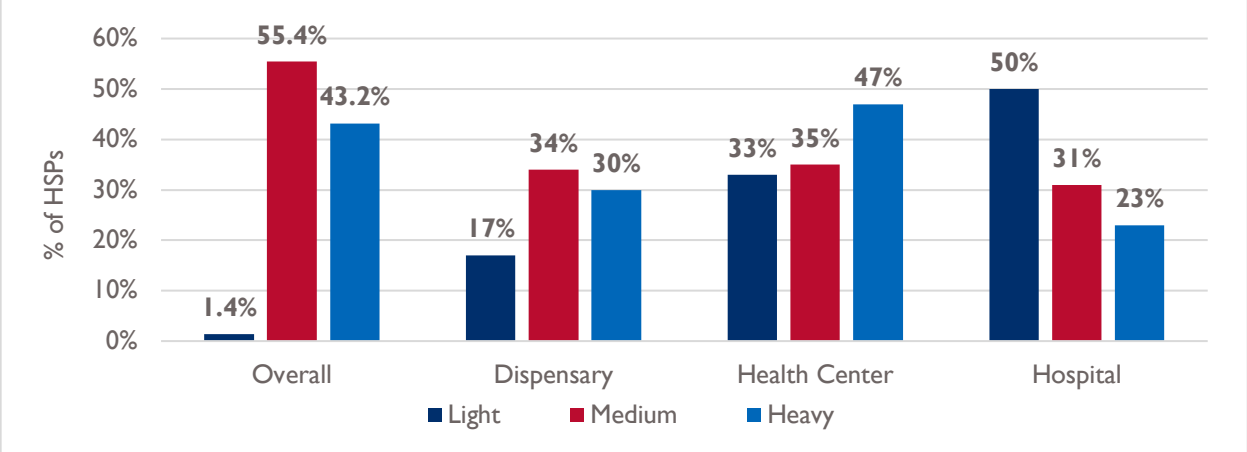
* Percentages do not tally to 100 because the question required multiple responses.

A previous study indicated that task shifting could allow more time for HSPs to perform other tasks (Naburi et al., 2017) such as integration of services, with a potential for increased productivity and client satisfaction (Sweeney et al., 2014). Most of the HSPs were guided by their work experience and volunteering spirit to perform additional tasks. HSPs indicated that informal task shifting was common due to staff shortages. This issue has also been cited as a factor affecting perceived high workload. Availability of task shifting policy and guidelines and proper supervision is critical to ensure appropriate task shifting (Baine & Kasangaki, 2014; Baine et al., 2018). However, this should go hand in hand with ensuring the availability of adequate skilled human resources for health at all levels of care in the country (Baine & Kasangaki, 2014; Baine et al., 2018).

HSPS' PERCEIVED WORKLOAD AND ASSOCIATED REASONS

Overall, most of the HSPs perceived their workload to be either medially (55.4%) or heavily (43.2%) overloaded. This was predominant in dispensaries, followed by health centers, due to staff shortages; on the other hand, half of the HSPs (50%) in hospitals perceived that their workload was light (**Figure 4).** HSPs also rated their perceptions of their workload as medium (53.8%) or heavy (44.6%).

Figure 6: Overall perceived workload by HSPs



Both the quantitative and qualitative results found that not all days of the week were overloaded except on clinic (CTC, ANC/PNC) days. HSPs in the qualitative interviews said that generally only about two to three days in a week were overloaded, especially on Monday and Friday.

> *Yes, we have many clients during the Monday and Friday clinics which will result in our work going past working hours at times until five in the evening…. At times the workload is exacerbated by holidays falling on consecutive days when many clients suddenly turn up for services after such occasions. [Health Service Provider]*

As indicated in **Table 8** below, three-quarters (76.1%) of all HSPs perceived Monday to be the heavy day of the week, while 60% cited Friday as loaded. Two-thirds (64.3%) and over half (53.5%) ranked Wednesday and Thursday, respectively, as medium.

Table 6: Percentage of HSP perceived workload by day of the week

VARIABLES	TOTAL	CTC YES (%)	ANC YES (%)	PNC YES (%)	CTC, ANC, PNC YES (%)
MONDAY					
Light	19	8 (42.1)	4 (21.1)	3 (15.8)	5 (26.3)
Medium	83	26 (31.3)	24 (28.9)	26 (31.3)	26 (31.3)
Heavy	324	56 (17.3)	119 (36.7)	116 (35.8)	130 (40.1)
TUESDAY					
Light	19	7 (36.8)	10 (52.6)	4 (21.1)	4 (21.1)
Medium	222	37 (16.7)	83 (37.4)	76 (34.2)	90 (40.5)
Heavy	185	46 (24.9)	54 (29.2)	65 (35.1)	67 (36.2)
WEDNESDAY					
Light	46	13 (28.3)	20 (43.5)	17 (37.0)	12 (26.1)
Medium	274	50 (18.2)	90 (32.8)	94 (34.3)	109 (39.8)
Heavy	106	27 (25.5)	37 (34.9)	34 (32.1)	40 (37.7)
THURSDAY					
Light	39	10 (25.6)	17 (43.6)	15 (38.5)	11 (28.2)
Medium	228	48 (21.1)	81 (35.5)	77 (33.8)	87 (38.2)

VARIABLES	TOTAL	CTC YES (%)	ANC YES (%)	PNC YES (%)	CTC, ANC, PNC YES (%)
Heavy	159	32 (20.1)	49 (30.8)	53 (33.3)	63 (39.6)
FRIDAY					
Light	39	13 (33.3)	12 (30.8)	12 (30.8)	10 (25.6)
Medium	131	36 (27.5)	38 (29.0)	48 (36.6)	43 (32.8)
Heavy	256	41 (16.0)	97 (37.9)	85 (33.2)	108 (42.2)
THE OVERALL PERCEIVED WORKLOAD AT THE CLINICS					
Light	6	1 (16.7)	2 (33.3)	3 (50.0)	2 (33.3)
Medium	236	60 (25.4)	77 (32.6)	81 (34.3)	80 (33.9)
Heavy	184	29 (15.8)	68 (37.0)	61 (33.2)	79 (42.9)
TOTAL		90 (21.1%)	147 (34.5%)	145 (34.0%)	161 (37.8%)

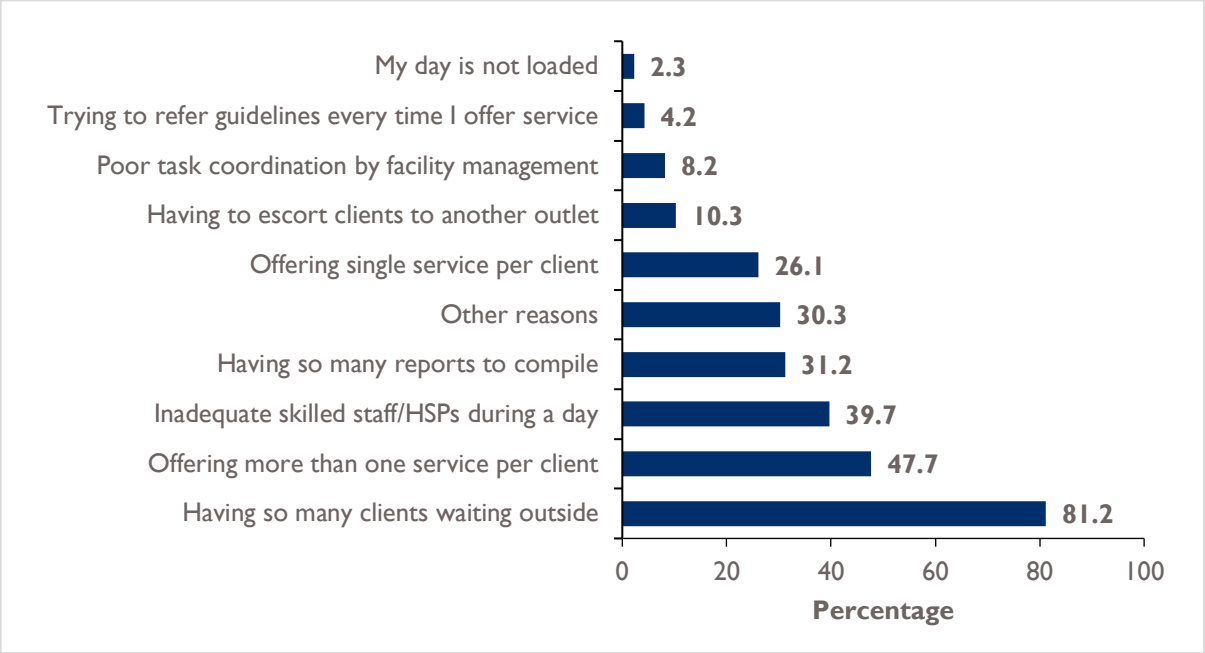
REASONS CITED FOR HEALTH SERVICE PROVIDERS' OVERLOAD

HSPs considered their day as overloaded for two common reasons across the survey components: having a high number of clients, and staff shortages together with an inadequate number of skilled HSPs. HSPs in the qualitative component cited staff shortages as a national issue.

The majority of HSPs (81.2%) consider their day as overloaded when they have many clients waiting for services at a given time (Figure 5). Nearly 62% of the HSPs perceived a light client load as being 20 clients per service provider per day. About 75% said that serving ≥30 clients per day makes for a heavy load. These findings are consistent across all levels of facilities and types of clinics. Additional reasons for overloaded clinics included offering more than one service per client (47.7%), inadequately skilled staff (39.7%), and having so many reports to compile (31.2%). Other reasons contributing to overloaded days included inadequate supplies or commodities, leaving HSPs to traverse from room to room to seek them out; heavy clinic days; patients irregularly turning up for their appointments; vaccination days; lack of adequate space and infrastructure; lack of breaks; emergency procedures such as Caesarean section.

We don't provide vaccinations such as for BCG [for tuberculosis] daily. For this reason, clients turn up on specific days. We also do not provide a vaccine against measles daily; rather it is provided only on Fridays. So, on Tuesdays and Fridays, the place is usually crowded. [Health Service Provider]

Figure 7: Reasons HSPs consider their day as loaded



Note: Percentages do not tally to 100 because the question required multiple responses

FACTORS AFFECTING HSP PERCEIVED WORKLOAD

HSPs were asked to rate different factors that they thought affected their ability to serve the required numbers of clients and to offer planned services during a typical day in their facilities. These factors were mentioned across all types of facilities and clinic types. According to the findings, about 40% and 36.6% of the HSPs respectively agree and strongly agree that there is less work burden whenever they can organize and plan their tasks. About half of the HSPs (31.9% agreed and 20.9% strongly agreed) felt overwhelmed by work demands in their units in the past month. HSPs perceived more time spent with clients as contributing to their increased workload, with 31.9% agreeing and 29.3% strongly agreeing. HSPs also cited facility In Charges as playing a significant role in ensuring HSP work balance (40.1% agree and 34% strongly agree). Over three-quarters of HSPs cited staff shortages as a factor in increasing the workload in their respective units (30.5% agree and 46.7 strongly agree). Just over 70% of the HSPs agreed (38%) and strongly agreed (33.1%) that the availability of enough physical space, commodities, and SOPs in the same room reduces workload and the time taken in going from one room to another to provide the same service (**Table 9**).

Table 7: Perceived factors affecting HSP workload

STATEMENTS	SD	D	N	A	SA	NA
Task organization: Whenever I organize and plan my task well, I feel less work burden	4.9	6.1	11.3	39.9	36.6	1.2
Perceived workload: For the past month, I felt overwhelmed by the work demands in my unit	6.1	18.3	21.6	31.9	20.9	1.2

STATEMENTS	SD	D	N	A	SA	NA
Role of leadership: My facility In Charge plays a great role to ensure my work is balanced	1.6	7.0	16.2	40.1	34.0	0.9
Time spent with clients: The more time I spent with the client, the more the work burden I experience	6.8	17.6	12.9	31.9	29.3	1.4
Teamwork: I get enough support from my colleague when the work burden is high	1.2	5.6	9.2	35.7	46.0	2.4
Physical space and commodity: Availability of enough space, commodities, and SOPs in the same room reduces the time to move with a client from one room to another to provide the same service	3.1	8.7	15.3	38.0	33.1	1.9
Sufficient staffing: Shortage of staff increases my workload as few of us have to attend to many clients in a day	2.6	6.6	10.3	30.5	46.7	3.3
Documentation of services: Doing non-clinical tasks such as data entry, reporting, inventory management, facility upkeep, dealing with interruptions and conflict contribute to increasing my work burden	7.3	22.1	12.0	28.4	29.1	1.2

SD: Strongly disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly agree, NA: Not applicable

RECOMMENDATIONS

This section summarizes the recommendations and ideas from providers and the evaluators to enhance HSP awareness, address contextual and behavioral drivers to optimize their time allocation practices, and address the causes of perceived high workload to improve the provision of integrated health services. Key findings and recommendations are summarized in Table 10 below.

Table 8: Summary Findings and Recommendations

MAJOR FINDING	RECOMMENDATION
HSPs are aware of and knowledgeable about the provision of integrated health services. The HSPs said that training improved their confidence and skills in providing multiple services. About 60% of HSPs reported that they had no formal training on how to offer integrated services. HSPs mentioned that supportive supervision and onsite training could help to address constraints to easily offering integrated services.	MOHCDGEC review/revise and roll out pre-service and in-service training interventions based on service integration demands to ensure that HSPs are trained to support quick scale up of integrated services delivery throughout facilities. Implementing partners and CHMTs ensure that supportive supervision and onsite training includes space reorganization, work organization, and commodity and supply management.
HSPs' capacity to consistently provide integrated health services is limited by perceived high workload and several binding constraints (lack of guidelines and SOPs for integrated services, commodity	Addressing staffing shortages is a larger systemic issue that cannot be addressed quickly. To improve provision of integrated services immediately, policy makers and health facility managers should support

MAJOR FINDING	RECOMMENDATION
shortages, inadequate training and supportive supervision, and staff shortages), which increase HSPs' workload and hinders provision of integrated services. Availability of standard operating procedures for integrated health service delivery, training and supportive supervison, enable HSPs to better allocate time to more consistently provide integrated health services.	the scaling up of workload strategies that HSPs have demonstrated are effective. These include; (i) MOHCDGEC develop and roll out of SOPs and guidelines for types of integrated services, (ii) CHMTs supportive supervision include mentorship of health service providers on proper work organization and prioritization; (iii) MOHCDGEC develop task shifting facility SOPs to enable assignment of non-clinical and administrative tasks to non-medical staff such as data clerks and community health workers; (iv) Health facility in charge reorganize space where to improve patient flow and consistent provision of integrated services; and (v) Implementing partners and CHMT supportive supervision to emphasize commodity management within the service room
HSPs are inclined and motivated to provide integrated health services. HSPs were motivated by improved time efficiencies when providing integrated services in the same room, improved privacy and confidentiality for clients by being served by one provider in same room, and increased opportunity for HSPs to build and apply their skills. Factors impeding the consistent provision of integrated health services include absenteeism, job descriptions not including provision of integrated services, and unfavorable working conditions.	Motivate health providers and build a culture to routinely offer integrated services through; - During supportive supervision, CHMT educate providers about benefits of offering integrated services including improved time efficiency, improved privacy and confidentiality for clients, and increased opportunities to expand their knowledge and skills. MOHCDGEC and CHMTs revise HSP job descriptions to clearly state provision of integrated health services to ensure their accountability.
Task sharing and task shifting are strategies employed by health services provider to mitigate heavy workloads and improve provision of integrated health services. Most HSPs (90.8%) reported engaging in task shifting, and 78.4% said task-shifting reduces the work burden in facilities with staff shortages. About half of HSPs (52.1%) could not cite policy guidelines to guide task delegation in their facility.	MOHCDGEC and PORALG, with support from USAID, should consider revising existing guidelines on task shifting/sharing to support this strategy. They should then distribute these new guidelines to all health facilities and encourage implementing partners and CHMTs to train and orient all HSPs who provide integrated services.

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ANNEXES

ANNEX 1: RESULTS TABLES

Table 9: Integrated services provided

INTEGRATION OF SERVICES	FREQUENCY	PERCENTAGE
SERVICES TARGETED FOR INTEGRATION AT THE HSP'S CLINIC (N=339) *		
FP counseling	312	92.0
FP method provision	286	84.4
Malaria screening/mRDT	218	64.3
Nutrition assessment	192	56.6
Others	123	36.3
Nutrition supplements	78	23.0
INTEGRATED SERVICES PROVIDED AT CTC (N=248) *		
FP counseling	243	98.0
FP methods	226	91.1
Nutrition assessment	209	84.3
Malaria screening	121	48.8
Nutritional supplements	84	33.9
Others	37	14.9
INTEGRATED SERVICES PROVIDED AT ANC (N=305) *		
FP counseling	295	96.7
Malaria screening	262	85.9
Nutrition assessment	253	83.0
FP methods	202	66.2
Nutritional supplements	124	40.7
Others	30	9.8

INTEGRATION OF SERVICES	FREQUENCY	PERCENTAGE
INTEGRATED SERVICES PROVIDED AT PNC (N=304) *		
FP counseling	300	98.7
FP methods	293	96.4
Nutrition assessment	240	78.9
Malaria screening	174	57.2
Nutritional supplements	117	38.5
Others	35	11.5

* Percentages do not tally to 100 because the question required multiple responses in these items

Table 10: Integrated services provided by facility level

TYPE OF SERVICE	DISPENSARY	HEALTH CENTER	HOSPITAL
INTEGRATED SERVICES PROVIDED AT CTC(N=248)			
FP Counseling	41.98	41.56	16.46
Malaria Screening	45.45	42.15	12.4
FP Methods	42.48	42.04	15.49
Nutritional Assessment	44.02	41.63	14.35
Nutritional Supplements	45.24	41.67	13.1
INTEGRATED SERVICES PROVIDED AT ANC(N=305)			
FP Counseling	35.59	38.98	25.42
Malaria Screening	38.55	41.6	19.85
FP Methods	35.15	39.11	25.74
Nutritional Assessment	36.76	39.53	23.72
Nutritional Supplements	33.06	43.55	23.39
INTEGRATED SERVICES PROVIDED AT PNC(N=304)			
FP Counseling	34.33	37.33	28.33

TYPE OF SERVICE	DISPENSARY	HEALTH CENTER	HOSPITAL
Malaria Screening	39.66	36.78	23.56
FP Methods	34.47	37.54	27.99
Nutritional Assessment	35	39.58	25.42
Nutritional Supplements	31.62	41.03	27.35

Table 11: HSP's perceived capacity to provide integrated services (N=426)

		NOT AT ALL	HARDLY TRUE	MODERATELY TRUE	EXACTLY TRUE
SELF-EFFICACY AREAS BY REGION	REGION				
If I experience work burden, I can find means/ways to deliver int services	Iringa	3.1	3.1	16.4	77.4
	Mara	3.7	3.7	17.3	75.3
	Dodoma	3.4	5.9	19.3	71.4
I have adequate experience and skills to cope with unexpected facility challenges	Iringa	2.7	8.8	36.3	52.2
	Mara	1.2	8.6	34.6	55.6
	Dodoma	2.5	11.8	32.8	52.9
An unexpectedly large number of clients reduces my ability to offer int services	Iringa	16.4	30.1	23.0	30.5
	Mara	23.5	21.0	25.9	29.6
	Dodoma	16.0	29.4	22.7	31.9
I can usually handle whatever comes my way when providing int services	Iringa	2.2	9.7	31.4	56.6
	Mara		12.3	33.3	54.3
	Dodoma	2.5	10.1	27.7	59.7
SELF-EFFICACY AREAS BY OUTLET	OUTLET				
If I experience work burden, I can find means/ways to deliver int services	CTC	3.33	5.56	14.44	76.67
	ANC	3.33	7.78	33.33	55.56
	PNC	15.56	27.78	27.78	28.89

		NOT AT ALL	HARDLY TRUE	MODERATELY TRUE	EXACTLY TRUE
	CTC, ANC, PNC	2.22	7.78	32.22	57.78
I have adequate experience and skills to cope with unexpected facility challenges	CTC	1.36	4.76	14.97	78.91
	ANC		11.56	38.10	50.34
	PNC	15.6	29.3	23.1	32.0
	CTC, ANC, PNC	0.7	11.6	30.6	57.1
An unexpectedly large number of clients reduces my ability to offer int services	CTC	2.07	3.45	15.86	78.62
	ANC	0.69	13.79	40.00	45.52
	PNC	13.79	28.28	26.21	31.72
	CTC, ANC, PNC		13.10	33.79	53.10
I can usually handle whatever comes my way when providing int services	CTC	4.35	1.86	20.50	73.29
	ANC	3.73	8.07	31.68	56.52
	PNC	21.12	26.09	20.50	32.30
	CTC, ANC, PNC	3.11	9.32	29.81	57.76
SELF-EFFICACY AREAS BY CADRE	CADRE				
If I experience work burden, I can find means/ways to deliver int services	Clinician	2.2	1.4	18.7	77.7
	Nurse	3.3	5.5	16.8	74.5
	Others	15.4	0.0	15.4	69.2
I have adequate experience and skills to cope with unexpected facility challenges	Clinician	2.2	8.6	27.3	61.9
	Nurse	2.2	9.9	38.7	49.3
	Others	7.7	15.4	38.5	38.5
An unexpectedly large number of clients reduces my ability to offer int services	Clinician	17.3	26.6	25.2	30.9
	Nurse	17.9	28.8	23.4	29.9
	Others	15.4	30.8	7.7	46.2

		NOT AT ALL	HARDLY TRUE	MODERATELY TRUE	EXACTLY TRUE
I can usually handle whatever comes my way when providing int services	Clinician	2.2	10.8	29.5	57.6
	Nurse	1.5	10.6	31.8	56.2
	Others	7.7	0.0	23.1	69.2

Table 12: HSP motivation to provide integrated services (n=426)

MOTIVATION AREA BY OUTLET		EM	VM	N	ALB	NAA	DK/NS
MOTIVATION AREA BY REGION	REGION						
Type of leadership and management support I get from the region, district, and facility	Iringa	9.7	30.5	32.3	13.3	11.5	2.7
	Mara	7.4	35.8	32.1	14.8	9.9	0.0
	Dodoma	13.4	33.6	26.9	16.8	6.7	2.5
Space availability and the general infrastructure environment to provide integrated health services	Iringa	10.2	28.3	36.3	11.5	12.4	1.3
	Mara	9.9	24.7	32.1	21.0	12.3	0.0
	Dodoma	6.7	24.4	38.7	14.3	12.6	3.4
Availability of commodities and supplies	Iringa	11.5	33.6	37.6	11.5	5.3	0.4
	Mara	8.6	29.6	32.1	14.8	14.8	0.0
	Dodoma	11.8	31.1	44.5	10.1	2.5	0.0
Longer time spent with clients when provide integrated service	Iringa	7.5	38.9	33.6	13.3	6.2	0.4
	Mara	4.9	33.3	35.8	18.5	7.4	0.0
	Dodoma	9.2	42.9	33.6	7.6	5.0	1.7
Availability of the SOP and guidelines	Iringa	15.9	50.0	20.4	5.8	5.8	2.2
	Mara	25.9	43.2	21.0	4.9	4.9	0.0
	Dodoma	21.8	49.6	16.0	6.7	5.0	0.8
The training received on the provision of FP, Malaria, and nutrition services within CTC, ANC-PNC	Iringa	13.3	29.6	25.2	14.6	12.4	4.9
	Mara	11.1	35.8	25.9	14.8	8.6	3.7
	Dodoma	11.8	36.1	28.6	10.9	9.2	3.4

MOTIVATION AREA BY OUTLET		EM	VM	N	ALB	NAA	DK/NS
Providing family planning, malaria, or nutrition services to a CTC, ANC, and PNC client	Iringa	11.1	32.3	34.5	11.9	9.3	0.9
MOTIVATION AREA BY OUTLET	OUTLET						
Type of leadership and management support I get from the region, district, and facility	CTC	7.8	38.9	34.4	10.0	8.9	0.0
	ANC	5.4	29.9	32.0	18.4	12.2	2.0
	PNC	6.9	29.0	33.1	18.6	9.0	3.4
	CTC, ANC, PNC	16.8	31.7	25.5	13.7	9.9	2.5
Space availability and the general infrastructure environment to provide integrated health services	CTC	11.1	28.9	32.2	15.6	10.0	2.2
	ANC	3.4	25.9	40.8	13.6	14.3	2.0
	PNC	5.5	25.5	42.1	15.2	10.3	1.4
	CTC, ANC, PNC	12.4	26.1	32.3	13.0	14.3	1.9
Availability of commodities and supplies	CTC	15.6	33.3	31.1	15.6	4.4	0.0
	ANC	8.2	29.9	43.5	11.6	6.8	0.0
	PNC	7.6	29.7	45.5	11.0	6.2	0.0
	CTC, ANC, PNC	12.4	30.4	38.5	9.9	8.1	0.6
Longer time spent with clients when provide integrated service	CTC	8.9	46.7	32.2	6.7	5.6	0.0
	ANC	6.1	40.1	34.0	11.6	7.5	0.7
	PNC	8.3	38.6	35.9	12.4	4.1	0.7
	CTC, ANC, PNC	6.8	34.2	34.2	16.8	6.8	1.2
Availability of the SOP and guidelines	CTC	21.1	47.8	20.0	6.7	4.4	0.0
	ANC	18.4	53.7	13.6	8.2	6.1	0.0
	PNC	19.3	49.0	16.6	9.7	4.8	0.7
	CTC, ANC, PNC	20.5	45.3	21.7	3.1	6.2	3.1

MOTIVATION AREA BY OUTLET		EM	VM	N	ALB	NAA	DK/NS
The training received on the provision of FP, malaria, and nutrition services within CTC, ANC-PNC	CTC	17.8	27.8	25.6	13.3	8.9	6.7
	ANC	10.9	31.3	27.2	12.2	15.0	3.4
	PNC	10.3	25.5	29.0	14.5	13.8	6.9
	CTC, ANC, PNC	11.8	36.6	26.7	14.3	8.1	2.5
Providing family planning, malaria, or nutrition services to a CTC, ANC, and PNC client	CTC	15.6	34.4	30.0	7.8	8.9	3.3
	ANC	13.6	34.0	32.0	11.6	8.8	0.0
	PNC	14.5	29.0	36.6	11.7	6.2	2.1
	CTC, ANC, PNC	9.9	39.8	31.1	13.0	5.6	0.6
	Mara	13.6	38.3	24.7	11.1	8.6	3.7
	Dodoma	13.4	38.7	32.8	10.9	3.4	0.8
MOTIVATION AREA BY CADRE	CADRE						
Type of leadership and management support I get from the region, district, and facility	Clinician	9.7	30.5	32.3	13.3	11.5	2.7
	Nurse	7.4	35.8	32.1	14.8	9.9	0.0
	Others	13.5	33.6	26.9	16.8	6.7	2.5
Space availability and the general infrastructure environment to provide integrated health services	Clinician	12.2	28.1	33.1	15.1	10.1	1.4
	Nurse	8.0	25.6	38.0	13.5	13.1	1.8
	Others	0.0	30.8	30.8	15.4	23.1	0.0
Availability of commodities and supplies	Clinician	13.0	30.9	39.6	10.1	5.8	0.7
	Nurse	10.2	32.1	38.7	13.1	5.8	0.0
	Others	7.7	46.2	23.1	0.0	23.1	0.0
Longer time spent with clients when provide integrated service	Clinician	9.4	36.7	37.4	10.1	5.8	0.7
	Nurse	6.6	39.8	32.9	14.6	5.5	0.7
	Others	7.7	46.2	23.1	0.0	23.1	0.0
Availability of the SOP and guidelines	Clinician	18.0	54.0	18.0	3.6	5.0	1.4
	Nurse	20.1	47.1	19.0	7.3	5.1	1.5

MOTIVATION AREA BY OUTLET		EM	VM	N	ALB	NAA	DK/NS
	Others	23.1	23.1	38.5	0.0	15.4	0.0
The training received on the provision of FP, malaria, and nutrition services within CTC, ANC-PNC	Clinician	11.5	39.6	20.9	14.4	6.5	7.2
	Nurse	12.4	29.6	29.9	13.5	11.7	2.9
	Others	23.1	23.1	7.7	7.7	38.5	0.0
Providing family planning, malaria, or nutrition services to a CTC, ANC, and PNC client	Clinician	15.8	36.7	33.8	5.0	7.2	1.4
	Nurse	10.2	35.0	31.8	14.6	6.9	1.5
	Others	15.4	23.1	23.1	15.4	23.1	0.0

EM: Extremely motivated, VM: Very motivated, N: Neutral, ALB: A little bit, NAA: Not at all, DK/NS: Don't know/Not sure

Table 13: Tasks performed daily on average – one-month recall (N=426)

EARLY MORNING* 7AM - 10.00AM		LATE MORNING* 10.01AM -12.00 NOON		AFTERNOON* 12.01PM-3.00PM	
Health education	56.3	PNC consultation	50.0	Documentation	61.3
Others **	50.9	ANC consultation	49.1	ANC consultation	37.8
Meetings	44.1	FP services	47.7	PNC consultation	36.9
ANC consultation	34.0	Health education	41.1	Administration works	35.2
PNC consultation	32.9	Others ***	29.8	Others ***	31.9
Administration works	29.3	Prescription	28.6	FP services	30.5
Cleanness	27.2	History taking	28.4	Health education	23.5
History taking	25.6	Documentation	26.1	Prescription	21.6
FP services	21.6	Nutrition assessment	19.3	History taking	16.9
Documentation	20.2	ART refill	18.8	Meetings	15.7
Nutrition assessment	15.3	Malaria screening/mRDT	18.5	ART refill	14.3
Prescription	15	Administration works	13.4	Nutrition assessment	11.3
ART refill	13.4	Cervical cancer screening	6.8	Malaria screening/mRDT	10.1
Malaria screening/mRDT	9.6	Meetings	4.0	Cervical cancer screening	4.5

EARLY MORNING* 7AM - 10.00AM		LATE MORNING* 10.01AM -12.00 NOON		AFTERNOON* 12.01PM-3.00PM	
Cervical cancer screening	4.9	Cleanliness	0	Cleanliness	0

* Percentages do not tally to 100 because the question required multiple responses. Results are for the HSPs who answered "Yes".

** Others include OPD, IPD, equipment preparation, weight monitoring, receiving a shift, ward rounds, providing vaccinations, drug dispensing, and emergency services, among others.

*** Other tasks in the late morning and afternoon hours include OPD, IPD, vaccination, CTC, patient discharge, dispensing, attending emergencies, TB services, pregnancy monitoring, and ward rounds.

RESULTS DISAGGREGATED BY SELECTED CHARACTERISTICS

Table 14: Perceived HSP workload by selected characteristics (N=426)

		HSP PERCEIVED WORKLOAD		
VARIABLES	TOTAL	LIGHT	MEDIUM	HEAVY
REGION				
Iringa	226	4 (1.8)	132 (58.4)	90 (39.8)
Mara	81	1 (1.2)	35 (43.2)	45 (55.6)
Dodoma	119	1 (0.8)	69 (58.0)	49 (41.2)
HEALTH FACILITY				
Dispensary	136	1 (0.7)	79 (58.1)	56 (41.2)
Health Center	171	2 (1.2)	83 (48.5)	86 (50.3)
Hospital	119	3 (2.5)	74 (62.2)	42 (35.3)
PROVIDER'S CADRE				
Clinician	139	4 (2.9)	81 (58.3)	54 (38.8)
Nurse	274	1 (0.4)	149 (54.4)	124 (45.3)
Others	13	1 (7.7)	6 (46.2)	6 (46.2)
CTC OUTLET				
No	336	5 (1.5)	176 (52.4)	155 (46.1)
Yes	90	1 (1.1)	60 (66.7)	29 (32.2)

VARIABLES	TOTAL	HSP PERCEIVED WORKLOAD		
		LIGHT	MEDIUM	HEAVY
ANC OUTLET				
No	279	4 (1.4)	159 (57.0)	116 (41.6)
Yes	147	2 (1.4)	77 (52.4)	68 (46.3)
PNC OUTLET				
No	281	3 (1.1)	155 (55.2)	123 (43.8)
Yes	145	3 (2.1)	81 (55.9)	61 (42.1)
CTC, ANC, AND PNC				
No	265	4 (1.5)	156 (58.9)	105 (39.6)
Yes	161	2 (1.2)	80 (49.7)	79 (49.1)
TOTAL		**6 (1.4%)**	**236 (55.4%)**	**184 (43.2%)**

Table 15: Awareness about the integration of services

VARIABLES	TOTAL	EVER HEARD OF THE INTEGRATION OF SERVICES	
		NO	YES
REGION			
Iringa	226	41 (18.1)	185 (81.9)
Mara	81	15 (18.5)	66 (81.5)
Dodoma	119	31 (26.1)	88 (73.9)
HEALTH FACILITY			
Dispensary	136	27 (19.9)	109 (80.1)
Health Center	171	33 (19.3)	138 (80.7)
Hospital	119	27 (22.7)	92 (77.3)
PROVIDER'S CADRE			
Clinician	139	35 (25.2)	104 (74.8)

VARIABLES	TOTAL	EVER HEARD OF THE INTEGRATION OF SERVICES	
		NO	YES
Nurse	274	49 (17.9)	225 (82.1)
Others	13	3 (23.1)	10 (76.9)
CTC OUTLET			
No	336	70 (20.8)	266 (79.2)
Yes	90	17 (18.9)	73 (81.1)
ANC OUTLET			
No	279	54 (19.4)	225 (80.6)
Yes	147	33 (22.4)	114 (77.6)
PNC OUTLET			
No	281	48 (17.1)	233 (82.9)
Yes	145	39 (26.9)	106 (73.1)
CTC, ANC, AND PNC			
No	265	64 (24.2)	201 (75.8)
Yes	161	23 (14.3)	138 (85.7)
TOTAL		**87 (20.4%)**	**339 (79.6%)**

Table 16: Ever learned to provide FP, malaria, and nutritional services at ANC/PNC and CTC platforms

VARIABLES	TOTAL	EVER LEARNED TO PROVIDE INTEGRATED SERVICES	
		NO	YES
REGION			
Iringa	226	139 (61.5)	87 (38.5)
Mara	81	55 (67.9)	26 (32.1)
Dodoma	119	68 (57.1)	51 (42.9)

VARIABLES	TOTAL	EVER LEARNED TO PROVIDE INTEGRATED SERVICES	
		NO	YES
HEALTH FACILITY			
Dispensary	136	92 (67.6)	44 (32.4)
Health Center	171	97 (56.7)	74 (43.3)
Hospital	119	73 (61.3)	46 (38.7)
PROVIDER'S CADRE			
Clinician	139	73 (52.5)	66 (47.5)
Nurse	274	183 (66.8)	91 (33.2)
Others	13	6 (46.2)	7 (53.8)
CTC OUTLET			
No	336	204 (60.7)	132 (39.3)
Yes	90	58 (64.4)	32 (35.6)
ANC OUTLET			
No	279	170 (60.9)	109 (39.1)
Yes	147	92 (62.6)	55 (37.4)
PNC OUTLET			
No	281	176 (62.6)	105 (37.4)
Yes	145	86 (59.3)	59 (40.7)
CTC, ANC, AND PNC			
No	265	159 (60.0)	106 (40.0)
Yes	161	103 (64.0)	58 (36.0)
TOTAL		**262 (61.5)**	**164 (38.5%)**

Table 17: Provide integrated services on usual practice

VARIABLES	TOTAL	PROVIDE INTEGRATED SERVICES ON USUAL PRACTICE	
		NO	YES
REGION			
Iringa	226	20 (8.8)	206 (91.2)
Mara	81	5 (6.2)	76 (93.8)
Dodoma	119	11 (9.2)	108 (90.8)
HEALTH FACILITY			
Dispensary	136	8 (5.9)	128 (94.1)
Health Center	171	11 (6.4)	160 (93.6)
Hospital	119	17 (14.3)	102 (85.7)
PROVIDER'S CADRE			
Clinician	139	17 (12.2)	122 (87.8)
Nurse	274	15 (5.5)	259 (94.5)
Others	13	4 (30.8)	9 (69.2)
CTC OUTLET			
No	336	27 (8.0)	309 (92.0)
Yes	90	9 (10.0)	81 (90.0)
ANC OUTLET			
No	279	28 (10.0)	251 (90.0)
Yes	147	8 (5.4)	139 (94.6)
PNC OUTLET			
No	281	22 (7.8)	259 (92.2)
Yes	145	14 (9.7)	131 (90.3)
CTC, ANC, AND PNC			
No	265	25 (9.4)	240 (90.6)
Yes	161	11 (6.8)	150 (93.2)

VARIABLES	TOTAL	PROVIDE INTEGRATED SERVICES ON USUAL PRACTICE	
		NO	YES
TOTAL		**36 (8.5)**	**390 (91.5)**

Table 18: A daily guide for task scheduling by health facility level

VARIABLES	TOTAL	DISPENSARY	HEALTH CENTER	HOSPITAL
NUMBER OF CLIENTS WAITING FOR SERVICES				
No	73	23 (31.5)	29 (39.7)	21 (28.8)
Yes	353	113 (32.0)	142 (40.2)	98 (27.8)
AVAILABLE CLIENT APPOINTMENT SYSTEM				
No	201	66 (32.8)	79 (39.3)	56 (27.9)
Yes	225	70 (31.1)	92 (40.9)	63 (28.0)
GUIDELINES AND ADMINISTRATIVE NORMS FOR SCHEDULING				
No	179	61 (34.1)	66 (36.9)	52 (29.1)
Yes	247	75 (30.4)	105 (42.5)	67 (27.1)
CLIENT'S EMERGENCY				
No	67	21 (31.3)	30 (44.8)	16 (23.9)
Yes	359	115 (32.0)	141 (39.3)	103 (28.7)
HSP PREFERENCE				
No	329	113 (34.3)	129 (39.2)	87 (26.4)
Yes	97	23 (23.7)	42 (43.3)	32 (33.0)
PROVISION OF MORE THAN ONE SERVICE				
No	200	70 (35.0)	80 (40.0)	50 (25.0)
Yes	226	66 (29.2)	91 (40.3)	69 (30.5)
TOTAL		**136 (31.9%)**	**171 (40.1%)**	**119 (27.9%)**

Table 19: Distribution of reasons for saying the day is loaded by facility level

VARIABLES	TOTAL	DISPENSARY	HEALTH CENTER	HOSPITAL
MY DAY IS NOT LOADED				
No	416	132 (31.7)	166 (39.9)	118 (28.4)
Yes	10	4 (40.0)	5 (50.0)	1 (10.0)
WHEN I OFFER A SINGLE SERVICE PER CLIENT				
No	315	96 (30.5)	128 (40.6)	91 (28.9)
Yes	111	40 (36.0)	43 (38.7)	28 (25.2)
WHEN I OFFER MORE THAN ONE SERVICE PER CLIENT				
No	223	68 (30.5)	92 (41.3)	63 (28.3)
Yes	203	68 (33.5)	79 (38.9)	56 (27.6)
WHEN I HAVE SO MANY CLIENTS WAITING OUTSIDE				
No	80	26 (32.5)	31 (38.8)	23 (28.7)
Yes	346	110 (31.8)	140 (40.5)	96 (27.7)
WHEN I HAVE SO MANY REPORTS TO COMPILE				
No	293	95 (32.4)	117 (39.9)	81 (27.6)
Yes	133	41 (30.8)	54 (40.6)	38 (28.6)
WHEN I HAVE TO ESCORT CLIENTS TO ANOTHER OUTLET				
No	382	121 (31.7)	154 (40.3)	107 (28.0)
Yes	44	15 (34.1)	17 (38.6)	12 (27.3)
WHEN I TRY TO REFER TO GUIDELINES EVERY TIME, I OFFER SERVICES				
No	408	129 (31.6)	162 (39.7)	117 (28.7)
Yes	18	7 (38.9)	9 (50.0)	2 (11.1)

VARIABLES	TOTAL	DISPENSARY	HEALTH CENTER	HOSPITAL
WHEN THERE IS POOR TASK COORDINATION BY FACILITY MANAGEMENT				
No	391	123 (31.5)	157 (40.2)	111 (28.4)
Yes	35	13 (37.1)	14 (40.0)	8 (22.9)
WHEN HSPS ARE INADEQUATELY SKILLED STAFF DURING A DAY				
No	257	78 (30.4)	100 (38.9)	79 (30.7)
Yes	169	58 (34.3)	71 (42.0)	40 (23.7)
TOTAL		**136 (31.9%)**	**171 (40.1%)**	**119 (27.9%)**

Table 20: A daily guide for task scheduling by service outlet

VARIABLES	TOTAL	CTC YES (%)	ANC YES (%)	PNC YES (%)	CTC, ANC, PNC YES (%)
NUMBER OF CLIENTS WAITING FOR SERVICES					
No	73	19 (26.0)	28 (38.4)	28 (38.4)	18 (24.7)
Yes	353	71 (20.1)	119 (33.7)	117 (33.1)	143 (40.5)
AVAILABLE CLIENT APPOINTMENT SYSTEM					
No	201	31 (15.4)	75 (37.3)	72 (35.8)	75 (37.3)
Yes	225	59 (26.2)	72 (32.0)	73 (32.4)	86 (38.2)
GUIDELINES AND ADMINISTRATIVE NORMS FOR SCHEDULING					
No	179	38 (21.2)	60 (33.5)	55 (30.7)	69 (38.5)
Yes	247	52 (21.1)	87 (35.2)	90 (36.4)	92 (37.2)
CLIENT'S EMERGENCY SITUATION					
No	67	17 (25.4)	23 (34.3)	20 (29.9)	21 (31.3)
Yes	359	73 (20.3)	124 (34.5)	125 (34.8)	140 (39.0)

VARIABLES	TOTAL	CTC YES (%)	ANC YES (%)	PNC YES (%)	CTC, ANC, PNC YES (%)
HSP PREFERENCE					
No	329	71 (21.6)	112 (34.0)	113 (34.3)	122 (37.1)
Yes	97	19 (19.6)	35 (36.1)	32 (33.0)	39 (40.2)
PROVISION OF MORE THAN ONE SERVICE					
No	200	45 (22.5)	67 (33.5)	62 (31.0)	77 (38.5)
Yes	226	45 (19.9)	80 (35.4)	83 (36.7)	84 (37.2)
TOTAL	**426**	**90 (21.1%)**	**147 (34.5%)**	**145 (34.0%)**	**161 (37.8%)**

Table 21: Distribution of reasons for saying the day is loaded by service outlet

VARIABLES	TOTAL	CTC YES (%)	ANC YES (%)	PNC YES (%)	CTC, ANC, PNC YES (%)
MY DAY IS NOT LOADED					
No	416	88 (21.2)	143 (34.4)	142 (34.1)	158 (38.0)
Yes	10	2 (20.0)	4 (40.0)	3 (30.0)	3 (30.0)
WHEN I OFFER A SINGLE SERVICE PER CLIENT					
No	315	61 (19.4)	112 (35.6)	112 (35.6)	121 (38.4)
Yes	111	29 (26.1)	35 (31.5)	33 (29.7)	40 (36.0)
WHEN I OFFER MORE THAN ONE SERVICE PER CLIENT					
No	223	46 (20.6)	78 (35.0)	75 (33.6)	85 (38.1)
Yes	203	44 (21.7)	69 (34.0)	70 (34.5)	76 (37.4)
WHEN I HAVE SO MANY CLIENTS WAITING OUTSIDE					
No	80	18 (22.5)	25 (31.3)	23 (28.7)	32 (40.0)
Yes	346	72 (20.8)	122 (35.3)	122 (35.3)	129 (37.3)

VARIABLES	TOTAL	CTC YES (%)	ANC YES (%)	PNC YES (%)	CTC, ANC, PNC YES (%)
WHEN I HAVE SO MANY REPORTS TO COMPILE					
No	293	57 (19.5)	101 (34.5)	98 (33.4)	115 (39.2)
Yes	133	33 (24.8)	46 (34.6)	47 (35.3)	46 (34.6)
WHEN I HAVE TO ESCORT CLIENTS TO ANOTHER OUTLET					
No	382	84 (22.0)	128 (33.5)	123 (32.2)	147 (38.5)
Yes	44	6 (13.6)	19 (43.2)	22 (50.0)	14 (31.8)
WHEN I TRY TO REFER TO GUIDELINES EVERY TIME, I OFFER A SERVICE					
No	408	87 (21.3)	139 (34.1)	137 (33.6)	154 (37.7)
Yes	18	3 (16.7)	8 (44.4)	8 (44.4)	7 (38.9)
WHEN THERE IS POOR TASK COORDINATION BY FACILITY MANAGEMENT					
No	391	83 (21.2)	135 (34.5)	133 (34.0)	146 (37.3)
Yes	35	7 (20.0)	12 (34.3)	12 (34.3)	15 (42.9)
WHEN HSPS ARE INADEQUATELY SKILLED STAFF DURING A DAY					
No	257	66 (25.7)	90 (35.0)	83 (32.3)	89 (34.6)
Yes	169	24 (14.2)	57 (33.7)	62 (36.7)	72 (42.6)
TOTAL	**426**	**90 (21.1%)**	**147 (34.5%)**	**145 (34.0%)**	**161 (37.8%)**

Table 22: Task shifting/sharing by service outlet

VARIABLES	TOTAL	DISPENSARY	HEALTH CENTER	HOSPITAL
PERFORM TASKS THAT ARE OUT OF YOUR DAILY SCHEDULE				
No	39(9.2%)	7 (5.1%)	16 (9.4%)	16 (13.4%)

VARIABLES	TOTAL	DISPENSARY	HEALTH CENTER	HOSPITAL
Yes	387(90.8%)	129 (94.9%)	155 (90.6%)	103 (86.6%)
TASK DELEGATION HELPS REDUCE WORK BURDEN IN SCARCITY OF SKILLED HRH				
No	44(10.3%)	16 (12.4%)	14 (9.1%)	14 (13.6%)
Yes	334(78.4%)	111 (86.0%)	136 (87.7%)	87 (84.5%)
Do not Know	9(2%)	2 (1.6%)	5 (3.2%)	2 (1.9%)
POLICY OR LEGAL GUIDELINES AVAILABLE TO GUIDE TASK DELEGATION IN YOUR FACILITY				
No	143(33.6%)	57 (41.9%)	61 (35.7%)	25 (21.0%)
Yes	204(47.9%)	57 (41.9%)	82 (48.0%)	65 (54.6%)
Do not Know	79(18.5)	22 (16.2%)	28 (16.3%)	29 (24.4%)
TOTAL		**136 (31.9%)**	**171 (40.1%)**	**119 (27.9%)**

Table 23: HSP perceived weekly workload by facility level (N=426)

VARIABLES	TABLE	DISPENSARY	HEALTH CENTER	HOSPITAL
MONDAY				
Light	19	4 (21.1)	9 (47.4)	6 (31.6)
Medium	83	24 (28.9)	28 (33.7)	31 (37.3)
Heavy	324	108 (33.3)	134 (41.4)	82 (25.3)
TUESDAY				
Light	19	9 (47.4)	5 (26.3)	5 (26.3)
Medium	222	71 (32.0)	101 (45.5)	50 (22.5)
Heavy	185	56 (30.3)	65 (35.1)	64 (34.6)
WEDNESDAY				
Light	46	12 (26.1)	16 (34.8)	18 (39.1)
Medium	274	84 (30.7)	104 (38.0)	86 (31.4)

VARIABLES	TABLE	DISPENSARY	HEALTH CENTER	HOSPITAL
Heavy	106	40 (37.7)	51 (48.1)	15 (14.2)
THURSDAY				
Light	39	13 (33.3)	16 (41.0)	10 (25.6)
Medium	228	81 (35.5)	87 (38.2)	60 (26.3)
Heavy	159	42 (26.4)	68 (42.8)	49 (30.8)
FRIDAY				
Light	39	10 (25.6)	15 (38.5)	14 (35.9)
Medium	131	30 (22.9)	55 (42.0)	46 (35.1)
Heavy	256	96 (37.5)	101 (39.5)	59 (23.0)
THE OVERALL PERCEIVED WORKLOAD AT THE CLINIC				
Light	6	1 (16.7)	2 (33.3)	3 (50.0)
Medium	236	79 (33.5)	83 (35.2)	74 (31.4)
Heavy	184	56 (30.4)	86 (46.7)	42 (22.8)
TOTAL		**136 (31.9%)**	**171 (40.1%)**	**119 (27.9%)**

Table 24: HSP perceived weekly workload by service outlet

VARIABLES	TOTAL	CTC YES (%)	ANC YES (%)	PNC YES (%)	CTC, ANC, PNC YES (%)
MONDAY					
Light	19	8 (42.1)	4 (21.1)	3 (15.8)	5 (26.3)
Medium	83	26 (31.3)	24 (28.9)	26 (31.3)	26 (31.3)
Heavy	324	56 (17.3)	119 (36.7)	116 (35.8)	130 (40.1)
TUESDAY					
Light	19	7 (36.8)	10 (52.6)	4 (21.1)	4 (21.1)
Medium	222	37 (16.7)	83 (37.4)	76 (34.2)	90 (40.5)

VARIABLES	TOTAL	CTC YES (%)	ANC YES (%)	PNC YES (%)	CTC, ANC, PNC YES (%)
Heavy	185	46 (24.9)	54 (29.2)	65 (35.1)	67 (36.2)
WEDNESDAY					
Light	46	13 (28.3)	20 (43.5)	17 (37.0)	12 (26.1)
Medium	274	50 (18.2)	90 (32.8)	94 (34.3)	109 (39.8)
Heavy	106	27 (25.5)	37 (34.9)	34 (32.1)	40 (37.7)
THURSDAY					
Light	39	10 (25.6)	17 (43.6)	15 (38.5)	11 (28.2)
Medium	228	48 (21.1)	81 (35.5)	77 (33.8)	87 (38.2)
Heavy	159	32 (20.1)	49 (30.8)	53 (33.3)	63 (39.6)
FRIDAY					
Light	39	13 (33.3)	12 (30.8)	12 (30.8)	10 (25.6)
Medium	131	36 (27.5)	38 (29.0)	48 (36.6)	43 (32.8)
Heavy	256	41 (16.0)	97 (37.9)	85 (33.2)	108 (42.2)
THE OVERALL PERCEIVED WORKLOAD AT THE CLINIC					
Light	6	1 (16.7)	2 (33.3)	3 (50.0)	2 (33.3)
Medium	236	60 (25.4)	77 (32.6)	81 (34.3)	80 (33.9)
Heavy	184	29 (15.8)	68 (37.0)	61 (33.2)	79 (42.9)
TOTAL		**90 (21.1%)**	**147 (34.5%)**	**145 (34.0%)**	**161 (37.8%)**

ANNEX 2: QUESTIONNAIRE FOR HEALTH CARE PROVIDERS (QUANTITATIVE)

PHONE SURVEY QUESTIONNAIRE

Introduction and Consent form

On behalf of USAID/Tanzania, the Coordinating Implementation Research to Communicate Learning and Evidence (CIRCLE), has commissioned the Kilimanjaro Christian Medical College (KCMC) to conduct a workload case study of Boresha Afya activities in Iringa, Dodoma, and Mara health facilities. The purpose of conducting this study is to decipher the factors affecting perceived workload among Health Service Providers (HSPs) and outline how such workload affects the provision of integrated health services within CTC, ANC/PNC outlets. The study will also identify the opportunities to improve efficiencies in the provision of integrated health services on each of the broad categories of CTC and ANC/PNC services to inform and advise stakeholders (USAID and Government of Tanzania) about the efficient provision of integrated health care services to Tanzanian citizens among pre-selected outlets.

As health care providers in this facility, we do recognize the critical role you are playing in the provision of quality health services and we want to make sure your voice and/or perspective is captured in helping USAID and the Government of Tanzania to understand best what you're encountering while providing integrated health services in a typical workday shift. As such, we ask you to confidentially share your perspectives on that through the attached survey. This study is not meant to "get anyone in trouble" but rather to improve the provision of integrated services while considering HSPs workload. The survey will take approximately 30 minutes.

The survey is completely confidential, and you don't need to record your name. All survey responses are anonymous and will only be accessed by the assessment team not otherwise. Your participation is completely voluntary, and you are free to withdraw from the survey process at any time or decline to answer any of the questions, without giving any reason, although your contribution is highly valued to help the USAID program with the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) improve CTC and MNC's health services.

Your participation is much appreciated and thank you for your time.

For further information about the study, please contact:

CIRCLE, Tanzania through Gerald Usika (+255745808704)

Do you consent to participate?

a. Yes

b. No

HSP DEMOGRAPHIC AND GENERAL INFORMATION QUESTIONNAIRE

QUESTION	INSTRUCTIONS	RESPONSE
1. Region	Select Region	Iringa, Dodoma, Mara
2. District	Type District	Auto populated as per the region
3. Provider Phone numbers	Enter HSP phone numbers (do not ask)	
4. Facility Name	Select Facility Name from the dropdown list	
5. Provider's cadre		1. Clinical Officer 2. Assistant Medical Officer (AMO) 3. Medical doctor (MD) 4. Specialist 5. Nurse-midwife 6. Enrolled nurse 7. Nurse attendant 8. Registered nurse 9. Others (mention……)
6. What is your age in years	Type providers age	
7. Provider's Sex	Circle one	Male Female
8. What is the highest level of education you have completed?	Circle one	a. Masters b. Bachelor c. Diploma d. Certificate e. Others, specify
9. How long have you worked since the completion of professional training? (in years)	Years of experience	
10. Which service outlet are you currently working at?	Tick all that apply	a. CTC b. ANC c. PNC d. All of the above
11. How long have you worked at ANC/PNC or CTC in years?	Years of experience at CTC/ ANC	

QUESTION	INSTRUCTIONS	RESPONSE
12. Do you also work in other service outlets on a separate day?	Select one	Yes No
13. If Yes, Mention the outlet a. If Yes in above, how many shifts do you have per week in each of the outlets?	Enter the number of shifts	
14. Which of the following training have you received (either classical or on-job training) between 2016 and 2021?	Multiple answers are possible	a. Malaria Case Management within CTC or ANC-PNC b. Family planning services within CTC or ANC-PNC c. Nutrition services (height and weight measurement and malnutrition treatment) within CTC or ANC-PNC d. CECAP services within CTC or ANC-PNC e. HIV/ PMTC care f. Integration of services g. Others, specify h. None of the above

Services provided at different outlets

15. Are the following services provided in the respective clinics? *Tick*	Tick where appropriate		ANC	PNC	CTC
		Malaria screening using mRDT	☐	☐	☐
		Nutrition services	☐	☐	☐
		Family planning services	☐	☐	☐

HSP TIME ALLOCATION

QUESTION	INSTRUCTIONS	RESPONSE
16. In the past month, which of the following drives your decision in assigning time on tasks in a shift day?	Circle that applies	a. Several clients waiting for services. b. Client Appointment System available in a facility c. Guidelines and administrative norms for scheduling d. Client's emergency situation e. HSP Preference f. Provision of more than one service. g. Others: Specify
17. Reflecting on the past one month, on average, what tasks do you normally perform in early Morning hours (7-10) am in a day?	Do not read responses, allow HSP to mention tasks, then circle all that applies	Task a. FP services _____ b. ART refill _____ c. Health education _____ d. Cervical Cancer Screening _____ e. Malaria Screening _____ f. History taking _____ g. Prescription h. mRDT _____ i. Nutrition assessment _____ j. Documentation _____ k. Administration works _____ l. Meetings _____ m. PNC Consultation _____ n. ANC consultation _____ o. Others, specify _____
18. Reflecting on the past one month, on average, what tasks do you normally perform in the late morning (10 am-12noon) in a day and why?	Do not read responses, allow HSP to mention tasks, then circle that applies	Task a. FP services _____ b. ART refill _____ c. Health _____ d. Cervical Cancer Screening _____ e. Malaria Screening _____ f. History taking _____ g. Prescription _____ h. mRDT _____

QUESTION	INSTRUCTIONS	RESPONSE
		i. Nutrition assessment _____ j. Documentation _____ k. Administration works _____ l. Meetings _____ m. PNC Consultation _____ n. ANC consultation _____ o. Others, specify _____
19. Reflecting on the past one month, on average, what tasks do you normally perform in the afternoon (12-3) pm a day and why?	Do not read responses, allow HSP to mention tasks, then circle that applies	Task a. FP services _____ b. ART refill _____ c. Health education _____ d. Cervical Cancer Screening _____ e. Malaria Screening _____ f. History taking _____ g. Prescription _____ h. mRDT _____ i. Nutrition assessment _____ j. Documentation _____ k. Administration works _____ l. Meetings _____ m. PNC Consultation _____ n. ANC consultation _____ o. Others, specify _____

PERCEIVED WORKLOAD

QUESTION	INSTRUCTIONS	RESPONSE
20. For what reasons do you consider your day as loaded?	Circle all that apply	a. When I offer a single service per client b. When I offer more than one service per client c. When I have so many clients waiting outside d. When I have so many reports to compile e. When I have to escort clients to another outlet f. When I try to refer to the guidelines every time I offer service g. When there is poor task coordination by facility management h. When HSPs are inadequately skilled staff during a day i. Others reasons, specify
21. Bearing in mind the number of clients served in a day, what do you consider a LIGHT, MEDIUM, HEAVY day?	Enter the number of clients	No of Clients(estimates) LIGHT _____ MEDIUM _____ HEAVY _____
22. Overall, how would you rate the client load at this clinic: LIGHT, MEDIUM, or HEAVY.	Circle one	Light Medium Heavy
23. Which days of the workweek would you consider as Light, Medium, or Heavy?	Tick where appropriate, once for each day	Mon Tue Wed Thu Fri LIGHT ☐ ☐ ☐ ☐ ☐ MEDIUM ☐ ☐ ☐ ☐ ☐ HEAVY ☐ ☐ ☐ ☐ ☐

24. Now, I am going to ask you about different factors that you think affect your ability to serve the required number of clients but also to offer planned services during a day in your clinic. I will ask you to rate whether you strongly agree, agree, neutral, disagree, or strongly disagree with each of the following statements. To what extent do you agree with the following statements?

	STRONGLY DISAGREE (1)	DISAGREE (2)	NEUTRAL (3)	AGREE (4)	STRONGLY AGREE (5)
i. Task organization: Whenever I organize and plan my task well, I feel less work burden	☐	☐	☐	☐	☐
ii. Perceived workload: For the past month, I felt overwhelmed by the work demands in my unit	☐	☐	☐	☐	☐
iii. Role of leadership: My facility in charge plays a great role to ensure my work is balanced	☐	☐	☐	☐	☐
iv. Time spent with clients: The more time I spent with the client, the more the work burden I experience	☐	☐	☐	☐	☐
v. Teamwork: I get enough support from my colleague when the work burden is high.	☐	☐	☐	☐	☐
vi. Physical space and commodity: Availability of enough space, commodities, and SOPs in the same room reduces my time to move with a client from one room to another to provide the same service	☐	☐	☐	☐	☐
vii. Sufficient staffing: Shortage of staff increases my workload as few of us have to attend to many clients in a day	☐	☐	☐	☐	☐
viii. Documentation of services: Doing non-clinical tasks such as data entry, reporting, inventory management, facility upkeep, dealing with interruptions and conflict contribute to increasing my work burden.	☐	☐	☐	☐	☐

AWARENESS AND EXPERIENCE ON THE INTEGRATION OF SERVICES

I am going to ask you about the awareness and experience of a service provider in providing integrated health *services. (In this context, integrated services mean the provision of malaria, family planning, and nutrition services within CTC and ANC-PNC platforms).*

QUESTION	INSTRUCTIONS	RESPONSE
25. Have you ever heard about the integration of services?		No Yes
a. If Yes, what does it mean to you?		
b. If Yes, which services are mainly target for integration at your clinic?	Record all mentioned	
26. Have you ever learned [through training/capacity-building (mentorships, OJT, supportive supervisions] on how to provide FP, Malaria, and Nutrition services within CTC, ANC, and PNC?		Yes No No response
27. Which of the following services do you provide as part of integrated service without skipping within CTC?	Circle all that apply	1. FP Counseling 2. Malaria Screening 3. FP Method Provision 4. Nutrition Assessment (weight and height measurement) 5. Provision of nutrition supplements
28. Which of the following services do you provide as part of integrated service without skipping within ANC?	Circle all that apply	1. FP Counseling 2. Malaria Screening 3. FP Method Provision 4. Nutrition Assessment (weight and height measurement) 5. Provision of nutrition supplements
29. Which of the following services do you provide as part of integrated service without skipping within PNC?	Circle all that apply	1. FP Counseling 2. Malaria Screening 3. FP Method Provision 4. Nutrition Assessment (weight and height measurement) 5. Provision of nutrition supplements

HSPS' MOTIVATION

Now, I am going to ask about your motivation to provide integrated services. *(Integrated services mean the provision of malaria, family planning, and nutrition services within CTC and ANC-PNC platforms).*

In each of the following motivation areas, I will ask you to rate whether you are "***Not motivated at all, Motivated a little bit, Very Motivated or Extremely motivated"***. Further, each of the options provides reasons for your rating.

MOTIVATION AREAS	NOT AT ALL (4)	A LITTLE BIT (3)	VERY MOTIVATED (2)	EXTREMELY MOTIVATED (1)	REASONS
Type of leadership and management support I get from the region, district, and facility	☐	☐	☐	☐	
Space availability and the general infrastructure environment to provide integrated health services	☐	☐	☐	☐	
Availability of commodities and supplies	☐	☐	☐	☐	
The longer time spent with clients when providing integrated service	☐	☐	☐	☐	
Availability of the SOP and guidelines	☐	☐	☐	☐	
The training received on the provision of FP, Malaria, and nutrition services within CTC, ANC-PNC	☐	☐	☐	☐	
Providing family planning, malaria, or nutrition services to a CTC, ANC, and PNC client	☐	☐	☐	☐	

TASK SHIFTING/SHARING

QUESTION	INSTRUCTIONS	RESPONSE
30. Do you perform tasks that are out of your assigned duties?	Select one	Yes No Don't know
31. If yes, is task delegation or expansion of roles helpful in reducing the work burden?	Select one	Yes No Don't know
32. Is there a policy or legal guidelines to guide task delegation or expansion of roles in your facility?	Select one	Yes No Don't know
33. If No, what guides you to perform task delegation or expansion of roles in your facility?	Circle all that apply	a. Volunteering spirit - the willingness of HSPs to perform tasks. b. Perception of self-efficacy (HSPs feels skilled to take more tasks) c. Because of the provision of integrated services d. Facility infrastructure e.g., space, information management systems, use of space, availability of commodities and supplies e. Work experience f. On the job training and mentorship/coaching received g. Good relationship and cooperation among staff h. Obeying order from top management i. Supportive supervision j. Others, specify.
34. What are the perceived consequences of task delegation or expansion of roles in your clinic?	Circle all that apply	a. Ensuring continuity of health service provision b. It is an HSPs' opportunity to learn c. It reduces client waiting time d. It reduces overcrowding of clients e. It improves HSPs' working relationships f. Increases workload without extra payment g. It results in inadequate equipment to perform assigned tasks

QUESTION	INSTRUCTIONS	RESPONSE
		h. It results in a lack of confidence for those who did not receive any training i. It delays service provision j. Others, specify

SELF-EFFICACY

Now, I am going to ask about your judgment of how well you can provide integrated services. (*Integrated services mean the provision of malaria, family planning, and nutrition services within CTC and ANC-PNC platforms*).

On a scale of 1 to 4, where 1 means low and 4 high. In each of the following self-efficacy areas, I will ask you to rate whether you are ***"Not at all true, hardly true, moderately true, and exactly true"***.

Further, each of the options provides reasons for your rating.

SELF-EFFICACY AREAS	NOT AT ALL TRUE (1)	HARDLY TRUE (2)	MODERATELY TRUE (3)	EXACTLY TRUE (4)
If I experience a work burden, I can find the means and ways to deliver integrated services.	☐	☐	☐	☐
I feel I have adequate experience and skills to cope with unexpected facility challenges e.g., shortage of space, unstandardized intra-facility, commodity unavailability, etc	☐	☐	☐	☐
An unexpectedly large number of clients reduces my ability to offer integrated services	☐	☐	☐	☐
No matter what comes along my way in the provision of integrated services, I can usually handle whatever comes my way.	☐	☐	☐	☐

ANNEX 3: IN-DEPTH INTERVIEW GUIDE FOR HEALTH CARE PROVIDERS

KII GUIDE FOR HSPS

Introduction and Consent Form

Hello. Thank you for agreeing to speak with me/ today. My name is_____ (moderator name) and my colleague(s) here is/are_____ (note-taker/co-interviewer name). We work for the Coordinating Implementation Research to Communicate Learning and Evidence (CIRCLE) Project, a USAID-funded project that seeks to facilitate real-time learning and adaptation for the USAID Boresha Afya project implemented in three zones of Tanzania (Southern, Lake, and Central and Northern zones). We are conducting a provider workload case study in Boresha Afya supported health facilities in three selected regions of Iringa, Dodoma, and Mara: one region in each of the three zones of implementation. The purpose of conducting this study is to learn factors affecting HSPs' perceived workload and understand how such workload affects the provision of integrated health services within CTC, ANC/PNC outlets. The study will also identify the opportunities to improve efficiencies in the provision of integrated health services on each of the broad categories of CTC and ANC/PNC services to inform and advise stakeholders (USAID and Government of Tanzania) about the efficient provision of integrated health care services to Tanzanian citizens among pre-selected outlets. You have been suggested as a key person to inform this study due to your involvement in the provision of integrated health services and/or collaboration with the USAID/Boresha Afya activities implementation and/or your role in the Central/Local Government in Tanzania, managing several interventions including this. We would therefore appreciate getting your perspective/views on this to get a clear understanding of HSPs workload and provision of integrated health services. The interview will not exceed an hour.

Confidentiality: As part of the Confidentiality and Privacy protocol, any information, or examples we gather during this interview will not be attributed to you personally. Your privacy will be protected; we will not include your name or any information in our reports that would make it possible to identify you without your consent. This study is not meant to "get anyone in trouble" but rather to improve the provision of integrated services while considering HSPs workload. We also ask that what we discuss today remains here with us.

Right to ask questions and report concerns: You also have the right to ask questions about this study and to have those questions answered by us during or after the interview. If you have any concerns, you also have the right to raise them and receive a response from us at any time during this interview session. But, if you have any further questions about the study or have any concerns at a later stage feel free to send them to Beati Mboya, Chief of Party, CIRCLE, at e-mail bmboya@socialsolutions.biz or via phone number 255 767 360 877. Again, the decision to participate in this study is entirely yours. You may refuse to take part in this interview, and you are free to decline to respond to any of our questions or stop the interview at any time. You will not be penalized if you choose to not answer any question or to withdraw from this discussion. The interview will take approximately one hour.

Consent to participate in the interview: Do you agree to participate in this interview today? Yes /No

Consent to a recording of the interview: With your consent, we would also like to record this interview so that we can analyze it accurately along with those of other interviewees.

May I start the recorder? Yes/No

INTERVIEW GUIDE

Awareness regarding the provision of integrated services

1. What does it mean to you for a client to receive integrated services within CTC, ANC, and PNC?

    a. What types of services do you consider as being integrated into those outlets and why? How is this different today, compared to five years ago or earlier (if at all)?

    b. In what ways do you think that having services integrated can benefit the client and/or HSPs, if at all?

    c. Do you think Integration of services is feasible in your clinic? Please describe your answer. What else would be needed to help you achieve this?

    d. How has BA support improved your skills to provide integrated services? How is this different today, compared to five years ago or earlier (if at all)?

    e. What more support do you think is needed to improve your ability to provide integrated services?

Perceived self-efficacy

2. What circumstances prevent or facilitate your ability to provide integrated services within CTC, ANC-PNC platforms?

    [*Interview; probe for the following circumstances that would affect HSPs self-efficacy, if not mentioned: An unexpectedly large number of clients, spaces availability, unstandardized intra-facility referrals, commodity unavailability, having to refer to guidelines many times, etc.*]

    a. What can be done to improve your ability to cope with facility/clinic prevailing environments so that you can provide integrated family planning, malaria, and nutrition without skipping?

    b. Considering facility environments, in what ways do you feel that the types of training provided to HSPs are relevant and adequate for you to offer integrated malaria, FP, and Nutrition services?

HSP time allocation

3. What types of tasks do you perform during a typical day in this clinic? [Interviewer: probe for the task performed in the morning, mid-morning, and afternoon hours]

    a. What drives your decision to plan your time on tasks above and why? [*probe drivers for morning, mid-morning, and afternoon hours. Probe for operational drivers/criteria (e.g., practice standards, guidelines, administrative norms for scheduling, staffing, task allocation; (2) cognitive/behavioral drivers/criteria (e.g., perceived support from management and staff team, perception of self-efficacy and control in work about integration, client behavior) and (3) contextual drivers/criteria (e.g., facility conditions, infrastructure, information management systems, use of space, availability of commodities and supplies*].

b. What support do you think is needed to improve your ability to better organize your day so that you don't feel the work pressure?

Perceived workload

4. In your view, what are the different situations or scenarios where you consider your day as loaded in your clinics?

   a. Which clinic among CTC, ANC, and PNC is more loaded and why?

   b. In those days, are clients likely to receive multiple services? If yes, what types of additional service are clients likely to receive and why?

      [*Interviewer; please probe if malaria, FP, and Nutrition types of services are included in the multiple service packages within CTC, ANC, and PNC*]

   c. In those days, please describe the situation you see in the client waiting area, are clients waiting longer than anticipated?

5. Personally, how do you cope with a loaded clinic day? What role does your facility management play to ensure that your workday is not loaded?

6. What needs to be done to ensure that your work burden is balanced?

HSPs' motivation

7. What are the different ways that make you willing to provide FP, malaria, and nutrition in an integrated fashion within CTC, ANC-PNC?

   a. We understand from previous DE findings that HSPs perceived provision of integrated services increases work burden. How willing are you to continue providing integrated services despite perceived workload circumstances in this clinic?

   b. What kind of support is needed to improve your willingness to provide integrated services?

Task shifting/sharing

8. Describe different ways used by HSPs to delegate or expanded tasks among HSPs in this clinic?

9.

   c. What types of tasks are being delegated/expanded among cadres? Which cadres are mostly involved? *[probe for both planned and unplanned task delegation/expansion]*

   d. What are the drivers for task delegation/expansion among the cadres in this clinic?

      [*Interviewer: probe for planned drivers (e.g., according to guidelines, administrative norms for tasks sharing, staffing reasons, task allocation buy administration; (2) unplanned/behavioral drivers (e.g., the willingness of HSPs to perform tasks, perception of self-efficacy, and control in work about integration,*

client behaviour) and (3) contextual drivers (e.g., facility conditions, infrastructure, information management systems, use of space, availability of commodities and supplies].

e. What is needed to be done to ensure that task delegation or expansion helps to cope with HSPs work pressure, if at all?

10. Which services do you perceive are easier to offer in an integrated package than others when you compare malaria, nutrition, and family planning services? Provide reasons for your answer.

ANNEX 4: KEY INFORMANT INTERVIEW GUIDE FOR CHMT MEMBERS

KII GUIDE FOR CHMTS (RCHCO AND/OR DAC)

Utangulizi

Habari! Ninakushukuru kwa kukubali kuongea na mimi leo. Jina langu ninaitwa …… Ninafanya kazi kwa kushirikiana na mradi unaoratibu utekelezwaji wa utafiti unaotoa mafunzo na vitendo (CIRCLE) ambao ni mradi unaofadhiliwa na USAID ukidhamiria kuchochea mafunzo yenye uhalisia na kupokeleka kwa ajili ya mradi wa Boresha Afya wa USAID unaotekelezwa katika kanda tatu za nchini Tanzania (Kusini, Kati Pamoja na kanda ya Ziwa, Kaskazini na Magharibi). Tunafanya utafiti kuangalia kwa undani kiwango cha kazi kwa watoa huduma za afya katika vituo vya afya vinavyofadhiliwa na Boresha Afya ndani ya mikoa mitatu iliyochaguliwa ya Iringa, Dodoma na Mara: ambapo ni mkoa mmoja katika kila kanda inayotekeleza mradi huo. Dhumuni la kufanya utafiti huu ni kuelewa utoaji wa huduma mseto (Integrated Services) ndani ya vitengo vya CTC, ANC-PNC na vitu vinavyochangia utoaji wa huduma hiyo ikiwamo mtazamo wa watoa huduma za afya kwenye kiwango cha kazi. Pia, utafiti huu utaibua uwezekano wa kuboresha ufanisi katika kutoa huduma mseto (Integrated Services) ndani ya vitengo vya CTC and ANC-PNC ili kuonesha na kushauri wadau (USAID na Serikali ya Tanzania) kuhusu ufanisi wa utoaji wa huduma mseto za afya kwa watanzania ndani ya vitengo hivyo vilivyochaguliwa. Umependekezwa kama mmoja wa watu muhimu kushiriki katika utafiti huu kutokana na ushiriki wako katika kutoa huduma mseto za afya au ushiriki wako katika utekelezaji wa shughuli za Boresha Afya za USAID au kutokana na majukumu yako katika sekta ya afya nchini Tanzania, katika kusimamia shughuli mbalimbali ikiwa ni Pamoja ud aw. Kwa hiyo, tungependa kuelewa unachukuliaje/mitazamo yako juu ya hili na kupata uelewa halisi wa kiwango cha kazi kwa watoa huduma za afya na utoaji wa huduma mseto za afya. Mahojiano haya hayatazidi ud awa saa moja.

Usiri: Kipengele kimojawapo cha muongozo wa usiri na faragha ina maana kwamba taarifa yoyote au mifano tunayokusanya wakati wa mahojiano haya havitahusishwa na wewe binafsi. Hali ya ufaragha kwako italindwa; hatutaambatanisha jina au taarifa yako yoyote katika machapisho yetu hali ambayo itawezesha kukutambua wewe bila ya ridhaa yako. Utafiti huu hauna nia ya "kumsababishia mtu yeyote matatizo" ud aw kwa ajili ya kuboresha utolewaji wa huduma mseto za afya kwa kuzingatia kiwango cha kazi kwa watoa huduma za afya.

Haki ya kuuliza maswali na kutoa taarifa kwa hoja zozote: Pia una haki kuuliza maswali yoyote kuhusu utafiti ud aw kujibiwa maswali hayo na sisi wakati au baada ya mahojiano. Ikiwa una hoja zozote, pia una haki ya kuzitoa na kupewa maelezo kutoka kwetu muda wowote wakati wa mahojiano haya. Lakini, ikiwa una maswali ya ziada kuhusiana na utafiti huu au una hoja zozote baadae jisikie huru kupeleka kwa Beati Mboya, Mkuu wa Kazi, CIRCLE, kupitia kwa barua pepe bmboya@socialsolutions.biz au kwa namba ya simu 255 767 360 877. Lakini pia, uamuzi wa kushiriki katika utafiti huu ni juu yako kabisa. Unaweza kukataa kushiriki katika mahojiano haya, na upo huru kukataa kujibu maswali yoyote au kusitisha mahojiano muda wowote. Hautaadhibiwa ikiwa utaamua kutojibu swali lolote au kukataa kuendelea na mahojiano. Mahojiano yatachukua takribani ud awa saa moja.

Ridhaa ya kushiriki katika mahojiano: Je, umekubali kushiriki katika mahojiano haya leo?
Ndio/Hapana

Ridhaa ya kunasa sauti ya mahojiano: Kwa ridhaa yako, tungependa pia kunasa sauti ya mahojiano haya ili kuweza kufanya uchambuzi kwa usahihi sambamba na mahojiano ya washiriki wengine.

Ninaweza kuwasha kinasa sauti? Ndio/Hapana

Mwongozo wa mahojiano

A. Maswali ya utangulizi

   i. Kada ya muhudmu (District RCH Coordinator/ District AIDS Coordinator)

   ii. Je umefanya kazi muda gani katika sekta ya afya?

   iii. Muda gani umefanya kazi kama DRCHco au DAC?

   iv. Umeshawahi kufanya kazi katika kitengo cha RCH? Au CTC? Kama ndio Kwa muda gani?

B. Ufahamu wa uwepo wa Boresha Afya na huduma wanazotoa

   i. Umeshawahi kusikia Boresha Afya (BA)? Tafadhali nielezee (Walianza lini, mradi wao unaisha lini, wapo kwenye vituo vingapi katika wilaya yake).

   ii. Ni huduma gani wanatoa au wamezitoa katika wilaya?

   iii. Dodosa: aina? wanazitoa kwa akina nani? Kwa muda gani?

   iv. Wadau gani wengine Zaidi ya sekta ya afya wanafanya nao kazi? Ni zipi?

C. Uelewa kuhusu huduma mesto na kama huduma inatolewa vituoni

   i. Umeshawahi kusiskia kuhusu huduma mesto "integrated services"? Ina maana gani? Inamaanisha nini kwako mteja anapopata huduma mseto? *Dodosa: katika ANC au PNC (RCH) na CTC?*

   ii. Ni aina gani za huduma ambazo wewe unazitambua kama huduma mseto katika kliniki za CTC, ANC au PNC? Kwa nini? Na ni kwa namna gani utoaji wa huduma mseto umeleta utofauti ukilinganisha leo na miaka takribani mitano iliyopita? Kwanini unaona hivyo?

   iii. Kuna faida yoyote kwa hizi huduma mseto? *Dodosa:* ikiwa ndio ni kwa vipi huduma mseto kunaweza mnufaisha mgonjwa? Na inaweza kumnufaisha mtoa huduma kwa njia ipi? Ikiwa hapana kwanini unaona hivyo?

   iv. Je ni kwa namna gani Boresha Afya imeboresha utoaji wa huduma mseto katika vituo vilivyo chini yako? *Dodosa:* wameboresha vitu gani ili kusaidia/ kuhamasisha utoji wa huduma mseto?

   v. Wewe binafsi unafaidikaje/umefaidikaje na wanavyo toa hizi huduma katika supervision zako?

D. Utoaji wa huduma mseto na kutambua ufanisi wa kibinafsi

   i. Ni mazingira gani yanasaidia au yanayowezesha watumishi wa afya watoe huduma mseto katika vituo? Hapa tunaongelea huduma kwenye maeneo ya CTC, ANC na PNC (RCH)?

ii. Ni changamoto gani wanakutana nazo zinazo zuia utoaji wa huduma mseto? *Dodosa:* Hapa tunaongelea huduma kwenye maeneo ya CTC, ANC na PNC (RCH)?

iii. Kwa maoni yako je watoa huduma ya afya huwa wanatoa hizi huduma mseto katika vitengo vya ANC or PNC, and CTC kila wateja wanavyokuja? Kwanini unafikiri hivyo? Je kuna kitengo kina ufanisi zaidi ya kingine? Kwanini unaona hivyo?

iv. Je unafikiri ni nini kinaweza kufanyika ili kuboresha uwezo wa watoa huduma kukabiliana na mazingira tofauti tofauti katika vituo vyao ili waweze kutoa hudumma mseto za uzazi wa mpango, lishe au malaria bila kuruka/ kuacha?

v. Wewe kama kiongozi wa wilaya unasaidia vipi au unafanya vitu gani kuwezesha utoaji wa huduma mseto katika vituo kwenye idara za CTC, ANC na PNC?

E. Utoaji wa huduma mseto kwa kuangaia mpangilio wa muda wa wahudumu wa afya

i. Je watoa huduma vituoni katika vitengo vya CTC au RCH (ANC au PNC) huwa wanapangaje muda wao wa kazi?

Dodosa: kazi unazozifanya:

- Saa 07:30-10:00,
- saa 11:00-13:00,
- saa 140:00-15:30]

Nini kinakupelekea kufanya maamuzi ya namna wanavyopanga muda wao na kazi ulizozitaja na kwanini?

Dodosa: Nini kinapelekea unaamua kupanga kazi……

- Saa 07:30-10:00,
- saa 11:00-13:00,
- saa 140:00-15:30

Dodosa:

- Visababishi vya kiutendaji (mf. Viwango vya utendaji, miongozo, taratibu za kiutawala katika ratiba za kazi, idadi ya wafanyakazi, mgawanyo wa kazi/majukumu;
- Visababishi/vigezo vya kujitambua/tabia (mf. Mtazamo juu ya ushirikiano kutoka kwa uongozi wa kituo na wafanyakazi wenzako, mtazamo wa uwezo binafsi wa kusimamia kazi zinazohusiana na huduma mseto, mtazamo wa *kujiamini kuwezo kutoa huduma zinazohusiana na huduma mseto,* mtazamo wa uwezo binafsi wa kukabiliana na tabia mbalimbali za wateja
- Visababishi vinavyohusiana na mazingira ya kazi (mf: mazingira/majengo ya kituo, miundombinu, mfumo wa utoaji/utunzaji taarifa, matumizi ya eneo la kazi, upatikanaji wa vifaa tiba na madawa].

ii. Kwa maoni yako kama kiongozi, je unahusika kwa namna gani katika kupanga ratiba kwa watoa huduma ili waweze kuhudumia wateja/wagonjwa?

iii. Je msaada gani unadhani unahitajika ili watumishi waweze kuboresha mpangilio wa kazi wa siku kwenye maeneo ya CTC, ANC na PNC (RCH)?

F. Kiwango cha kazi na utoaji huduma mseto

i. Je watoa huduma vituoni katika vitengo vya CTC au RCH (ANC au PNC) huwa wanaripoti kuhusu kulemewa na kazi? Ni mazingira gani tofauti-tofauti yanayowafanya waone wamelemewa na kazi?

ii. Ni kliniki ipi kati ya CTC, ANC na PNC imeelemewa na kazi na kwanini?

iii. Je katika siku waliyo lemewa na kazi; uwezekano wa wateja kupata huduma mseto unakuwaje? Kwanini au kwanini sio? Je ni huduma zipi za mseto mteja ana uwezekano wa kupata? Na kwanini?

iv. Je unafamanu ni mbinu gani wahudumu wa afya wanazitumia ili kukabiliana na siku walizolemewa?

v. Kwa maoni yako kama kiongozi, unahakikishaje kuwa wahudumu wa afya hawalemewi? unawezaje kusaidia kuona wafanyakazi hawalemewi?

G. Motisha kwa wahudumu wa afya kuweza toa huduma mseto

i. Je ni vitu gani vinawafanya au vinawawezesha wafanyakazi katika CTC, ANC na PNC kuendelea kutoa huduma mseto Pamoja na changamoto walizo nazo?

ii. Kama kiongozi ni mbinu gani unatumia kuhakikisha wahudumu wa afya wanakuwa na utayari wa kutoa huduma mesto?

H. Kuhamisha au kushirikiana kazi (Task sharing and task shifting)

i. Tafadhali unieleze njia tofauti zinazotumiwa na watoa huduma wa afya katika kugawa au kuongeza majukumu kati ya watoa huduma wa afya katika kliniki za CTC, ANC na PNC?

ii. Je ni aina gani ya majukumu yanayogawanywa/au kuongezwa kati ya kada? Ni kada zipi zinahusishwa Zaidi? Dodosa: majukumu yaliyopangwa au kutokupangwa]

iii. Je ni vigezo vipi vinatumika kugawa/kuongeza majukumu ya kazi miongoni mwa kada mbalimbali ndani ya kliniki hii?

Dodosa:

(1) Vigezo vilivyopangwa mfano,

- kulingana na miongozo,
- kanuni za kiutawala za kushirikiana majukumu,
- idadi ya watumishi,

- upangaji wa majukumu kiutawala;

(2) Vigezo vya dharura mfano

- utayari wa HSPs kufanya kazi,
- mtazamo wa uwezo binafsi wa kusimamia kazi zinazohusiana na huduma mseto,
- mtazamo wa kujiamini kuwezo kutoa huduma zinazohusiana na huduma mseto,
- mtazamo wa uwezo binafsi wa kukabiliana na tabia mbalimbali za wateja

(3) Visababishi vinavyohusiana na mazingira ya kazi (mf:

- mazingira/majengo ya kituo
- miundombinu,
- mfumo wa utoaji/utunzaji taarifa
- matumizi ya eneo la kazi,
- upatikanaji wa vifaa tiba na madawa)

iv. Kama mtendajii unahusikaje au unasaidiaje katika swala la kushirikiana majukumu ''task shifting''?

I. Kabla ya kumalizia:

Kwa maoni yako, ni kwa kiasi gani unaonaBA imewezesha vituo vituo kutoa huduma mseto? Kwa vipi?

i. kwa maoni yako BA wakimaliza mradi wahudumu wataendelea kutoa huduma mseto? Kwanini au kwa nini sio?

ii. Kama kiongozi mna mikakati gani ya kuhakikisha uendelevu wa utoaji huduma mseto katika wilaya yako pindi BA wakiondoka?

J. Kumaliza/ kufunga

Je kuna jambo lolote ambalo hatujajadili katika mada zetu za leo na ungependa kunishirikisha?

ANNEX 5: CASE MANAGEMENT FORM

Complete Case Management Form for each sampled Health Service Provider (HSP) you have been assigned. **Contact attempts should be done on a different day and at a different period of the day each time.**

Contact name:			Contact unique 5-digit ID:	
SECTION A. CONTACT ATTEMPTS				
CONTACT ATTEMPT #1				
Date:	Time:	Outcome: ☐ Interviewed ☐ No answer ☐ Number not valid ☐ Someone else answered. ☐ Availability/time (fill out rescheduled field)	☐ Refused (specify the reason): ☐ Other (specify):	Re-scheduled to: Date: Time:
CONTACT ATTEMPT #2				
Date:	Time:	Outcome: ☐ Interviewed ☐ No answer ☐ Number not valid ☐ Someone else answered. ☐ Availability/time (fill out rescheduled field)	☐ Refused (specify the reason): ☐ Other (specify):	Re-scheduled to: Date: Time:
CONTACT ATTEMPT #3				
Date:	Time:	Outcome: ☐ Interviewed ☐ No answer ☐ Number not valid ☐ Someone else answered. ☐ Availability/time (fill out rescheduled field)	☐ Refused (specify the reason): ☐ Other (specify):	Re-scheduled to: Date: Time:
NOTES: The interview went well				

FOR MORE INFORMATION

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