Task Shifting for Maternal Healthcare Services:

A Qualitative Study of Policy and Practice in Nigeria's Primary Healthcare System

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ABSTRACT

Task shifting is the delivery of healthcare services by less specialised healthcare workers due to workforce shortages following requisite training and supervision. It has been used to deliver maternal and other essential healthcare services in Nigeria's primary healthcare facilities. A decade after the formulation of the first national task-shifting policy, there is limited understanding about the policy's emergence and evolution, and the influences that have shaped its practice for delivering maternal healthcare services which are a priority for Nigeria given its high maternal mortality rate in the last two decades. Most studies that have explored task shifting in Nigeria adopted a rational view, failing to interpretively uncover how task shifting happens in primary healthcare settings and under what influences. Notably, no previous study has used an interpretive policy analysis (IPA) framework to examine the evolution of task shifting policy and its practice in Nigeria. This study addresses these gaps by providing an understanding of how Nigeria's task-shifting policy emerged and evolved, as well as the influences that shaped its practice in the Federal Capital Territory (FCT), with a focus on its application for delivering maternal health services in primary healthcare settings.

I designed a qualitative study using an IPA framework to explore the meanings, beliefs, values, and interests of policy actors involved in developing, interpreting, and implementing policy. I collected data by iteratively integrating three methods: documentary analysis, semi-structured interviews, and focus group discussions. My analysis focused on identifying interpretive communities, defined as policy actors sharing common values, interests, and meaning-making, to explore their interpretations and meanings of the task-shifting policy and the influences shaping its practice in the FCT's primary healthcare facilities.

My findings demonstrate that the task-shifting policy and its practice in Nigeria are socially constructed and shaped by the interpretations, meanings, and interests of policy actors in four interpretive communities: optimists, advocates, guardians, and practitioners. The emergence

and evolution of the task-shifting policy followed global and regional recommendations and was mainly influenced by the interests of policy actors in the interpretive communities of optimists and advocates, with some resistance from some policy actors in the interpretive communities of guardians and practitioners. The practice of task shifting was shaped by the interests, interactions, and agency of frontline healthcare workers, and by gaps in several key requirements for task shifting such as training and supervision, human resources, referral systems, regulatory mechanisms, commodities, and infrastructure.

Amid the resource constraints and tensions between healthcare workers, the delivery of maternal health services was sustained by a facility sustenance fund raised through collective social entrepreneurship. However, the delivery of maternal healthcare services through task-shifting has prioritised increased access at the expense of quality of care, thereby putting patients at risk of adverse outcomes. I argue that, ideally, the practice of task-shifting for maternal healthcare in primary healthcare settings should be discontinued. However, it remains an indispensable stopgap measure and, in the interim, should be implemented with a clear focus on quality of care. Until the FCT's primary healthcare system can be weaned off its reliance on task-shifting through sustained investments in long-term workforce development and system strengthening, task-shifting should be used cautiously, with careful attention to regulation, supervision, the quality of care delivered and the interests of policy actors.

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DECLARATION

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's Regulations and Code of Practice for Research Degree Programmes and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is my own work. Work done in collaboration with, or with the assistance of others, is indicated as such. Any views expressed in the dissertation are mine.

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LIST OF ABBREVIATIONS

AMAC	Abuja Municipal Area Council
ANC	Antenatal Care
BHCPF	Basic Health Care Provision Fund
CHEWs	Community Health Extension Workers
CHOs	Community Health Officers
CHWs	Community Health Workers
CP	Community Pharmacist
DRF	Drug Revolving Fund
FCT	Federal Capital Territory
HEW	Health Extension Workers
HHSS	Health and Human Services Secretariat
IPA	Interpretive Policy Analysis
JCHEW	Junior Community Health Extension Workers
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
LARC	Long-Acting Reversible Contraceptives
LMICs	Low- and Middle-Income Countries

MDGs	Millennium Development Goals
NCDs	Non-communicable Diseases
PEPFAR	U.S. President Emergency Plan for AIDS Relief
PHC	Primary Health Care
PPMV	Patent and Proprietary Medicine Vendors
SBAs	Skilled Birth Attendants
TBAs	Traditional Birth Attendants
TSTS	Task Shifting and Task Sharing
UNAIDS	Joint United Programme on HIV/AIDS
WHO	World Health Organisation

GLOSSARY OF TERMS

Glossary Term	Glossary Definition
Cadre	Refers to a group or category of health workers, often distinguished by their skill level, training, or role within the healthcare system
Collective Social Entrepreneurship	"Collaboration amongst similar as well as diverse actors for the purpose of applying business principles to solving social problems."(Montgomery et al., 2012, p. 376)
Commodities	Refer to essential health products, supplies and materials needed for providing healthcare services such as medicines, vaccines, medical supplies, and laboratory consumables.
Community Health Worker	Community health workers (CHWs) are health care providers who live in the community they serve and receive lower levels of formal education and training than professional health care workers such as nurses and doctors. (WHO, 2021)
Development Partners	They are organizations, institutions, or entities that collaborate with governments, healthcare providers or other actors to support and improve health systems and outcomes, often through funding, technical expertise or capacity building.
Facility Manager	Also known as 'In-charge'. The most senior healthcare worker in a primary healthcare facility who is responsible for coordinating all other healthcare workers to deliver services and oversee the overall running of the facility.
Frontline Healthcare Workers	These are health workers who play a crucial role in providing care in primary healthcare facilities and usually working in unprecedented situations.
Infrastructure	Refers to essential facilities, systems, and services that support healthcare delivery and public health, encompassing everything from hospitals and clinics to laboratories, information technology, equipment and transportation networks. (Luxon, 2015)
Interpretive Policy Analysis	Refers to an approach to policy analysis the focuses on understanding the meanings, values, and beliefs embedded in policies, and how these meanings are communicated and interpreted by different policy actors. (Yanow, 2011)
Intrinsic Motivation	Refers to the satisfaction gained from performing actions that benefit other people, community or society and the interests or enjoyment of a task itself. (Lagarde et al., 2019)

Out of Pocket Payment	Refer to direct payments made by individuals or households for healthcare services, goods and medications from private funds without reimbursement from insurance or any other sources.
Policy	Refers to decisions, plans, and actions taken by governments, organizations, or institutions to achieve specific health goals within a society. It encompasses everything from laws and regulations to community outreach efforts, aiming to improve public health.
Policy Actors	Refers to any individual, group or organisation that is directly or indirectly, formally or informally, involved in the construction of policy narratives, evidence and processes and influence the development, implementation, or outcomes of policy. (McHugh et al., 2023)
Policymakers	Refers to individuals or groups responsible for formulating, implementing and evaluating health-related decisions, plans and actions to achieve specific health goals.
Professional Identity	Refers to the sense of self that healthcare workers hold, both as individuals and as a professional group, shaped by the specific roles and responsibilities they are trained for and socially recognised to perform. (Cornett et al., 2023)
Professional Rivalry	Refers to a competitive relationship between individuals or teams, often driven by a desire for advancement, recognition, or resources and mostly in the occurs in settings of limited access to opportunities or resources.
Role Certainty	Refers to the state of healthcare workers being clear, confident and without doubt about their scope of practice and the range of tasks or services they are perform based on their training and clinical guidelines.
Scope of Practice	Refers to the tasks that licensed health professionals are authorised to carry out, with these tasks being defined by state laws or regulations set by the relevant licensing authority. (AMA, 2022)
Skilled Birth Attendant	Refers to accredited healthcare workers (including doctors, nurses, midwives and community health workers), trained to provide essential healthcare services to women during pregnancy, childbirth and the postnatal period, and who can identify, manage and refer complicated cases as needed. (Utz et al., 2013)
Social Entrepreneurship	Refers to the identification of a social problem and the application of entrepreneurship skills to organise, create and manage a venture – to attain social change, and not necessarily to make a profit. (Nteere, 2021)
Social Value	Refer to the broader societal benefits and positive impacts of health interventions and policies on people and communities, going beyond purely economic or individualistic outcomes.

Stock Out	Refers to the complete unavailability or absence of a medicine, health product, or vaccine at the point of service.
Supportive Supervision	Refers is a non-authoritarian, respectful and collaborative approach to supervision that focuses on continuous improvement of health worker skills and performance through guidance, feedback and problem-solving.
Task Shifting	Refers to the rational redistribution of tasks within a healthcare team, where specific tasks are moved from highly qualified health workers to those with shorter training or fewer qualifications, aiming to efficiently utilise available healthcare workers and improve access to care in settings with health workforce shortages.
Traditional Birth Attendant	Refers to a person (often a woman) who assists the mother during childbirth and has acquired her skills through experience, either by delivering babies herself or apprenticeship to other traditional birth attendants, rather than formal training.
User Fees	Refers to charges levied on individuals at the point of care for accessing or utilising public health services.
Vertical Programmes	Refers to targeted health initiatives focused on a specific disease or a small group of diseases with short to medium term objectives and managed separately from the broader health system, often funded by external donors.

WORD COUNT: 70, 691

CHAPTER 1: INTRODUCTION

1.1 Prologue

> *'I think that there's no question that the solution to the problem of access to health care is what we've called task shifting, that the things that the doctors do in some health systems should be moved to nurses. Nurses should take a very much stronger leadership role, especially in developing country healthcare systems and that utilizing community health workers is both a great employment programme and also is tremendously helpful in improving outcomes.'* (Kim, 2014)
>
> **(Dr Jim Yong Kim, Former President, World Bank, 19 September 2014)**

> *'We must act now. We must invest in multidisciplinary teams of health workers and establish services close to communities to promote health, prevent illness and protect populations. Health workers need decent pay and decent working conditions with education linked to jobs, especially for women and youths. These include community health workers who far too often are undervalued and underpaid. A strong health workforce is essential for strong primary healthcare as the foundation of both universal health coverage and global health security.'* (Ghebreyesus, 2023)
>
> **(Dr Tedros Adhanom Ghebreyesus, Director General, WHO, 26 March 2023)**

The two quotes above emphasise the centrality of the health workforce as a vital pillar of health systems. The first presents task shifting as a strategy to address limited access to healthcare caused by doctor shortages, highlighting the important role of nurses and community health workers in improving health outcomes. The second calls for increased investment in the health workforce, stressing that despite their critical role, healthcare workers often face inadequate support and recognition. Although made nearly a decade apart, both statements illustrate that the effective deployment and management of healthcare workers remains a persistent health-system challenge globally.

Healthcare workers play a critical role across all levels of healthcare service delivery, including primary, secondary, and tertiary care. At the primary healthcare level, they are particularly essential because they often serve as the first point of contact for most of the population, especially in rural and underserved areas. However, their performance and effectiveness are

shaped by the actions (or inactions) of several policy actors, such as policymakers and regulators.

Despite the essential role of healthcare workers in delivering services, global shortages continue to place significant strain on health systems, particularly in low- and middle-income countries. Nigeria, like many sub-Saharan African countries, faces a critical shortage of healthcare workers, with the primary healthcare level being especially affected. To address these human resource gaps, 'task shifting', which is an approach that involves the delivery of specific tasks by healthcare workers with lower levels of training and qualification, due to the absence or inadequacy of highly-trained healthcare personnel (Akinyemi et al., 2020) has been adopted at both national and sub-national levels. However, there remains limited understanding of the influences shaping the development and implementation of task-shifting policies in Nigeria. To address this evidence gap, I undertook a DPhil study, exploring the evolution and practice of task shifting for maternal health services within primary healthcare settings, an area that remains under-researched despite its importance.

In this chapter, I provide the background and rationale for focusing my study on task shifting in Nigeria, specifically within the context of maternal health services. I outline the relationship between two major global health challenges: maternal mortality and health workforce shortages. I also demonstrate how human resource gaps in primary healthcare settings limit access to essential maternal healthcare services. I introduce task shifting as a policy response to these shortages and provide an overview of the Nigerian primary healthcare system. The chapter concludes with a rationale for the study, and a synopsis of the structure and content of the subsequent chapters in the thesis.

1.2 My Background: 'From whence thou cams't'?

To begin this section, I reflected on a line from William Shakespeare's play, *All's Well That Ends Well*: 'From whence thou cam'st', examining how my clinical and policy experience in Nigeria shaped the focus of this study. I am a medical doctor with over 12 years of experience spanning clinical and policy roles across different levels of the health system. As a clinician, I worked in both public and private healthcare settings, providing generalist and specialist services across primary, secondary, and tertiary care facilities. This experience allowed me to gain firsthand insight into how healthcare workers collaborate to deliver maternal health services, and to observe the persistent challenges that undermine service delivery. These included critical shortages of healthcare workers, poor infrastructure, inadequate supplies of essential commodities, and weak supervisory and monitoring systems. Working for over three years in primary healthcare settings, I became particularly aware of how workforce shortages at this level negatively impact the quality and accessibility of maternal health services.

After six years of clinical practice, I transitioned to a policy role within the Department of Health Planning, Research and Statistics at the Federal Ministry of Health (FMOH) in Nigeria. In this capacity, I engaged with a broad range of stakeholders, including government officials, regulators, development partners, and professional associations of healthcare workers. Working at the intersection of policy development and service delivery exposed me to the complexities of health system governance and the varying interpretations and applications of health policies. It was during this time that I first encountered the 2014 Task-Shifting and Task-Sharing Policy for Essential Health Care Services in Nigeria. From a policymaker's perspective, the policy appeared clear and well-structured, aimed at addressing human resource gaps through the redistribution of tasks among different cadres of healthcare workers.

However, reflecting on my clinical experience, I recognised that the realities of healthcare delivery often diverged from policy intentions. Although the policy provided clear guidelines,

I realised from my experiences that its implementation appeared to be shaped by the persistent challenges I had witnessed firsthand in clinical practice, such as inadequate resources, professional hierarchies, and system-level constraints. A master's degree in health policy, planning, and financing further deepened my understanding of the dynamics between health systems and service delivery outcomes; my dissertation focused on the cost of maternal health services in low- and middle-income countries.

Subsequently revisiting the task-shifting policy, the gap between policy formulation and on-the-ground practice for task-shifting in Nigeria's primary healthcare system became more evident, motivating me to embark on a DPhil study to critically examine how task-shifting policies are interpreted and implemented in Nigeria, with a particular focus on maternal health services. Given Nigeria's persistently high maternal mortality rates, and the nexus between maternal deaths and limited access to maternal healthcare services in primary healthcare facilities, I chose to focus my study on maternal health services, seeking to explore broader issues related to task-shifting policy emergence, evolution and practice in the context of maternal healthcare services.

In Box 1 below, I have included a fictionalised vignette highlighting the key issues around task shifting for maternal health services, informed by my experiences. Although fictionalised, the vignette reflects true events I saw and heard about from others while working as a clinician. The vignette illustrates the context for task shifting of maternal health services in Nigeria, the roles of different actors, and how task-shifting practice is less about rational task reallocation and more about the interactions and agency of healthcare workers practicing amid resource constraints in primary healthcare facilities.

Box 1: Vignette on task-shifting for maternal health services in Nigeria

Aisha's story: Receiving maternal health services through the task-shifting approach in Bauchi State, Nigeria

Aisha lives in a rural community in Bauchi State. She is 23 years old and has received care from either nurses or community health workers (CHWs) throughout her pregnancy at the primary healthcare clinic. The CHWs were trained four years ago during a WHO-supported pilot programme aimed at advancing task-shifting for maternal health services but, despite promises, the Government failed to sustain the programme following the pilot, so they have had no further formal training since. The nurses informally teach certain skills (e.g., giving episiotomy, active management of the third stage of labour, identifying signs of post-partum bleeding) to the CHWs as they work together. The clinic has limited resources; there is one doctor who covers eight other primary healthcare facilities, and supervises all nurses and community healthcare workers, serving the local population of almost 8,000. He visits each clinic weekly to handle 'complicated' cases. The CHWs have not been paid for four months, yet they continue to work out of commitment to their community.

Aisha is taken to the clinic when she goes into labour at night. Two CHWs are on duty, without nursing or medical cover. They deliver a healthy baby boy, but Aisha has a cervical laceration with postpartum bleeding. The nearest hospital is 4 hours away so the CHWs decide to try to repair the cervical laceration for fear Aisha may bleed to death. The CHWs were not trained in this task because the task-shifting policy states CHWs and nurses are not supposed to suture cervical laceration. However, the CHWs drew on previous experience of assisting the doctor with this procedure and acted to save Aisha's life. The correct sutures were not available, so they improvised, stopping the bleeding, and placing Aisha on IV fluids. Aisha, having lost 1.5 litres of blood, needed a blood transfusion which was not possible at the clinic since it is a primary healthcare clinic without a blood bank. She was referred to a hospital for a blood transfusion but faced significant challenges: the absence of an ambulance to convey her and limited bedspace for admission in the hospital. One of her husband's colleagues used his tricycle to transport her to nearby hospitals. After visiting three hospitals, she eventually got admitted, had a blood transfusion and made a full recovery a few days later. Six months later, the two CHWs who saved Aisha were given an award in recognition of their efforts to save lives in their community. At the award ceremony, an official from the Bauchi State Ministry of Health proclaimed that the Government's efforts to advance task shifting were yielding positive outcomes and reducing maternal mortality.

The vignette raises several unanswered questions about task-shifting in Nigeria. For instance: How have healthcare workers translated the task-shifting policy into practice in primary healthcare facilities? What influences shape the actions and inactions of healthcare workers in the context of task shifting? What circumstances facilitate or impede task shifting of maternal health services within primary healthcare settings? To answer these questions, I embarked on this study to provide a deeper understanding of task shifting in Nigeria and generate empirical evidence that could inform strategies for strengthening task shifting as an approach to improve access to maternal health services in Nigeria's primary healthcare system. Building upon the insights regarding task shifting showcased in the preceding vignette, I proceed to provide details about Nigeria's healthcare system, focusing on two interconnected issues: the limited access to maternal healthcare services, and the shortage of healthcare workers.

1.3 Nigeria's Healthcare System: Health workforce shortage and access to maternal health services

Nigeria is a Federal Republic comprising 36 States and a Capital Territory with 774 Local Government Areas. Each state, including the FCT, has autonomy over the health system within their geographical boundaries with the Federal Government through the Federal Ministry of Health, providing policy guidance for the national health system (Federal Ministry of Health, 2016). Standing as the most populous country in Africa, with English as the official language, in 2023, Nigeria had a population of approximately 224 million, with an average fertility rate of 5.1 births per woman and a life expectancy of 55.76 years (Macrotrends, 2024). Nigeria is very diverse, with over 300 ethnic groups and over 400 languages, of which Hausa, Igbo, and Yoruba are the three main languages (Olanrewaju et al., 2017). It is divided into six geopolitical zones – northeast, northwest, north-central, southeast, southwest, and south-south regions (see **Figure 1**).

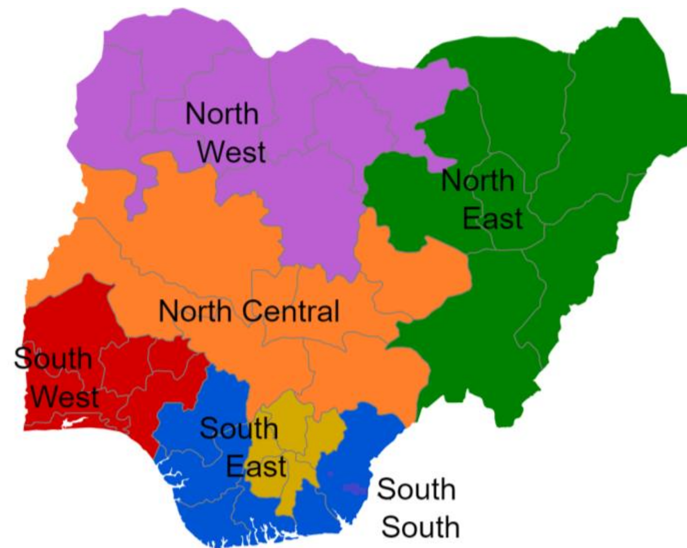


Figure 1: Map of Nigeria showing the six geopolitical zones

Nigeria has a three-tiered healthcare system, with healthcare services delivered at primary, secondary and tertiary levels (Abubakar et al., 2022). Primary health facilities account for 88.2% of all health facilities, while secondary and tertiary facilities represent 11.6% and 0.2%, respectively (Makinde et al., 2018). Primary healthcare services are the responsibility of the local governments, while secondary and tertiary care are provided by state and federal governments respectively (Odutolu et al., 2016). Although responsible for providing primary healthcare services, local governments face financial constraints, because their funds are controlled by state governments in the joint state-local government accounts. This fiscal arrangement and limited financial autonomy impact the ability of the local governments to meet their mandate of providing primary healthcare services, resulting in significant resource constraints in most primary healthcare facilities (Akinwumi et al., 2022). As such, only about 20 per cent of Nigeria's 30,000 primary healthcare facilities are functional (Aregbeshola and Khan, 2017). To support the delivery of primary healthcare services, the local governments receive financial and technical assistance from the federal and state governments through national and state Primary Healthcare Development Agencies (Tilley-Gyado et al., 2016). The

private sector plays a significant role in Nigeria's healthcare system, with privately owned healthcare facilities accounting for one-third of all healthcare facilities (Makinde et al., 2018).

Nigeria has a significant shortage of healthcare workers, with some of the available healthcare workers having limited skill sets (Abubakar et al., 2022). With a skilled health workforce density of 1.83 per 1000 people, Nigeria has only 41% of the WHO recommended density of 4.45 per 1000 people (Olatunji et al., 2024). The WHO identifies health workers as 'people engaged in actions whose primary intent is to enhance health' (WHO, 2006, p. 1). The health workforce comprises different categories of health professionals, with different roles, based on their training and experience. These healthcare worker categories (also known as cadres) are professional groupings based on their training, expected skills, and the range of services they are expected to deliver. There are several healthcare worker cadres in Nigeria, including doctors, nurses, midwives, pharmacists, and community health workers (Sunny C. Okoroafor et al., 2022).

In Nigeria, the health workforce distribution is skewed, with a high population of healthcare workers in urban settlements and within secondary and tertiary healthcare facilities. This results in marked health workforce shortages in rural settlements and within primary healthcare facilities (Nwankwo et al., 2022). Furthermore, many healthcare workers are dissatisfied with their low remuneration, heavy workload, poor conditions of service, limited health facility infrastructure, and uncertain career prospects (Abubakar et al., 2022). The health workforce shortage is exacerbated by brain drain, which depletes the already-limited health workforce population. This health workforce crisis in Nigeria is worsened by recurrent industrial disputes linked to inter-professional rivalry and demands for improved remuneration (Abubakar et al., 2022).

The shortage of healthcare workers in Nigeria has a direct impact on the accessibility of maternal healthcare services. Skilled healthcare workers, such as midwives, nurses, doctors, and CHWs, are either unavailable or insufficient to provide needed maternal healthcare services, especially at the primary healthcare level (Aluko et al., 2019). Maternal health services are a spectrum of health services required by women of reproductive age, and related directly to pregnancy and childbirth, such as antenatal care, emergency obstetric care, delivery, post-natal care, safe abortion, post-abortion care and family planning (Banke-Thomas et al., 2021, 2020). Most maternal health services should be delivered by 'skilled birth attendants' (SBAs), who are accredited healthcare workers (including doctors, nurses, midwives and community health workers), trained to provide essential healthcare services to women during pregnancy, childbirth and the postnatal period, and who can identify, manage and refer complicated cases as needed (Utz et al., 2013). However, in several countries in sub-Saharan Africa there is a dire shortage of SBAs (Roser and Ritchie, 2024), with about 70% of childbirths in Nigeria occurring without an SBA present, increasing the risks of maternal and neonatal morbidity and mortality (Afape et al., 2024).

In primary healthcare facilities, maternal healthcare services are provided by a broad range of healthcare workers, including doctors, nurses, midwives, and CHWs (Aluko et al., 2019). However, these healthcare workers are not adequate to meet the demand for maternal health services in primary healthcare facilities. Some patients avoid facility-based services due to concerns about service quality, cost, or distrust of the healthcare system (Abubakar et al., 2022). Instead, many seek care from informal providers such as patent and proprietary medicine vendors (PPMVs), community pharmacists, and traditional birth attendants (TBAs). PPMVs and community pharmacists primarily retail over-the-counter and prescription medicines, but may also offer basic consultations, including maternal health advice and family planning services (OlaOlorun et al., 2022).

TBAs, as distinct from SBAs, are individuals who assist women during childbirth but lack formal medical training or certification. TBAs typically learn through informal apprenticeships and operate in rural communities where there is limited access to functional healthcare facilities and trained health personnel (Ntoimo et al., 2022). While TBAs are widely patronised in rural areas, they are not formally recognised as healthcare workers, neither are they considered to be SBAs based on national guidelines and recommendations from WHO (Priebe et al., 2024).

The health workforce shortage and low SBA coverage in Nigeria limits access to quality and safe maternal health services (Exley et al., 2016). This limited access to maternal health services is greater in northern Nigeria, where women are less likely to deliver in healthcare facilities compared to southern Nigeria (Chukwuma and Ekhator-Mobayode, 2019; Olarewaju, 2021). The contrast in demand for and access to maternal healthcare services is influenced by differences in cultural norms, socioeconomic status across the regions, and the availability of healthcare workers and infrastructure (Meh et al., 2019). For example, insecurity arising from the Boko Haram insurgency, a violent armed conflict involving Islamist extremist groups operating primarily in northeastern Nigeria, significantly reduced access to maternal health services in affected regions, as health facilities were destroyed, healthcare workers were displaced, and women's mobility was restricted (Chukwuma and Ekhator-Mobayode, 2019).

Furthermore, the culture of child marriage and religion-based restrictions on women's movements have also influenced access to maternal health services in northern Nigeria (Meh et al., 2019). The limited access to maternal health services in Nigeria resulted in very high maternal mortality for several decades. Although maternal mortality (both in Nigeria and globally) has reduced over the past four decades, Nigeria recorded 82,000 maternal deaths, the highest number of maternal deaths in 2020 globally, accounting for an estimated 28.5% of global maternal deaths (WHO, 2023). Recent estimates indicate that, as of 2023, Nigeria continued to report alarmingly high maternal mortality figures, accounting for 28.7% of global

maternal deaths, with 75,000 deaths and a maternal mortality ratio of 993 deaths per 100,000 live births.(WHO, 2025)

Accounting for a significant share of global maternal deaths, maternal mortality remains a major health challenge in Nigeria, reflecting persistent gaps in healthcare access and quality (WHO, 2025, 2023). WHO defines maternal death as 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes' (WHO, 2015, p. 1069). Haemorrhage is the leading cause of maternal death globally, followed by maternal sepsis, hypertensive disorders in pregnancy, obstructed labour, eclampsia, and unsafe abortion (Kassebaum et al., 2014; Say et al., 2014). These causes of maternal death are largely preventable with timely access to quality healthcare and skilled care providers, yet persist in settings where healthcare systems are weak, and SBAs are scarce (Ajegbile, 2023). For Nigeria, these challenges present a heightened risk of maternal deaths, particularly within primary healthcare facilities (Udenigwe et al., 2021).

Recognising the connection between healthcare worker shortages and limited access to maternal health services, several policy interventions have been adopted in Nigeria to improve access to maternal health services at the primary healthcare level over the past four decades (Udenigwe et al., 2021). One of these policy interventions is task shifting, the delivery of specifics tasks by healthcare workers with lower levels of training and qualification, due to the absence or inadequacy of highly-trained healthcare personnel (Akinyemi et al., 2020). As such, task shifting was considered to a viable strategy to address workforce shortages and increase access to maternal healthcare services in primary healthcare facilities and by extension, reduce preventable maternal mortality. Next, I explore task shifting as a policy intervention, and its adoption in Nigeria's primary healthcare system.

1.4 Task shifting: A strategy to reduce the impact of health workforce shortages

There is no globally agreed definition of task shifting, however the WHO definition is widely used:

> *'task shifting involves the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health'* (WHO, 2008a, p. 81)

Task shifting involves healthcare workers with less training delivering services typically performed by more highly-trained professionals, addressing workforce shortages (WHO, 2006). The WHO definition conveys the expectation that using task shifting to reorganise and decentralise healthcare services can reduce the impact of health workforce shortages and increase access to healthcare services generally (WHO, 2008a). Task shifting involves either transferring tasks from specialised healthcare workers to other existing health workers with fewer years of training, or creating a new category to carry out the shifted tasks (Hosler et al., 2018).

This definition of task shifting focuses primarily on **the redistribution of tasks among healthcare workers to make more efficient use of available human resources**. It emphasises increasing access to healthcare services by reallocating duties, but does not provide detailed guidance on how task shifting should be achieved in practice (WHO, 2008a). This way of conceptualising task shifting is predicated on two assumptions. First, that all the policy actors involved in task shifting have similar interests in optimising healthcare access and have a clear understanding of how task shifting should work. Second, that tasks can be rationally broken down into easily identifiable, discrete components, and 'simply' reallocated to different cadres of healthcare workers. This conceptualisation is somewhat idealistic, as policy actors may have varying interests; also, most medical services, such as supporting a woman in labour during childbirth, do not consist of tasks that are easily separable or performed independently. Rather, healthcare delivery typically comprises a series of interdependent processes that necessitate

coordination among multiple healthcare workers. The complexity and interconnectedness of these tasks underscore the critical importance of collaboration between healthcare professionals, to ensure the delivery of safe and effective care (Rosen et al., 2018).

WHO recommends that countries develop and periodically review policies and guidelines for shifting and sharing of tasks across the healthcare workforce (WHO, 2008a, 2012a). Task-shifting policies outline the different tasks that can be undertaken by different healthcare workers, and the referral pathways for the delivery of healthcare services (WHO, 2012a). Task shifting requires supportive regulatory frameworks, functional referral systems, robust quality assurance mechanisms, adequate remuneration for health workers, and infrastructure for health service delivery (WHO, 2008a). In addition, appropriate training, supportive supervision, and adequate financing are key to implementing task shifting (Leong et al., 2021). **Figure 2** below outlines some of requirements for task shifting recommend by the WHO.

Figure 2: WHO-recommended essential requirements for task shifting

Although the factors listed above are essential requirements for task shifting, viewing them as the only key determinants oversimplifies the process. Most recommendations for task shifting do not fully acknowledge the broader influences involved. These include the interdependencies within medical work, the professional identities of healthcare workers, the role of government policies, and the complex, adaptive nature of health systems. Further exploration of how the

interests and values of different stakeholders influence the task shifting process are discussed in the findings section of this thesis (in Chapters 4-6), after the literature review and methodology for the study have been outlined.

In 2012, WHO recommended task shifting for delivering maternal health services. The advice was that SBAs should support all births, and WHO identified roles for different healthcare workers, including non-specialist doctors, associate clinicians, nurses, midwives, auxiliary nurses, and lay health workers (WHO, 2012a). In summary, WHO's recommendations provided a framework for redefining healthcare roles, emphasising the importance of maximising available human resources through task shifting to address maternal health needs, particularly in resource-constrained settings like Nigeria.

1.5 The Policy and Practice of Task Shifting in Nigeria

Premised on WHO recommendations, and a small but growing evidence base, Nigeria published its first policy on task shifting in 2014. The policy focused on several priority healthcare services and diseases, such as maternal health, child health, HIV/AIDS, Tuberculosis and Malaria. The maternal health services to be shifted or shared, based on the task-shifting policy, included antenatal care, childbirth, postnatal care, and family planning services, which were mainly delivered by medical doctors, nurses, midwives, and community health workers (FMOH, 2014). By 2018, more than half of the 37 sub-national governments in Nigeria had formally adopted task-shifting policies aligned with the national framework. While these governments nominally conformed to the national task-shifting policy, by formulating state level task-shifting policies, policy implementation remained inconsistent and poorly prioritised by the national and state governments (FMOH, 2018). Despite limited government prioritisation, the 2014 national task-shifting policies were reviewed and updated in 2018 and 2022, indicating some sustained interest from certain policy actors.

Although the government's endorsement of task shifting was implied by the formulation of the policy, it provided limited financial and infrastructural support for its implementation. Rather, early task-shifting pilot programmes were backed by development partners and NGOs such as WHO and UNFPA, which provided targeted performance-based incentives alongside ad-hoc training, supervisory systems, and referral support (Deller et al., 2015). Although the outcome of these task-shifting pilot programmes in Nigeria was positive, validating the proposition that task shifting can increase access to essential healthcare services (Baruwa et al., 2022; Charyeva et al., 2015; Deller et al., 2015), the long-term sustainability of these programmes remains unclear, as there is limited evidence on whether these pilot initiatives were scaled up or integrated into broader government-led healthcare programmes.

It is also unclear what influences shaped the emergence, evolution and implementation of the task-shifting policy. This necessitates the exploration of the policy and practice of task shifting to understand how task-shifting policy has evolved and is being implemented in Nigeria. Furthermore, there is an uncertainty about how healthcare workers and other policy actors in Nigeria's primary healthcare system interpreted and operationalised the task-shifting policy, particularly given their varied interests and values. This uncertainty underscores the need for research on how policy intentions translate into frontline healthcare practices. As such, I have adopted a methodological approach that interpretively explores the meanings, interests and values of actors related to the task-shifting policy, and how these shape their actions (or inactions) in the context of maternal healthcare services.

1.6 Study Rationale

Healthcare delivery is a social process (Braithwaite et al., 2021), where accomplishing one or more medical tasks involves negotiation and interaction between health workers. Accordingly, the practice of task shifting is shaped by several influences, such as the interactions between healthcare workers, the interests, value and meanings linked to the policy and the value and

meanings, and the availability (or not) of infrastructure and commodities. These influences shape how task shifting is practiced, and determine the success or failure of task-shifting interventions (Nzinga et al., 2019).

Since Nigeria formally adopted task shifting as an approach to address health workforce gaps, there has been no study that explored how maternal healthcare services are delivered via task-shifting in primary healthcare settings. There has also been no study that has interpretively sought to understand how the task-shifting policy emerged and evolved, and the considerations that have influenced its success or failure. Existing studies on task shifting in Nigeria have largely adopted a rationalist perspective, framing task-shifting as a logical, technical solution to health workforce shortages, divorced from the social, political, and contextual realities shaping its implementation. This rationalist view is predicated on the assumption that task shifting would function effectively if all key requirements were in place. However, given the social nature of medical work, and the involvement of diverse policy actors in the formulation and implementation of task-shifting policy, an interpretive approach that acknowledges the influence of several dependencies and the lived experiences of policy actors, is more suited to explain how or why the policy emerged, and the circumstances under which it has been implemented.

To understand the evolution of the national task-shifting policy and identify the influences that have shaped the practice of task shifting for maternal health services within primary healthcare settings in one state in Nigeria (the Federal Capital Territory, or FCT), I designed and conducted a qualitative study. In Chapter 3 of this thesis, I provide details about healthcare delivery in the FCT, alongside a justification for locating the study here. I used three qualitative methods (documentary analysis, interviews, and focus group discussions) to answer the following research questions on task-shifting for maternal health services within primary healthcare settings in the FCT:

i. How did the national task-shifting policy emerge, how has it evolved, and what meaning has been ascribed to it?

ii. Which influences and actors have shaped the practice of task shifting for maternal health services in the FCT?

iii. How can the practice of task shifting for maternal health services be improved within the FCT and across Nigeria?

To answer the above questions, I adopted an interpretive approach, guided by interpretive policy analysis (IPA) as the overarching methodological framework. This approach focuses on how policy actors understand and experience policy, and how their interests, beliefs, values, and interpretations of policy influence their actions (or inactions). Further details of the interpretive approach and study methods are provided in Chapter 3. The next section presents an overview of the thesis, highlighting key insights from each chapter.

1.7 Thesis Overview

Having introduced the concept of task shifting and its link to maternal health services in this chapter, I give an overview of the subsequent chapters of this thesis. Chapters 2 and 3 cover the literature review and the methodology for the study. Chapters 4 to 6 present the results and key findings of the study. The results chapters do not report the findings from each method separately. Rather, each results chapter addresses a different thematic focus related to the research questions and emerging from the concerted analysis of the data from the three methods, in keeping with an IPA framework. Chapter 7 is the penultimate chapter, discussing the findings of the study; Chapter 8 is the concluding chapter of the thesis. Further details of these chapters are provided below:

1.7.1 Chapter 2: Literature Review

This chapter outlines the findings of a narrative review of the literature on task shifting for maternal health services in Nigeria and across Africa, following a synthesis of the literature. I curate the experience of task shifting for maternal and other essential healthcare services from Nigeria and other countries in sub-Saharan Africa. I identify the facilitators and barriers impacting task shifting and highlight key considerations that influence task-shifting policy and practice. I conclude the chapter by outlining the gap in the literature on task shifting in the context of maternal health services and primary healthcare settings in Nigeria's FCT.

1.7.2 Chapter 3: Methodology and Methods

In this chapter, I discuss the methodological approach adopted for the study and provide a rationale for using an interpretive framework. I justify the choice of IPA as the overarching theoretical lens, given its focus on how policy actors understand and enact policy within complex social contexts. I explain how IPA guided both the research design and the analysis, allowing for the interpretive exploration of task-shifting policy and its practice. I outline the three qualitative methods used: documentary analysis, semi-structured interviews, and focus group discussions; describing how these methods were selected to capture insights on the emergence, and evolution of task-shifting policy and its practice in primary healthcare settings. I explain how I iteratively and simultaneously analysed all the study data, using principles of interpretive analysis to concertedly synthesise insights from the three methods, while reflecting on my reflexivity and key ethical considerations.

1.7.3 Chapter 4: Findings I – Evolution and Interpretation of Task-shifting policy

In Chapter 4, I explore the emergence and evolution of the national task-shifting policy in Nigeria. Drawing on IPA, I identify interpretive communities – groups of policy actors with shared values, interests and interpretations of the task-shifting policy. I explore the values and interests of four interpretive communities: optimists, advocates, guardians and practitioners. I then examine how each interpretive community ascribes meaning to the task-shifting policy. I

also draw on Yanow's work to identify interpretive symbols, which are specific objects, acts, and language, that act as 'carriers of meaning' within these communities (Yanow, 1996).

1.7.4 Chapter 5: Findings II – Competence, Availability and Motivation of the Health Workforce

In this chapter, I identify the healthcare workers involved in task shifting for maternal health services in the FCT. I provide details about their competence, awareness of roles, availability, and motivation, and explain how these considerations shape the practice of task shifting. I explain that the practice of task shifting in primary healthcare settings is influenced by healthcare workers' training and supervision, their awareness of professional roles, the precarious employment of volunteers, and the gaps in the referral system. These influence task-shifting practice, because healthcare workers' competence, availability and motivation shape their actions and decisions regarding the delivery of maternal healthcare services, via task shifting.

1.7.5 Chapter 6: Findings III: Health Workforce Dynamics and Collective Social Entrepreneurship

In this chapter, I examine the interactions among healthcare workers during the delivery of services through task shifting. I show that relationships between healthcare professionals are complex, with ongoing collaboration, despite potential tension due to professional rivalry. These tensions between the nurses/midwives and CHWs are driven by efforts to protect professional boundaries, secure financial resources, and compete for leadership within primary healthcare facilities. I show that, despite the tension, healthcare workers work collaboratively to address gaps in human resources, infrastructure and commodities, leveraging a 'facility sustenance fund' to keep primary healthcare facilities functional. I explain the concept of collective social entrepreneurship as it applies here, showing how healthcare workers create shared solutions to maintain the functionality of primary healthcare services amid resource constraints.

1.7.6 Chapter 7: Discussion

In this chapter, I discuss the implication of my study findings for ongoing task shifting for maternal health services. I foreground the major insights generated through an IPA lens – challenging the notion that the emergence and evolution of the task-shifting policy and its practice are rationally determined. Rather, I posit that the **meanings, interests, and values of key policy actors shape how task shifting is interpreted and practiced.** I demonstrate that the interpretations of these policy actors influence their decisions and actions. I indicate the original contribution of my work, as the first study to use an interpretive lens to explore task-shifting policy and practice in Nigeria. I explain that adopting an IPA framework and using a practice-oriented lens has fostered a deeper understanding of task-shifting policy emergence, evolution and practice as a socially constructed process, rather than a purely administrative intervention. I also argue that task-shifting tends to prioritise increased access to healthcare services without a commensurate focus on quality of care, thereby placing patients at risk of adverse health outcomes. Finally, I make recommendation for task shifting policy and practice, outline the strengths and limitations of my study, reflect on my experiences during the study and suggest areas for further research.

1.7.7 Chapter 8: Conclusion

In this final chapter, I make recommendations that, beyond the rational view of task shifting, an interpretive perspective that acknowledges the interests and interpretations of interpretive communities should guide the policy and practice of task shifting. I propose the adoption of collective social entrepreneurship as a framework for operationalising primary healthcare facilities, building on the shared interests of healthcare workers and other policy actors. I outline my concluding reflections, emphasising the relevance of my study for primary healthcare and task shifting in Nigeria.

CHAPTER 2: TASK SHIFTING FOR MATERNAL HEALTHCARE SERVICES IN NIGERIA AND SUB-SAHARAN AFRICA: A LITERATURE REVIEW

2.1 Introduction

In Chapter 1, I introduced the concept of task shifting, explaining how it was adopted as a policy intervention to address health workforce shortages and increase access to maternal healthcare services in Nigeria. In this chapter, I conduct a narrative review of the literature on task shifting in Nigeria and sub-Saharan Africa. While task shifting has been applied to deliver different healthcare services, I focus particularly on its application for delivering maternal health services. I first explain the rationale for adopting a narrative review approach and outline how I selected and analysed relevant literature. I then present the review findings, highlighting how task shifting has been applied in maternal health services, the key influences shaping the practice of task shifting, and the gaps in the literature on task shifting that my study seeks to address.

2.2 Understanding Task Shifting

Task shifting was formally recognised by WHO in 2006, as a strategic but temporary response to global health workforce shortages (WHO, 2006). While the term gained prominence after it was highlighted in the 2006 World Health Report, reallocating tasks to less specialised health workers dates back to the 1960s in China, where the 'barefoot doctors' and subsequent 'village doctor' programmes were used to extend healthcare services to communities (Hu et al., 2017). These programmes were relevant to primary healthcare as they connected the formal healthcare system and the community. In the last two decades, the task-shifting approach has informed the design of CHW programmes in several low- and middle-income countries (LMICs) (Hu et al., 2017).

'Task shifting' and 'task sharing' have been commonly used together, and sometimes interchangeably. However, 'task shifting' is used predominantly or sometimes combined with

task sharing (i.e., task shifting *and* sharing). While task shifting refers to the transfer of responsibility for specific tasks from a single cadre of healthcare workers, task sharing denotes a collaborative approach, in which multiple cadres jointly assume responsibility for specific tasks (Coales et al., 2023; WHO, 2012a). The term 'task sharing' underscores the collaborative nature of the task reallocation, indicating that tasks are not really shifted *away* from any cadre of health workers, but rather all healthcare workers formally recognised by guidelines can share the responsibility of delivering services, depending on their availability. In the literature, other terms that refer to task shifting or task sharing include 'substitute health workers', 'skills substitution', and 'task delegation' (Deller et al., 2015).

Task shifting has been used to deliver maternal health services in several countries following WHO recommendations in 2012. However, countries like Senegal, South Africa, Malawi, Mozambique, Ethiopia, and the Dominican Republic utilised the task-shifting approach to provide maternal health services before WHO formally recommended it (Dawson et al., 2014). Maternal health services such as childbirth, emergency obstetric care, family planning, caesarean sections, uterine evacuations, and manual removal of placenta have been delivered via task shifting in several LMICs (Schneeberger and Mathai, 2015).

However, countries have had varying experiences with task shifting. There have been reported concerns about the safety and quality of care provided by lower-trained healthcare workers. These concerns have been expressed primarily by healthcare workers with higher qualifications, who perceive that the training received by other healthcare workers may not make them competent enough to provide safe and quality healthcare services (Deller et al., 2015). There have also been concerns about healthcare workers undertaking tasks beyond the scope of their training (Mijovic et al., 2016; Okyere et al., 2017). Although these concerns may be valid, reports from WHO suggest that healthcare workers with lower training can provide

safe and quality healthcare services, if given adequate training, supervision, and monitoring (WHO, 2008a, 2012a).

As highlighted in Chapter 1, my study is focused on task shifting in Nigeria, using maternal health services as an exemplary service, to understand the interpretation of the task-shifting policy, and explore the practice of task shifting in primary healthcare settings. To understand these task-shifting experiences and identify the influences that shaped its practice in Nigeria and across sub-Saharan Africa, I conducted a narrative review of the literature. The findings from the literature review provided insights that helped me to interpret and analyse my study data. I now describe the methodology adopted to conduct the narrative review.

2.3 Literature Review Methodology

I conducted this narrative literature review to develop a broad understanding of task shifting for maternal health services, particularly focusing on its implementation in Nigeria and across sub-Saharan Africa. I systematically searched peer-reviewed journal articles, policy documents, and relevant grey literature, to identify studies discussing the experiences and influences shaping task shifting. Although my primary focus is on Nigeria, I expanded the scope to sub-Saharan Africa to identify whether similar or contrasting experiences exist. Through this process, I mapped key findings from the literature to understand common trends, enabling factors, barriers, and the broader socio-political influences on task shifting for maternal health services. In analysing the literature, I assessed how different contexts and actors shaped task shifting practices. The review was guided by the following questions:

a) What has been the experience of Nigeria and other countries in sub-Saharan Africa with task shifting for maternal health services?

b) What considerations have enabled or hindered the practice of task shifting and its application to delivering maternal health services?

Given the broad nature of the research questions, using a narrative review enables an exploration of the literature through a flexible, iterative but interpretive approach, that is suited for complex or emerging phenomena like task shifting (Ferrari, 2015; Green et al., 2006). In addition, narrative reviews are valuable in summarising literature and creating new insights, by drawing connections across studies, allowing the refinement of the review findings based on recurring patterns and evolving interpretations (Ferrari, 2015; Snyder, 2019).

2.3.1 Review Methods

I conducted a narrative literature review following four main steps: developing clear research questions, identifying relevant literature, interpreting the literature, and writing out the review (Snyder, 2019). I iteratively searched five databases (CINAHL, Embase, Global Health, Global Index Medicus, and Medline) using predefined search terms related to maternal health services, task shifting, and the health workforce. To supplement the database search, I also snowballed the reference lists of relevant articles and used Google Scholar to identify additional sources. Drawing on search strategies from previous systematic reviews on task shifting(Mijovic et al., 2016; Seidman and Atun, 2017), I adapted key terms and Boolean operators to ensure a comprehensive search. Initial search strategies were reviewed and refined with support from a librarian at the University of Oxford Bodleian Health Care Libraries.

In **Table 1**, I outline the key terms used for the search strategy (see **Appendix I** for a detailed search strategy).

MATERNAL HEALTH SERVICES		**TASK-SHIFTING**		**HEALTHCARE WORKERS**
OR		OR		OR
Maternal Health		Task-shifting		Doctors
Maternal Care	AND	Task-sharing	AND	Nurses
Reproductive Health		Task delegation		Midwives
Maternity Services		Task reallocation		CHWs
Antenatal Care		Role redistribution		Community Health Volunteers
Childbirth		Role sharing		Non-Physician

Child Delivery				Non-Specialist
Pregnancy Care				Substitute Physician
Postnatal Care				Doula
Post-abortion care				Health Auxiliary
Family Planning				Lay Health Worker
Contraception				Birth Assistant
Obstetric Care				

Table 1: Search terms used for database searches

The database searches were limited to articles published in English and geographically limited to articles published in Nigeria and other countries in sub-Saharan Africa. The first literature search in the databases was conducted in June 2022. I snowballed the references of relevant articles and updated the database searches iteratively until July 2024, when I stopped the literature search to consolidate the analysis and interpretation of findings for the literature review. As I iteratively searched the literature, I was guided by an inclusion criteria to ensure a comprehensive and relevant synthesis of the literature. Given that narrative reviews do not require exhaustive coverage of all relevant literature (Sukhera, 2022), I did not aim to include every relevant article in the review. Instead, I included articles into the review purposively (Greenhalgh et al., 2018), until I had selected sufficient articles to understand country experiences and the influences that shaped task shifting for maternal health services in sub-Saharan Africa. I included articles into the review if they were:

- studies that examined task shifting for maternal health services in Nigeria and other sub-Saharan African countries; and
- peer-reviewed primary research articles, policy briefs, literature reviews, and grey literature; and
- studies that employed qualitative, quantitative, or mixed methods approaches and published in English Language.

I did not apply any temporal limitations across all databases, allowing for the inclusion of studies from any publication year. My preliminary search produced a few articles focused

specifically on task shifting for maternal health services in Nigeria. To broaden the scope, I refined the inclusion criteria to consider studies related to task shifting for maternal healthcare and other healthcare domains, such as non-communicable diseases (NCDs).

After completing the preliminary search, I exported the list of articles into Zotero (reference management software) and removed duplicates. I screened titles and abstracts to exclude studies that did not meet the research objectives or inclusion criteria. I then reviewed the full texts of the remaining articles for relevance, ensuring articles were only selected for the review if they met the inclusion criteria. I did not formally assess study quality using an appraisal tool, as I did not intend to exclude any article based on quality given the flexible nature of the narrative review approach (Carroll and Booth, 2015), but all selected studies were relevant to the topic and clearly outlined their objectives, methods and results. After repeated screening and database searches, I selected 35 articles for inclusion in the review.

2.4 Results of the Literature Review

In this section, I outline the findings of the review, outline the influences (facilitators and barriers) that have shaped task shifting, then go on to discuss the findings and summarise the key points relevant to task shifting for maternal health services in Nigeria and other countries in sub-Saharan Africa.

I included a total of 35 articles written between 2011-2024, with varying study designs. These included quantitative studies, qualitative studies, mixed-method studies, literature reviews, cohort studies, case studies, operations research and comparative analyses. Among the included studies, 14 articles were exclusively focused on Nigeria. Of these, seven specifically addressed maternal health services, with three articles focusing on pre-eclampsia, two on family planning, one on prevention of mother-to-child transmission (PMTCT) of HIV, and one on cervical

screening. The remaining five articles on Nigeria addressed other essential health services unrelated to maternal health, with two focusing on NCDs such as hypertension and diabetes.

Ten articles I included in the review were from other African countries. These included one article each focused on Benin, Ethiopia, and Mozambique. Two articles primarily focused on task shifting in Kenya and Ghana, respectively, while three articles examined task shifting in Uganda. Several other articles addressed task shifting for maternal health services from more than one country focus, either as multi-country primary studies or literature reviews. In **Table 2** below, I present a summary of the articles included in this review, providing key information such as the author(s), publication year, country focus, article type, and main findings.

Authors	Year Published	Country of Focus	Type of Study	Summary of Main Points
Adejumo et al.	2024	Sub-Saharan Africa	Review	This review examined the implementation of task-shifting strategies for hypertension management in Africa, where the limited availability of physicians presents significant challenges to healthcare delivery. It highlights the success of task-shifting interventions, particularly those involving nurses, which have been associated with improved blood pressure control and enhanced patient outcomes. However, it identifies barriers to effective implementation, including regulatory constraints, the need for adequate training of non-physician health workers, and potential resistance to task shifting from physicians (Adejumo et al., 2024).
Adepoju et al.	2021	Nigeria	Cluster randomized controlled trial	This study assessed the capacity of CHWs to administer methyldopa and magnesium sulphate safely to pregnant women with hypertension, given the shortage of physicians. It established that through task shifting, CHWs were able to effectively identify and treat hypertension in pregnancy, significantly reducing treatment delays (Adepoju et al., 2021).
Aifah et al.	2020	Nigeria	Qualitative Study	The study investigated nurses' perceptions of factors influencing the integration of a task shifting/sharing strategy for hypertension control (TASSH) into routine HIV care in Lagos,

				Nigeria. The findings highlighted perceived gaps in hypertension knowledge among HIV-care nurses, and emphasised the importance of ongoing supervision, underscoring the need for targeted training and sustained support to enable effective task-shifting implementation (Aifah et al., 2020).
Ajisegiri et al.	2023	Nigeria	Qualitative Study	This study explored the informal task-shifting and task-sharing practices of CHWs in managing hypertension and diabetes care in Nigeria. The findings revealed that CHWs frequently operated beyond their formally authorised roles, to address critical gaps in healthcare service delivery, highlighting the need for improved supervision and stronger regulatory systems (Ajisegiri et al., 2023).
Aborigo et al.	2020	Ghana	Qualitative Study	This study examined stakeholder perspectives on task-sharing in abortion care in Ghana, emphasising the roles of various healthcare providers within a structured referral system. The findings highlighted the critical need to expand task shifting to include community health officers, physician assistants and pharmacists, to enhance access to abortion care, particularly in primary care settings where midwives are frequently unavailable (Aborigo et al., 2020).

Akeju et al.	2016	Nigeria	Qualitative Study	This study investigated the feasibility of task sharing for pre-eclampsia management by community health extension workers (CHEWs) in Ogun State, Nigeria. The findings revealed that CHEWs are already engaged in informal task sharing to address workforce shortages. Stakeholders expressed support for formalising task sharing practices; however, CHEWs voiced concerns about potential conflicts with the 'Standing Order', highlighting the need to address regulatory challenges and provide infrastructural support for task shifting (Akeju et al., 2016).
Auma et al.	2023	Uganda	Qualitative Study	This study detailed the development and implementation of a task-shifted, point-of-care cervical cancer prevention programme in Uganda, which trained and utilised CHWs to lead targeted awareness campaigns and combine cervical cancer screening with HIV services. The findings demonstrate the potential for task shifting to support the integration of cervical cancer screening into Uganda's public health system, especially in resource-limited settings (Auma et al., 2023).
Ayuk et al.	2022	Sub-Saharan Africa	Systematic Review	This systematic review evaluated the safety, acceptability, and effectiveness of task shifting the administration of injectable contraceptives to CHWs in Sub-Saharan Africa. The review found evidence that well-trained CHWs can safely and competently provide injectable

				contraceptives, resulting in high levels of client satisfaction and increased uptake of family planning services (Ayuk et al., 2022).
Baruwa et al.	2022	Nigeria	Mixed methods evaluation	This study analysed data from the IntegratE Project in Kaduna and Lagos states, Nigeria, which aimed to enhance the quality of family planning services provided by Community Pharmacists (CPs) and Patent Proprietary Medicine Vendors (PPMVs) through training and a tiered accreditation system. The findings highlighted the role of job aids in significantly improving knowledge retention, and underscore the importance of targeted training and practical tools in sustaining competency and improving family planning service delivery through task shifting in community settings (Baruwa et al., 2022).
Charyeva et al.	2015	Nigeria	Operations research (Pre- and Post-Intervention Study)	This study examined the feasibility and effectiveness of task-shifting contraceptive implant provision to CHEWs in Bauchi and Sokoto States, Nigeria. The findings demonstrated significant improvements in CHEWs' counselling and implant insertion skills, high levels of client satisfaction, and evidence of sustained knowledge and competence over time, underscoring the importance of training healthcare workers (Charyeva et al., 2015).

Coales et al.	2023	LMICs	Literature Review	This study reviewed qualitative data examining the perspectives regarding task shifting of both specialist and non-specialist healthcare workers in LMICs. The findings underscore the need to improve governance frameworks for task shifting, align the task-shifting approach with the personal values and beliefs of healthcare workers, and the importance of addressing factors influencing healthcare worker perspectives, such as training and resource availability (Coales et al., 2023).
Deller et al.	2015	LMICs (including Nigeria)	Review	This paper reviews the experiences with task shifting for maternal and newborn health programming in several countries. It identifies that successful task shifting requires engagement with policymakers and regulatory bodies, task analysis to determine appropriate roles, development and implementation of competency-based training, ensuring the availability of adequate supplies and infrastructure, and the provision of systems for supportive supervision (Deller et al., 2015).
Ebenso et al.	2020	Nigeria	Realist Evaluation	This study investigated the mechanisms driving motivation among primary healthcare workers in a maternal and child health programme in Nigeria. The findings revealed five key mechanisms influencing motivation: feeling supported, comfortable work environment, feeling valued, morale and confidence to perform tasks, and companionship. Additional contextual factors included a sense of duty, fairness, teamwork, and recognition, suggesting

				that supportive and appreciative work environments enhance healthcare worker motivation and performance (Ebenso et al., 2020).
Gbagbo and Morhe	2020	Ghana	Qualitative Case Study	This study examined stakeholders' views on task sharing intrauterine device (IUD) services with community health nurses in Ghana and reported that most stakeholders supported task sharing, recognising the potential for community health nurses to provide safe IUD services with adequate training, resources, and supervision (Gbagbo and Morhe, 2020).
Jennings et al.	2011	Benin	Non-Inferiority evaluation Study	This study evaluated task-shifting antenatal counselling from nurse-midwives to lay nurse aides, using job aids, and reported that, in comparison to nurse-midwives, lay nurse aides with proper training and job aids can deliver non-inferior counselling. The study also reports that both nurse-midwives and lay nurse aides had positive perceptions about task shifting (Jennings et al., 2011).
Katzen et al.	2022	LMICs	Qualitative Evidence Review	This review explores CHW experiences of supervision in maternal and child health programmes across various LMICs, and identified four key themes: frequency of supervision, type of supervision, the relationship between supervision and motivation, and supportive supervision. The study findings emphasise the importance of regular, supportive, field-based supervision as a strategy to improve CHW motivation and performance (Katzen et al., 2022).

Lar et al.	2022	Nigeria	Qualitative Study	The study investigated how inter-border conflict influences perspectives on task-sharing among Community Health Volunteers (CHVs) in Nigeria. The study findings indicate that, while task-sharing is viewed favourably, the conflict creates challenges that include security risks, restricted access to communities, and disruptions to service delivery. The study also identifies systemic barriers like inadequate incentives, commodity shortages, and gender inequality as factors impacting task-sharing (Lar et al., 2022).
Schaefer	2015	Global	Literature Review	This review discusses the potential for task-shifting implant insertion to CHWs, and highlights the need for structured training, supportive supervision, and integration of task-sharing within the existing health system. Potential challenges include maintaining contraceptive supply chains, navigating community perceptions about CHW-provided services, and ensuring optimal quality of care (Schaefer, 2015).
Mijovic et al.	2016	Sub-Saharan Africa	Systematic Review	This review explored health workers' experiences with task-shifting in sub-Saharan Africa, focusing on how these programmes influence existing health worker perceptions and ability to provide care. The review found that task-shifting can cause existing health workers to expand their roles beyond their formal mandates to meet demand. The review recommends the consideration of the potential impact of task shifting on all health workers involved before its implementation (Mijovic et al., 2016)

Nzinga et al.	2019	Kenya	Ethnographic Qualitative Study	The study aimed to understand neonatal nursing practices in public hospitals in Nairobi, Kenya, and assess the potential for task-shifting to reduce nurses' workload. The findings suggest that informal task-shifting already occurs, with support staff and students often performing tasks for which they are not formally trained. The study also highlights a discrepancy between official policy and actual practice regarding task delegation in neonatal units, with senior nurses raising concerns about safety and competency, as frontline staff rely on informal task-shifting to manage their workload (Nzinga et al., 2019).
Monicah et al.	2020	Uganda	Comparative Analysis	The study compared the quality of healthcare delivered in two Ugandan districts with varying levels of task-shifting. Quality was measured across five dimensions: safety, accessibility, equity, timeliness, and patient-centeredness. The study reported that the quality of care was better in the district that had more task-shifting, emphasising that, although that district had comparatively fewer healthcare workers, the supervision, in-service training and mentorship available to the healthcare workers enabled them to provide a higher quality of care (Rullonga Monicah et al., 2020).
Lukhele et al.	2023	Africa	Scoping Review	This scoping review examined training programmes for midwives performing obstetric ultrasound scans in Africa, as a form of task-shifting to improve maternal health service access. The review indicated challenges in the training of midwives to provide obstetric

				ultrasound scans, and emphasised that shifting this task to midwives can increase access to maternal health services (Lukhele et al., 2023).
Odero et al.	2019	Kenya	Randomized Control Trial	This study investigated whether post-abortion contraceptive counselling could be effectively shared between physicians and midwives in Kisumu County, Kenya, and reported that it was successful (Odero et al., 2019).
Okereke et al.	2019	Nigeria	Qualitative Research Design	This study investigated the potential benefits and challenges of introducing community midwifery in Nigeria as a complement to other healthcare workers delivery of maternal healthcare services at the community level. The study found that, while community midwifery has the potential to improve access to maternal and newborn healthcare, particularly in rural areas, there are concerns about potential duplication of duties, and disharmony among existing health worker cadres. The study reported suggestions for the training and retraining of existing CHWs instead of introducing community midwifery (Okereke et al., 2019).
Okoroafor et al.	2023	Nigeria	Qualitative Review	This study explored the perceptions of policymakers on the barriers, promoters, and strategies for implementing task shifting and task sharing in Nigeria. Key barriers identified include health worker shortages, inter-cadre rivalry, concerns about the capacity of healthcare workers, and a lack of infrastructure. Factors promoting task shifting and sharing include

				adapted policies, political will, acceptance by health workers, and improved training (Sunny C. Okoroafor and Christmals, 2023a).
Okoroafor et al.	2023	Africa	Scoping Review	This study synthesised evidence on the rationale and scope of task shifting and task sharing in Africa. The main rationales for task shifting were health worker shortages, optimal utilisation of existing health workers, and expanding access to health services. The scope of task shifting and sharing was found to be broad, covering HIV/AIDS, TB, hypertension, diabetes, mental health, eye care, maternal and child health, sexual and reproductive health, surgical care, medicines management, and emergency care (Sunny C. Okoroafor and Christmals, 2023b).
Ouedraogo et al.	2021	Burkina Faso, Cote d'Ivoire, Ethiopia, Ghana, and Nigeria	Rapid Programme Review	This study explored the implementation of task sharing for family planning programmes in five Sub-Saharan African countries. The review found that task sharing, primarily involving CHWs, midwives, and nurses, led to increased contraceptive uptake. Key barriers identified included poor retention of lower-cadre providers, inadequate documentation, and poor data systems (Ouedraogo et al., 2021).

Oyebode et al.	2021	Nigeria	Mixed methods	This study focused on improving HIV PMTCT coverage and access in communities in Jos, Nigeria, by shifting tasks to volunteer CHWs. The article discusses a ‘hub and spoke’ model that links HIV counselling and testing (HCT) facilities with PMTCT and antiretroviral therapy (ART) facilities to create a more integrated and accessible system of care. The study reports a positive perception about task shifting, and emphasises that supportive supervision and timely remuneration contribute to successful task shifting (Abimbola Oyebode et al., 2021).
Paul et al.	2014	Uganda	Qualitative Study	This study explored the perceptions of physicians and midwives regarding post-abortion care (PAC) at the district level in central Uganda. Findings showed that midwives are the main providers of PAC, but lack sufficient skills and up-to-date guidelines. Barriers to providing quality PAC included limited training, inadequate supervision, heavy workloads, and shortages of supplies and contraceptives (Paul et al., 2014).
Sevene et al.	2021	Mozambique	Mixed Methods	This study assessed the feasibility of task sharing with CHWs for pre-eclampsia management in Mozambique. It found that CHWs could identify basic pregnancy danger signs, but lacked training and resources for obstetric emergencies. While nurses supported task sharing, barriers like limited equipment, supervision, and irregular drug availability at health facilities posed challenges (Sevene et al., 2021).

Sotunsa et al.	2016	Nigeria	Qualitative Study	This study investigated CHWs’ knowledge and practice related to pre-eclampsia in Ogun State, Nigeria. Findings showed that CHWs possessed basic knowledge but lacked confidence in managing pre-eclampsia. The study recommends regular CHW training and retraining, emphasising the importance of equipping them with necessary skills and resources for successful task sharing (Sotunsa et al., 2016).
Tilahun et al.	2017	Ethiopia	Mixed methods	This study examined the Integrated Family Health Programme in Ethiopia, which trained Health Extension Workers (HEWs) to insert ‘Implanon’ contraceptive implants. The study found that there was an unmet need for long-acting reversible contraceptives, which could be reduced through task shifting. It highlighted the effectiveness of task sharing in expanding contraceptive access and use, following requisite training of frontline healthcare workers (Tilahun et al., 2017).
Umuago et al.	2018	Nigeria	Cross-sectional Analytic Study	This study evaluated the competence of primary healthcare workers in performing cervical cancer screening after competency-based training, and found that trained healthcare workers demonstrated fair to excellent proficiency. Their findings suggest that task sharing in cervical screening can be successfully implemented with proper training and supervision of primary healthcare workers (Umuago et al., 2018).

Villar Uribe et al.	2018	Nigeria	Cross-Sectional Survey	This study compared the knowledge and diagnostic accuracy of non-physician clinicians (NPCs) to that of medical officers in Nigeria, focusing on common illnesses like diarrhoea, pneumonia, diabetes, TB, and malaria. The study found that NPCs performed as well as physicians in diagnosis and treatment knowledge, supporting the use of task shifting to improve access to primary care in resource-constrained settings (Villar Uribe et al., 2018).
Mbouamba Yankam et al.	2023	Sub-Saharan Africa	Literature Review	This review provides an overview of task shifting and task sharing for healthcare services in sub-Saharan Africa. It discusses the evidence, success indicators, challenges, and opportunities for task shifting. The review highlights the importance of a comprehensive approach that includes supportive policies, adequate training and supervision, and monitoring and evaluation mechanisms to ensure successful and sustainable task shifting and sharing programs (Yankam et al., 2023).

Table 2 Articles included in the Narrative Literature Review on Task shifting for Maternal Health Services

2.4.1 Country experiences with task shifting for maternal health and other health services

Across the countries covered in the review, several maternal health services were delivered via task shifting. These services include childbirth, post abortion care, ante-natal care counselling, pre-eclampsia treatment, obstetric ultrasound scans, placement of injectable contraceptives and cervical cancer screening. In this sub-section, I provide answers to the first question of the review by outlining the experience of task-shifting policy and practice in Nigeria and across sub-Saharan Africa, pertaining to the delivery of maternal healthcare services and other essential healthcare services.

2.4.1.1 Nigeria-specific findings

Task shifting has been a pivotal strategy in the delivery of maternal health services in Nigeria amid the persistent shortage of skilled healthcare workers. The introduction of the National Task Shifting and Sharing Policy aimed to redistribute tasks from specialist health workers to less specialised cadres such as CHEWs, nurses, and midwives, improving access to essential maternal health services (Akeju et al., 2016; Sunny C. Okoroafor and Christmals, 2023a). This policy has enabled these workers to perform tasks such as antenatal care, contraceptive provision, and early detection of maternal complications. For instance, CHEWs have been trained to conduct blood pressure monitoring, detect signs of pre-eclampsia, and provide antenatal care in rural and underserved areas where midwives are scarce. In the Nigerian state of Ogun, CHEWs were trained to detect signs of pre-eclampsia and measure blood pressure, tasks traditionally undertaken by physicians or midwives. This approach extended healthcare coverage but reduced the burden on higher cadres, demonstrating the feasibility of task shifting in improving maternal health outcomes (Akeju et al., 2016). Adepoju et al. reported a similar finding and reported that CHWs were trained to identify pre-eclampsia and treat patients with the right doses of magnesium sulphate and methyldopa (Adepoju et al., 2021).

Regarding family planning, CHEWs have been empowered to deliver long-acting reversible contraceptives (LARCs), such as implants and intrauterine devices, traditionally provided by doctors or nurses. Research in northern Nigeria highlighted that, with appropriate training and supervision, CHEWs achieved high levels of competency in contraceptive implant insertions, which led to increased contraceptive uptake and client satisfaction. This intervention reduced unmet family planning needs and highlighted the potential of task shifting to support the delivery of contraceptive services (Charyeva et al., 2015). CPs and PPMVs have also been central to task shifting initiatives, particularly in family planning. Baruwa et al. reported that CPs and PPMVs contributed to task shifting for contraceptives at community level, following appropriate training and support via job aids (Baruwa et al., 2022).

Midwives and nurses have also played significant roles in task shifting, particularly in providing maternal health education, counselling, and postpartum care in community settings. Their ability to take on expanded responsibilities, supported by targeted training, has enhanced their effectiveness in preventing complications and managing high-risk pregnancies (Aifah et al., 2020; Sunny C. Okoroafor and Christmals, 2023a, 2023b). Midwives have also expanded their roles to include community outreach and education on maternal health, further improving antenatal and postnatal care access (Umuago et al., 2018).

Beyond maternal healthcare, task shifting has proven effective in providing other healthcare services in Nigeria, such as services for infectious diseases, NCDs, and reproductive health. In HIV care, the integration of task-shifting strategies enabled nurses and CHWs to provide routine clinical services, including counselling, adherence monitoring, and basic clinical assessments. This approach improved the coverage and quality of HIV care, particularly in rural areas where access to specialist care is limited (Aifah et al., 2020). Task shifting has been used to provide services for NCDs such as hypertension and diabetes management. Ajisegiri et al. highlighted how CHWs and

nurses were trained to deliver NCD services at the primary care level, including blood pressure monitoring, patient counselling, and lifestyle modification support. They revealed that CHWs often provided services beyond the scope of their training to meet the needs of their patients (Ajisegiri et al., 2023). Adepoju et al. established that CHWs were able to manage hypertensive pregnancies using methyldopa and magnesium sulfate, significantly reducing treatment delays (Adepoju et al., 2021). In conflict-affected regions of northern Nigeria, task sharing among CHVs was critical in maintaining access to healthcare services. Despite challenging conditions, such as ethnoreligious crises, resources shortages and logistical barriers, volunteer CHWs successfully provided promotive and preventive healthcare services, linking communities with the formal health system (Lar et al., 2022).

2.4.1.2 Findings from other African countries

Task shifting has been used in several African countries to address critical health workforce shortages and improve healthcare delivery, particularly in maternal health and infectious disease management. For instance, in Uganda, task shifting has been instrumental in scaling up cervical cancer prevention programmes. Auma et al. documented the integration of CHWs into point-of-care cervical cancer screening services. This approach not only expanded screening access in rural areas, but also successfully integrated these services into existing public health programmes for high risk populations (Auma et al., 2023). Monicah et al. showed that healthcare quality improved in districts with more task shifting, due to enhanced supervision and training, despite fewer healthcare workers (Rullonga Monicah et al., 2020). In Ghana, task sharing has been explored to improve access to reproductive health services. Gbagbo and Morhe reported that stakeholders supported the task sharing of IUD services with community health nurses (Gbagbo and Morhe, 2020). Similarly, Aborigo et al. emphasised the need to integrate community health officers into abortion care, noting their potential to fill critical gaps in primary care settings. They also

highlighted that task shifting helped to reduce the cost of abortion care, as services were more affordable when delivered by nurses (Aborigo et al., 2020). In Ethiopia, Tilahun et al. demonstrated that training HEWs to insert contraceptive implants significantly reduced the unmet need for LARCs (Tilahun et al., 2017). A similar finding was reported by Ayuk et al., who highlighted that adopting task shifting for the administration of injectable contraceptives to CHWs was successful and increased access to contraceptive services (Ayuk et al., 2022). In Benin, Jenning et al. reported that with appropriate training and supervision, lay nurse aides provided optimal counselling services similar to nurses/midwives (Jennings et al., 2011).

In Kenya, task shifting has supported neonatal care in public hospitals, where overburdened nurses often work under challenging conditions with high nurse-to-patient ratios. Nzinga et al. observed that the informal delegation of tasks to nursing students, support staff, and even mothers, referred to as 'subconscious triage', allowed nurses to prioritise critical cases. While this organic form of task shifting alleviated immediate workload pressures, it also highlighted the need for structured frameworks to formalise and support these practices. Concerns over professional boundaries and insufficient supervision have underscored the necessity of institutionalising task-shifting policies to ensure sustainability and quality care (Nzinga et al., 2019). Odero et al. demonstrated the success of post-abortion contraceptive counselling delivered by midwives instead of physicians, significantly expanding access to these services in Kisumu County (Odero et al., 2019). In Mozambique, Sevene et al. assessed task sharing with CHWs for pre-eclampsia management. While CHWs effectively identified danger signs in pregnancy, barriers such as limited resources, irregular drug availability, and inadequate supervision posed challenges (Sevene et al., 2021).

Challenges such as insufficient training, poor supervision, and weak infrastructure were consistently reported across multiple studies on task shifting in sub-Saharan Africa (Adejumo et al., 2024; Aifah et al., 2020; Ouedraogo et al., 2021; Sevene et al., 2021). For instance, Ouedraogo

et al. found that task sharing for family planning in Burkina Faso, Côte d'Ivoire, Ethiopia and Ghana (as well as Nigeria) faced barriers such as poor financial incentives to encourage retention of lower-cadre workers and inadequate documentation of successful task-sharing processes to foster peer-to-peer learning (Ouedraogo et al., 2021). Furthermore, Mijovic et al. noted that across sub-Saharan Africa, task shifting was impacted by workforce tension related to professional identity, high workload, and poor remuneration. They recommended that task-shifting programmes should be designed in a way that enables healthcare workers to maintain their professional identify, earn commensurate remuneration, and have manageable workloads (Mijovic et al., 2016).

The country experiences with task shifting indicate that it has been used widely to deliver maternal and other essential healthcare services across sub-Saharan Africa. The inclusion of non-Nigerian studies enhanced the breadth of my review and enabled me to establish that countries across sub-Saharan Africa have similar experiences of utilising task shifting to deliver maternal and other essential healthcare services, though with nuances that reflect country peculiarities. Furthermore, these experiences indicate that the practice of task shifting has been shaped by several influences, affecting it as either facilitators or barriers. I draw from the articles in this review to outline the identified facilitators and barriers of task shifting across sub-Saharan Africa.

2.4.2 Facilitators of task shifting

This sub-section explores how various contextual influences and considerations have shaped task shifting across sub-Saharan Africa. Following my analysis of the articles included in the review, I report that task shifting in sub-Saharan Africa has been facilitated by several influences, which have supported its implementation, expansion, and sustainability across diverse settings. Task-shifting policy is important, because the existence of national policy frameworks which legitimise task shifting have fostered its practice across sub-Saharan Africa. In Nigeria, for instance, the

National Task Shifting and Sharing Policy provided a framework that defined roles, responsibilities, and training requirements for healthcare cadres involved in task shifting (Sunny C. Okoroafor and Christmals, 2023a). Similarly, in Kenya and Ghana, national health policies have aligned task-shifting interventions with broader goals to strengthen primary healthcare, ensuring that they are embedded within the formal health system (Gbagbo and Morhe, 2020; Nzinga et al., 2019). Although task-shifting policy frameworks exist, they do not straightforwardly translate into uniform practice. Rather, task-shifting practice is shaped by several influences; hence the need for studies that explore how the practice of task shifting is negotiated.

Training programmes have also facilitated task shifting. Across many African countries, the provision of targeted training for lower-cadre health workers (such as CHEWs, CPs, and lay health workers) has enabled these groups to take on expanded roles in service delivery. In Uganda, comprehensive training allowed CHWs to deliver cervical cancer prevention services, including screening and cryotherapy, with high levels of competence (Auma et al., 2023). Similarly, training programmes in Nigeria equipped CHEWs to detect pre-eclampsia symptoms and provide family planning services, bridging significant gaps in maternal healthcare (Akeju et al., 2016; Charyeva et al., 2015). Coales et al. reported that supportive supervision was an enabler of task shifting, as it helped healthcare workers to hone their skills for delivering shifted tasks. However, they indicated that supervision was not always supportive, which discouraged healthcare workers (Coales et al., 2023). They also highlighted that community and workplace recognition received by healthcare workers fostered task shifting, alongside the values and beliefs which shaped their perceptions about it (Coales et al., 2023).

Financial and technical assistance provided by development partners and donor agencies played a crucial role in scaling task shifting. These organisations supported training, infrastructure development, and the provision of essential supplies, particularly in resource-constrained settings

(Deller et al., 2015). In Nigeria, international collaborations have supported the rollout of task-shifting policies and capacity-building initiatives, enhancing healthcare delivery across underserved areas (Ajisegiri et al., 2023; Baruwa et al., 2022). The engagement and acceptance of task shifting by service users has also been pivotal in advancing it. In many African countries, CHWs are trusted persons, and their involvement in delivering healthcare services increased the uptake of services such as family planning, antenatal care, and HIV counselling. In Nigeria, community mobilisation efforts and education campaigns facilitated the acceptance of task shifting, improving access to maternal and reproductive health services (Lar et al., 2022; Umuago et al., 2018). In Ghana, Gbagbo and Morhe highlighted the role of community buy-in in ensuring the sustainability of task-shifting programmes for family planning and maternal health services (Gbagbo and Morhe, 2020). Supportive supervision and ongoing mentorship have further enabled task shifting, by maintaining service quality and addressing implementation challenges (Katzen et al., 2022). For example, in Kenya, Nzinga et al. noted that structured supervision ensured that tasks delegated to lower cadres, such as nursing students, were performed safely and effectively (Nzinga et al., 2019).

2.4.3 Barriers to task shifting identified in the review

Despite addressing healthcare workforce shortages, several barriers which I outline below have impacted task shifting in sub-Saharan Africa. Human resource constraints impact task shifting as there are only few healthcare workers available to take on shifted tasks, resultantly overworking the available health workforce (Ebenso et al., 2020; Lukhele et al., 2023). In Nigeria, for example, CHEWs struggled to manage the additional workload caused by task shifting, as the broader workforce remains understaffed (Charyeva et al., 2015; Lar et al., 2022; Sunny C. Okoroafor and Christmals, 2023a). This challenge is exacerbated in rural and conflict-affected areas, where the scarcity of health professionals is even more pronounced due to security concerns. In fragile and

conflict-affected settings, security challenges complicate the implementation of task shifting. For instance, Lar et al. highlighted how ethnoreligious crises and ongoing violence in northern Nigeria disrupted task shifting interventions, reducing the availability and mobility of CHVs (Lar et al., 2022). Furthermore, there have been reports of healthcare workers being victims of kidnapping, theft and armed robbery, with some of them reporting that they worked in fear of security issues, especially at night (Agwu and Onwujekwe, 2023; Etiaba et al., 2020). Regulatory and policy constraints also present significant barriers (Adejumo et al., 2024). In many countries, including Nigeria, regulatory guidelines, such as the 'Standing Orders', restricts the scope of practice for lower-cadre health workers like CHEWs and CPs. However, weak regulatory mechanisms limit the ability of regulators to ensure that they remain within their scope of practice (Akeju et al., 2016; Okereke et al., 2019). When healthcare workers go beyond their scope of practice, it causes inter-cadre tensions, as senior professionals perceive others as encroaching on their professional roles (Adejumo et al., 2024). The concern about role encroachment or about losing influence to lower-trained healthcare workers caused some senior healthcare workers to oppose task shifting (Adejumo et al., 2024; Ebenso et al., 2020; Gbagbo and Morhe, 2020; Nzinga et al., 2019). In Ghana, it was reported that there was an opposition to task shifting abortion services to nurses, as abortion was not generally accepted due to cultural and religious factors, highlighting the need for community engagement to advance task shifting for specific services (Aborigo et al., 2020).

Logistical and infrastructural challenges, including the lack of medical supplies, inadequate facilities, and poor transportation networks, are further barriers of task shifting (Lukhele et al., 2023; Sevene et al., 2021). In Nigeria, Akeju et al. reported the lack of equipment and stock-out of essential medicines which made it difficult for task shifting for obstetric services (Akeju et al., 2016); in Uganda, the absence of reliable equipment for cervical cancer screening, such as cryotherapy machines, limited the ability of CHWs to deliver comprehensive services (Auma et

al., 2023); similarly, CHEWs in Nigeria reported shortages of essential contraceptives and diagnostic tools, which hinder their ability to perform delegated tasks effectively (Baruwa et al., 2022; Charyeva et al., 2015).

Training and supervision deficits are additional barriers to task shifting (Adejumo et al., 2024; Aifah et al., 2020). While task shifting relies heavily on training to equip lower-cadre workers with new skills, inadequate training often results in suboptimal service delivery. In Kenya, Nzinga et al. observed that informal delegation of tasks without structured training led to variability in the quality of neonatal care (Nzinga et al., 2019). Furthermore, insufficient supervisory mechanisms left healthcare workers without the necessary support to perform their roles effectively, increasing the risk of errors and compromising patient outcomes (Katzen et al., 2022; Lar et al., 2022). Financial constraints and uncertainty about career progression also play a significant role in impeding task shifting (Adejumo et al., 2024). Many lower-cadre workers (such as CHWs and CHEWs) receive inadequate remuneration, which affects motivation and retention. In Nigeria, the lack of financial incentives for these workers has been cited as a key factor undermining their long-term commitment to task-shifting programmes (Baruwa et al., 2022; Sotunsa et al., 2016). Additionally, donor dependency in countries like Uganda and Ghana raises concerns about the sustainability of task-shifting interventions once external funding ceases (Auma et al., 2023; Gbagbo and Morhe, 2020).

Overall, the literature indicates that task shifting for maternal health services has been influenced by varying influences across sub-Saharan Africa. Common enablers include national policy frameworks, structured training programmes, community recognition, and strong community engagement. Conversely, key barriers include resource constraints, professional resistance, weak regulatory systems and poor supervisory mechanisms. Although task shifting has improved service coverage in many settings, its sustainability remains dependent on consistent funding and system

support. These findings on country experiences and influences related to task shifting provide the basis for the discussion below.

2.5 Discussion

The review demonstrates that task shifting has been tried in different countries and adapted to different contexts and healthcare services. Across the countries in the review, the healthcare workers commonly involved in task shifting were nurses, midwives, CHWs, CHEWs, CPs and PPMVs (Adejumo et al., 2024; Adepoju et al., 2021; Akeju et al., 2016; Baruwa et al., 2022; Charyeva et al., 2015; Katzen et al., 2022; Sevene et al., 2021; Sotunsa et al., 2016). Several factors influenced task shifting, including training, supervision, remuneration, and infrastructural challenges. Given the extent of their influence, alongside the interests, interpretation and values of key policy actors, these influences should be considered when designing and evaluating task-shifting interventions. Additionally, the consideration of other influences is important, since many of the authors of the studies in my review adopted a rationalist perspective, *assuming that task shifting will succeed once essential requirements are met*. This perspective is problematic, because it overlooks how policy actors are influenced by their own values, interests, and institutional environments (Shearer et al., 2016). In other words, the assumption that task-shifting will work if all technical conditions are satisfied fails to acknowledge the political, social, and institutional factors that shape how task-shifting policies are implemented in practice. To address these gaps, my study adopts an interpretive approach.

Rather than treating task shifting as a purely technical solution, I aim to explore how the interests and values of policy actors influence the policy and practice of task shifting, particularly in maternal health services. This perspective allows for a deeper understanding of the contextual and meaning-making processes that traditional rationalist frameworks often overlook. I now draw from the review to discuss the influences that shape task shifting.

2.5.1 Policy frameworks and governance

The practice of task shifting is supported by policy frameworks and guidelines that define roles, responsibilities, and boundaries for health workers. These policies formalise and legitimise the shifting and sharing of tasks across cadres within the workforce (Deller et al., 2015). Governance mechanisms embedded within these policies, such as regulatory oversight and monitoring, aim to standardise task-shifting practices to guarantee the quality of healthcare services delivered(Mijovic et al., 2016) However, as Nzinga et al. report, policy frameworks are sometimes insufficiently robust, prompting healthcare workers to make their own interpretations of policy, and deliver the required services based on the realities of their working environments. Therefore, they argue that task-shifting policies should consider the contextual realities faced by healthcare workers (Nzinga et al., 2019). In addition to challenges in policy formulation, the review highlighted that task shifting is frequently affected by poor policy implementation. For example, Ajisegiri et al. noted that the government's failure to provide adequate remuneration and the weak regulatory systems continue to undermine task-shifting practices. These challenges persist, despite formal policies explicitly recommending adequate remuneration and strong regulatory oversight to support task-shifting initiatives.

2.5.2 Training and supervision

Training and supportive supervision are integral to the success of task shifting (Charyeva et al., 2015; Deller et al., 2015). Training ensures that lower-cadre workers, such as CHEWs and community health nurses, are equipped to perform tasks traditionally reserved for higher-skilled professionals (for instance, in Nigeria, CHEWs were trained to monitor blood pressure, identify pre-eclampsia, and insert contraceptive implants, enabling them to support the delivery of maternal health services (Akeju et al., 2016; Charyeva et al., 2015)). Beyond technical skills, training also enhances workers' confidence, improving service delivery and patient outcomes. For example,

Charyeva et al. reported that CHEWs had increased job satisfaction when their skills improved following training (Charyeva et al., 2015). Capacity building through in-service education, mentorship, and job aids further strengthens the readiness of healthcare workers to take on expanded roles (Adejumo et al., 2024; Sunny C Okoroafor and Christmals, 2023). Periodic integrated supportive supervision enables healthcare workers to deliver shifted tasks more effectively, by boosting their confidence and motivation (Charyeva et al., 2015; Katzen et al., 2022). However, while the importance of training and supervision for successful task shifting is widely acknowledged, several studies have reported that training and supervision practices have often been suboptimal and require improvement (Ajisegiri et al., 2023; Ayuk et al., 2022; Sunny C. Okoroafor and Christmals, 2023a; Yankam et al., 2023).

2.5.3 Community engagement and acceptance

Accepting and integrating task-shifting interventions into communities is critical to their success. In this context, the ‘community’ refers to local populations around primary healthcare facilities, with healthcare workers acting as trusted intermediaries between formal health systems and community members. Primary healthcare facilities, often the first point of contact for populations, play a key role in community-based engagement. In Uganda, mobilisation campaigns and education initiatives increased community acceptance of maternal health services delivered via task shifting, improving the uptake of antenatal care and family planning services (Auma et al., 2023). Similarly, in Ghana, the involvement of community health nurses in maternal health education enhanced service utilisation and patient satisfaction while in Nigeria, community-level mobilisation activities aimed at increasing the use of injectable contraceptives were highlighted (Charyeva et al., 2015), emphasising the need for culturally-sensitive strategies that build community trust, and increase acceptance and demand for services provided through task shifting.

2.5.4 Values, beliefs and motivation of healthcare workers

The actions and attitudes of healthcare workers towards task shifting are significantly shaped by their values and beliefs (Coales et al., 2023). Studies show that when healthcare workers' values align with the principles of task shifting, they exhibit greater enthusiasm and intrinsic motivation to deliver shifted tasks (Coales et al., 2023; Deller et al., 2015; Jennings et al., 2011). For example, Coales et al. found that healthcare workers who believed in expanding access to services were more engaged and supportive of task-shifting initiatives (Coales et al., 2023). Motivation has also been identified as a key determinant of successful task shifting. Research highlights that healthcare workers are more likely to be motivated when they are provided with adequate remuneration, clear career progression opportunities, and appropriate infrastructure support (Coales et al., 2023; Deller et al., 2015; Jennings et al., 2011). Additionally, the recognition and respected status of healthcare workers delivering services through task shifting can enhance motivation, as noted by Deller et al., who reported that recognition increased workers' commitment to task-shifted roles (Coales et al., 2023; Deller et al., 2015; Jennings et al., 2011). Furthermore, the availability of resources and infrastructure, as well as optimal remuneration and training, all contribute to the motivation of the workforce (Coales et al., 2023; Deller et al., 2015; Katzen et al., 2022). Thus, ensuring alignment between healthcare workers' values and task-shifting objectives, combined with institutional support, adequate remuneration, and recognition, is critical to sustaining their engagement and performance in task shifting practice.

2.5.5. Resource availability, infrastructure and referral systems

Adequate resources, including finances for remuneration, medical supplies, equipment, and infrastructure are essential for effective task shifting (Deller et al., 2015). However, in practice, several studies highlight persistent resource shortages that constrain task-shifting practice. In Ghana and Nigeria, resource shortages impacted the practice of task shifting, with lack or shortage

of commodities limiting the capacity of lower-cadre workers to perform their roles effectively (Baruwa et al., 2022; Charyeva et al., 2015; Gbagbo and Morhe, 2020). For example, a shortage of consumables was noted in several primary healthcare facilities in Nigeria, while lack of contraceptives and diagnostic tools constrained the ability of CHEWs to deliver comprehensive maternal health services (Charyeva et al., 2015). Deller et al. also reported that an irregular supply of medications, consumables, and infrastructure impacted task shifting for maternal health services in Nigeria (Deller et al., 2015). Inadequate financial support from the government also impacts task shifting, as resources are needed to provide infrastructure and commodities, as well as for the remuneration and training of healthcare workers (Ayuk et al., 2022; Coales et al., 2023). As such, there is a need for government to prioritise the provision of resources and infrastructure for task shifting, as the long-term sustainability of task-shifting initiatives requires stronger government investment to ensure resource availability and workforce motivation (Charyeva et al., 2015; Yankam et al., 2023). Additionally, functional referral systems are critical to successful task shifting for maternal health services, as weak referral pathways have been linked to increased risks of complications or maternal deaths (Deller et al., 2015).

2.5.6 Inter-cadre collaboration and resistance

Task shifting often creates tensions between different health worker cadres. Higher-level professionals, such as doctors and midwives, sometimes perceive task shifting as encroaching on their professional domains, leading to resistance. In addition to concerns over professional identity, fears about job security, loss of status, and potential devaluation of professional roles contribute significantly to resistance among higher-cadre workers. These concerns may stem from the perception that shifting tasks to lower-level cadres could undermine professional autonomy or lead to redundancy (Ebenso et al., 2020; Nzinga et al., 2019). Collaborative efforts, including clear role definitions, structured supervision, and inclusive decision-making processes are necessary to foster

inter-cadre trust and cooperation. Robust stakeholder engagement that acknowledges and addresses job security concerns, alongside clear definitions of roles, have the potential to reduce inter-cadre tensions and support collaboration within the healthcare workforce (Adejumo et al., 2024; Sunny C Okoroafor and Christmals, 2023; Orkin et al., 2021).

2.5.7. Monitoring, evaluation and sustainability of task-shifting interventions

Monitoring and evaluation (M&E) frameworks are critical for assessing the practice and effectiveness of task shifting. However, existing M&E efforts in countries like Nigeria and Tanzania have been judged as sub-optimal, based on evaluations reported in the literature that highlight limited data collection, irregular reporting, and weak feedback mechanisms (Munga et al., 2012; Sunny C Okoroafor and Christmals, 2023). These studies emphasise that, without robust monitoring, it is difficult to determine whether task-shifting initiatives meet their intended goals of increasing access to essential healthcare services, improving health outcomes, and ensuring service quality. Consequently, periodic and systematic assessments are recommended to strengthen the evidence base for task-shifting practices and guide policy adjustments (WHO, 2012a). Programme sustainability should be a key consideration for task shifting, particularly when donor funding or external support underpins the practice of task shifting. Task-shifting programmes should be designed to transition from donor funding to country ownership, and be integrated into national health strategies and budgets to ensure long-term viability (WHO, 2012a). Additionally, creating career development pathways and incentives for lower-cadre workers is essential to sustain their participation and motivation over time (Yankam et al., 2023).

2.5.8. Context-specific approaches for task shifting

The adaptation of task shifting to suit country and community contexts, following appropriate needs assessments, and the engagement of relevant policy actors is important (WHO, 2012a). The review findings indicate that, since there are multiple dependencies that influence the practice of

task shifting, it is important to tailor task shifting to the needs and context of the country and community where services will be delivered. For example, in conflict-affected regions of Nigeria, CHVs sustained the delivery of healthcare services within the context of security and logistics challenges (Lar et al., 2022). Similarly, a task-shifting programme in Ghana focused on addressing rural-urban disparities in access to maternal health services, tailoring task-shifting interventions to the needs of the local community and gaps in service delivery (Aborigo et al., 2020).

2.6 Task Shifting for Maternal Health Services in Nigeria: The Gap in the Literature

Through this literature review, I have determined that task shifting has been used to address workforce shortages and improve access to essential healthcare services. I have also shown the use of task shifting within healthcare facilities, and other contexts, such as conflict-prone settings. I have highlighted *enablers* such as training, stakeholder engagement, and donor support, alongside *barriers* like resource constraints, regulatory gaps, and inter-cadre tensions. These findings provide a foundation for understanding task shifting, and its application for the delivery of maternal healthcare services in Nigeria.

While existing studies included in the narrative review offer valuable national and regional perspectives from the literature, gaps remain, particularly in relation to policy emergence, practice processes, and contextual nuances regarding task shifting within sub-Saharan Africa. Although some of the existing research has focused on maternal healthcare services in Nigeria, only a few studies have been focused on task shifting at the sub-national level, and none focused on Nigeria's FCT. Furthermore, the national task-shifting policy in Nigeria has been reviewed and updated thrice in less than a decade, yet no published study has explored its emergence and the influences that shaped its evolution. Given the unique position of the FCT as Nigeria's capital, its central geographic location in northcentral Nigeria, and its recent formulation of a task-shifting policy, there is an opportunity to explore the emergence and evolution of national task-shifting policies,

while concurrently investigating the influences that shape task-shifting practice within primary healthcare settings in the FCT. In addition, most of the studies on task shifting in Nigeria have adopted positivist approaches focused on outcomes, with little attention given to the meanings, values, and interpretations that underpin task-shifting practice. Given the persistently high maternal mortality rate in Nigeria, despite over a decade of national adoption of task shifting for maternal health service delivery, there is a need for an interpretive examination of the influences that have shaped task-shifting policy and practice in Nigeria. Insights from such an inquiry could inform future task-shifting policy reforms and guide the review of practice processes aimed at enhancing quality of care and expanding access to maternal health services in Nigeria.

Based on the foregoing, there are evident gaps in the literature about the emergence and evolution of national task-shifting policies in Nigeria, and the influences that have shaped the practice of task shifting for maternal healthcare services in Nigeria's FCT. An understanding of the dynamics of task shifting in the FCT through an interpretive lens is crucial, to generate evidence that can inform policy reforms and practices adjustments needed to increase access to the essential healthcare services delivered through task shifting. Given my understanding of the background literature on task shifting in Nigeria, and the identification of gaps in the literature, I designed my study to interpretively explore the emergence and evolution of the task-shifting policies in Nigeria, understand the influences that shape the practice of task shifting for maternal healthcare services in FCT primary healthcare facilities, and provide recommendations that can improve task-shifting policy and practice in the FCT and across Nigeria.

2.7 Summary and Conclusion

This literature review has provided insights into task shifting for maternal health services and other healthcare services in Nigeria and across sub-Saharan Africa. It has outlined country experiences with task shifting, and identified the influences that shape its practice, classifying them into

enablers and barriers. Having identified gaps in the literature on task shifting in Nigeria, I am then able to interpretively study the emergence and evolution of national task-shifting policies, and the influences that shape its practice in the FCT primary healthcare setting, answering the research questions for this study. In the next chapter I provide details about the chosen methodology and methods through which I aim to do so.

CHAPTER 3: METHODOLOGY AND METHODS

3.1. Introduction

In this chapter, I outline the methodology and methods used in my study, starting with the overarching aim and the research questions that guided the investigation. The primary aim of the study is to interpretively explore the policy and practice of task shifting for maternal healthcare services within primary healthcare facilities in Nigeria's FCT. My specific objectives were to examine the emergence and evolution of the task-shifting policies in Nigeria, understand the influences and actors that shape task-shifting practice within primary healthcare settings in the FCT, and provide recommendations to improve the practice of task shifting. To address the aim and objectives of the study, I formulated three research questions:

i. How did the national task-shifting policy emerge, how has it evolved, and what meaning has been ascribed to it?

ii. Which influences and actors have shaped the practice of task shifting for maternal health services in the FCT?

iii. How can the practice of task shifting for maternal health services be improved within the FCT and across Nigeria?

To explore these questions, I adopted interpretive policy analysis (IPA) as the overarching methodological framework for my study, seeking deep understanding into the evolution of task-shifting policy and the influences that shape its practice. In line with this framework, I employed qualitative methods to generate the data for my study: documentary analysis, semi-structured interviews, and focus group discussions.

3.2 Methodological and Theoretical Underpinning

In this section, I set out the methodological and theoretical underpinnings of my study, beginning with an exploration of the concept of policy and policy analysis. I then justify adopting IPA as the guiding framework to study task shifting.

3.2.1 Understanding policy and policy analysis

'Policy' is a widely used term which connotes variable meanings across different disciplines. It can be viewed as a *set of principles* that guide a deliberate course of action undertaken by the government to achieve specific objectives, which could either be legally binding or otherwise serve as documents that guide administrative processes (Porter et al., 2018). In health and social care, policies are typically presented as principles, legislation, regulations, and guidelines that are enforced to achieve public health goals or address specific issues (Porter et al., 2018). Policy is also understood as a *process* through which ideas and principles are put into practice, and serve as a means for the government to showcase its values and address societal issues (Ward et al., 2016). Though viewed commonly as text, policy can be interpreted differently by policy actors, depending on their context, lived experiences, skills, and available resources (Ball, 1993).

For this study, I consider policy to be not just a rational process, but rather the sum of the processes, values, and interests of different policy actors relevant to addressing a particular societal issue (Yanow, 2000). In the context of this study, these policy actors include government officials responsible for *formulating* policies, and frontline workers and others responsible for *implementing* policies. My views about policy align with Lipsky's concept of 'street-level bureaucracy,' which emphasises the human angle of policy. Lipsky posits that the environment and context of policy actors influences their perception of policy problems and their approach to addressing these problems. He suggests that policy actors act as street-level bureaucrats, making policy happen by interpreting and practicing it based on their context and values (Lipsky, 1980).

Acknowledging that policy is shaped by multiple influences, such as beliefs, values, interests, and context, Buse et al. emphasise that policy analysis should be conducted, to understand these influences and ascertain how they affect policy formulation and implementation (Buse et al., 2023). Although policy analysis can be done using varying approaches, interpretive approaches to policy analysis enables researchers to understand the actors responsible for developing and implementing policies, the interests involved, the policy implementation mechanisms, and the effects that policy has on outcomes and broader systems (Yang et al., 2023). To understand task-shifting policy and the influences that shape its evolution and practice, I adopt an interpretive approach, methodologically guided by an IPA framework. This approach allows me to examine the underlying meanings and values that influence the decision and actions (or inactions) of policy actors involved in both the policy and practice of task shifting.

3.2.2 Adopting an interpretive approach to studying task shifting

In Chapter 2, I outlined the reality that the practice of task shifting is context-dependent and shaped by varying influences such as the availability of resources, the nature of the work environment, and the interests of healthcare workers. This informed the choice of an interpretive approach to study task-shifting policy and practice. Given the influence-prone and context-dependent nature of task-shifting policy and practice, constructivism is the ontological position that allows for the exploration of the complexities and dependencies that influence it. Likewise, to explore how policy actors understand task-shifting policy and practice in varying contexts, I adopt interpretivism as the epistemological stance to answer my study's research questions, because it recognises that knowledge is subjective and dependent on values, context and individual experiences (Chowdhury, 2019).

There are several approaches to viewing policy, one of which is the linear approach. This assumes policy moves from agenda-setting through policy formulation, implementation, evaluation, and

maintenance in a linear cycle, without consideration for other dependencies (Walt et al., 2008). Although, a linear approach can be useful for policy evaluation in certain contexts, is not suitable to explore the influences, the dependencies and complexities associated with task-shifting policy and practice, neither can it explain the process linked to success or failure of task-shifting interventions (Werner and Kai, 2007). An interpretative approach, however, considers the complexity of policy processes, recognising that they are shaped by multiple actors, interests, and values (Porter et al., 2018). Having adopted an interpretive approach, I now highlight IPA as the methodological framework for my study.

3.2.3 Interpretive Policy Analysis

My study design is predicated on IPA: 'an approach that recognises that knowledge is not disinterested, that policy is constructed in an environment of shared language and practice and that policy analysis is a moral activity' (Shaw et al., 2015, p. 61).

This description indicates that IPA views knowledge as never being completely neutral, but always influenced by people's beliefs, experiences and interests. It also indicates the view that policy is shaped by shared ways of thinking and acting, suggesting a recognition that policy actors operate within communities. Known as 'interpretive communities', these are comprised of policy actors who share a common understanding and sense-making approach regarding a particular policy. They have similar perspectives, beliefs and interests, which are linked to them having shared professional or cultural backgrounds and experiences. Interpretive communities are not always clearly delineated, as there could be points of overlap or commonality across their views and the meanings they ascribe to policy (Yanow, 2000). Sense-making in IPA is elicited and understood through interpretive symbols which are symbolic artefacts, such as language, acts, and objects, which convey the 'meanings' that policies have for interpretive communities. IPA considers the language used in the textual content of policy documents and the oral statements made by relevant

policy actors as potential sources of meaning (Yanow, 2011). Symbolic objects and acts convey meanings that different policy actors can understand. Some symbolic acts may occur repeatedly, such as some meaning-laden policy rituals (Yanow, 2011). For example, formulating legislation, holding meetings with specific policy actors, and reviewing policy may be symbolic acts that convey varying meanings to different interpretive communities.

Using IPA as the methodological framework for my study will allow an exploration of the policy and practice of task shifting for maternal health services from multiple perspectives, and account for the complexities therein (Yanow, 2011). This approach pays attention to the meaning of policy and the expressed values and beliefs related to a policy (Yanow, 2000). IPA enables researchers to move beyond asking *'what' a policy means*, in terms of the policy content and context, to *'how' a policy has meaning*, seeking deeper meanings that a policy conveys and how this is understood and communicated by different interpretive communities (Yanow, 2015). IPA lends itself to understanding the influences and actors that shape policy; allows the mapping of varying meanings, points of tension, or conflict (Yanow, 2011); and tracing how policy actors can use their knowledge and powers to influence the policy process (Yanow, 2007). Sources of data for IPA include written policy documents/guidelines, oral sources such as interviews, and observation of policy actors to get a sense of their lived experiences (Yanow, 2011).

Recognising that task-shifting policy can be understood differently and assigned varying meanings by different groups, I sought to identify the interpretive communities involved in task shifting, focusing specifically on the policy actors relevant to the task-shifting policy in Nigeria's FCT and primary healthcare workers. I aimed to understand how these communities ascribed different meanings to task shifting, the symbols they used to convey these meanings, and how their perceptions, values, and interests influenced the practice of task shifting for maternal health

services in Nigeria. To achieve this, I designed a qualitative study, employing three methods: documentary analysis, semi-structured interviews, and focus group discussions.

3.3 Study Design and Methods

In this subsection, I describe my design for a qualitative study and outline the study setting and methods.

3.3.1 Exploring task shifting using qualitative methods

For this study, I iteratively integrated three methods: documentary analysis, interviews and focus group discussions (FGDs). These methods complemented each other to provide a deep understanding of how policy actors interpret task-shifting policy and practice it within primary healthcare settings in the FCT.

Documentary analysis is a research method that involves the systematic examination and interpretation of documents to gain insights into the phenomenon under study (Bowen, 2009). In the context of IPA, documentary analysis enables an exploration of the historical trajectory of a policy and the influences that shape the formal policy narrative (Yanow, 1996). As such, I chose to do a documentary analysis to gain insights into the emergence and evolution of task-shifting policies and the influences that have shaped them.

I used ***semi-structured interviews*** as another method, because these provide insights about personal experiences and perspectives on a particular topic while allowing for spontaneity and flexibility (DeJonckheere and Vaughn, 2019; Kvale and Brinkmann, 2009).

Focus group discussions were employed to complement the semi-structured interviews, allowing for the exploration of group-level narratives and fostering participant interaction, which stimulates the sharing of perspectives on the same issues and may provide insights that may not be made in

individual interviews (Carter et al., 2014; Morgan, 1997). In the next sub-section, I provide insights into the choice of the FCT as the location of my study and its suitability for the study of task shifting for maternal health services.

3.3.2 Study Setting: Federal Capital Territory, Nigeria

As highlighted in Chapter 1, Nigeria is a federal republic comprising 36 states and a capital territory. The FCT is one of the Nigerian states that has adopted the task-shifting policy, supporting the shifting of specific essential services to healthcare workers such as nurses, midwives, and CHWs. I chose the FCT as the setting for the study for several reasons. Firstly, it is located in northern Nigeria, a region that reports higher maternal mortality rates and greater health workforce shortages compared to the southern part of the country (Meh et al., 2019). As such, the primary healthcare facilities in the FCT utilise the task-shifting approach to deliver essential healthcare services in primary healthcare facilities (FCT HHSS, 2021), making it an ideal setting to explore the interpretation of task-shifting policy and its practice. Secondly, the northcentral part of Nigeria, within which the FCT is situated, has lower security risks compared to the northwestern and northeastern parts, that face more significant challenges such as the Boko Haram terrorists' attacks and armed banditry (Chukwuma and Ekhator-Mobayode, 2019; Wada et al., 2022). Therefore, to reduce the risk associated with doing field work in Nigeria, I chose to conduct my study in the FCT. Thirdly, since the FCT adopted the national task-shifting policy in 2021, policy actors relevant to the task-shifting policy and its practice at national and FCT-levels would be familiar with task shifting, and potentially willing to participate in the study. Practically speaking, in addition to these factors, I chose the FCT as the study setting because most national-level policy actors linked to task shifting had their offices in the FCT, making it an ideal location with fewer travel logistics to manage during fieldwork; I am also familiar with the geographic and policy landscape of the FCT, having lived and worked there for several years.

The FCT is the capital city of Nigeria, with a population of 3.8 million in 2023 (Macrotrends, 2023). It is administratively divided into six (6) area councils: Abaji, Bwari, Gwagwalada, Kuje and Kwali. These area councils provide political leadership at the local government level, which is the tier of government responsible for primary healthcare services. The location of the FCT in north central Nigeria and its areas councils is shown in **Figure 3**, below.

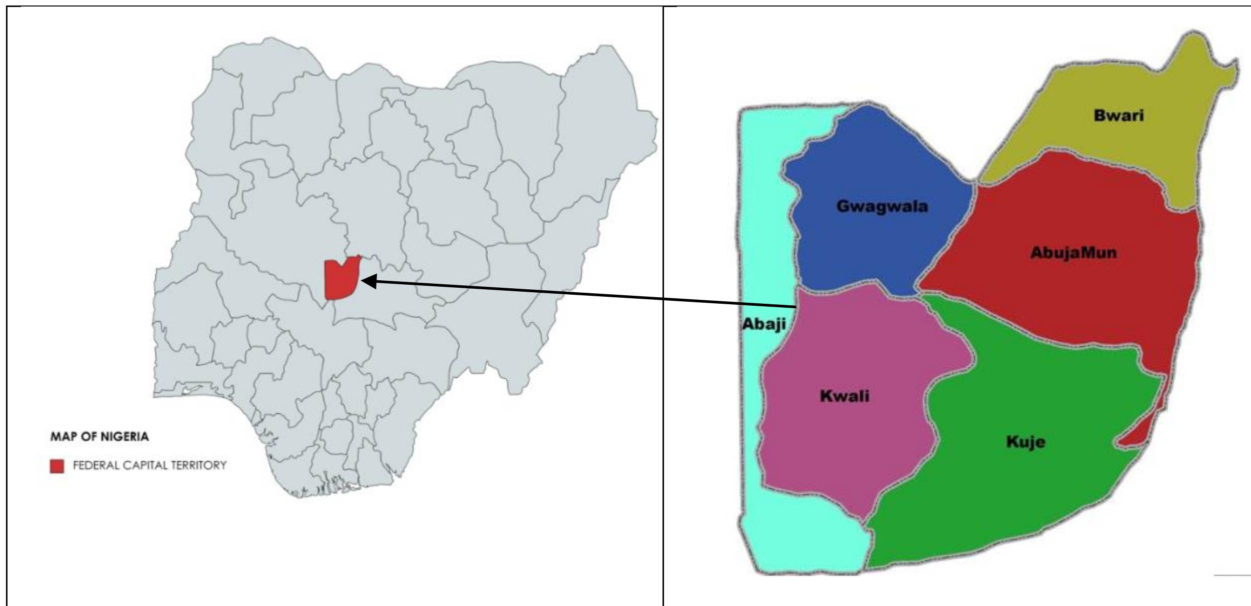


Figure 3: Map showing the location of the FCT and its six council areas

The FCT faces health workforce shortages; its stock of healthcare workers was estimated to be deficient by 57% in 2019, based on the minimum standards recommended for the health workforce in Nigeria (FCT HHSS, 2021). As of 2022, there were 6395 healthcare workers in the FCT, of which 17% were community healthcare workers, 2% were midwives and 24% were nurses, the majority of whom were working in secondary healthcare facilities (FCT HHSS, 2023). WHO recommendations are for a health workforce density of 134.22 per 10,000 population for the attainment of at least 70% of the UHC service coverage index. The FCT had a health workforce density of 7.68 per 10,000 population in 2022, indicating a huge healthcare workforce deficit (FCT HHSS, 2023). Across the six area councils in the FCT, just 1500 healthcare workers served 247

PHC facilities (FCT HHSS, 2021). The distribution of the workforce in the FCT is skewed, with 62% of the healthcare workers in the FCT working in the Abuja Municipal Area Council, and the rest of the workforce (38%) spread across the other five area councils (FCT HHSS, 2023). Health workforce recruitment in the FCT has been low, with only 1542 healthcare workers were employed across all levels in the decade between 2012 and 2021, with 339 (30%) of them deployed to work in primary healthcare facilities (FCT HHSS, 2023).

As of 2017, the primary healthcare system in the FCT had 115 comprehensive healthcare centres, 345 primary health centres, 150 health clinics, and 32 primary healthcare posts (Obembe et al., 2017). Given the prevailing shortage of highly-trained healthcare workers, most primary healthcare facilities leveraged task shifting, and moving the delivery of essential services to nurses, midwives, and particularly community health practitioners, who formed the bulk of the primary healthcare workforce (Obembe et al., 2017). The range of maternal health services provided within the primary healthcare facilities in the FCT includes antenatal care, childbirth, postnatal care, and family planning (Obembe et al., 2017).

I chose to conduct my study in three of the six area councils in the FCT. The area councils are the local government areas within the FCT responsible for the provision of primary healthcare services, as indicated in Chapter 1. To explore the experiences of task-shifting practice in urban, semi-urban, and semi-rural communities, I conducted my study in Abuja Municipal, Bwari and Kuje Area council, respectively. Given the shortage of healthcare workers in primary healthcare facilities, I enrolled healthcare workers from two or more primary healthcare facilities within each area council. Details of the healthcare facilities from which participants were recruited are provided in **Appendix II**.

Having identified FCT as the setting for the study, provided some insights about the health workforce situation in the FCT, and indicated the area council from where I enrolled primary healthcare workers for the study, I give details about the data collection process in the next sub-section.

3.4 Data Collection

For this study, I drew three qualitative methods as the main sources of data: semi-structured interviews, FGDs, and documentary analysis. These methods were selected to align with the IPA framework, aiming to generate data that would provide complementary perspectives to answer the study research questions about the policy and practice of task shifting for maternal healthcare services in Nigeria. Data collection was organised into three interconnected work packages, each aligned with a specific method. The sampling approach, recruitment processes, and data collection for each method varied, though the data collection across the methods was done simultaneously.

Overall, I collected my data from the analysis of 11 policy documents, semi-structured interviews with 24 participants and seven FGDs with 86 participants. Below, I present the data collection for each method, beginning with the documentary analysis, followed by the semi-structured interviews and concluding with the FGDs.

3.4.1. Documentary analysis

Documentary analysis was incorporated into this study to explore the policy framework for task shifting at national and FCT levels, map the evolution of the national task-shifting policy between 2014 and 2022, and showcase the ways in which policy language reflects the values and priorities considered as paramount in the policy. Documentary analysis begins with the selection of documents that are relevant to the study focus (Morgan, 2022); therefore, I scanned through publicly-available health policy documents published between 2014 and 2022 at national and FCT-

level. Policy documents were selected for analysis if they were directly relevant to task shifting, primary healthcare, or human resources for health, and had been published by a relevant government agency between 2014 and 2022.

At the start of my DPhil, I read the ‘2014 National Task-shifting and Task-Sharing Policy’, the ‘2018 National Human Resources for Health Policy’ and the ‘2018-2022 National Strategic Health Development Plan’ for Nigeria. I started with these documents, to obtain a broad overview of the policy framework guiding task shifting and human resources for health in Nigeria. For the collection of the documents for analysis, I used multiple channels including the websites of the Federal Ministry of Health and the National Primary Health Care Development Agency (NPHCDA), and direct engagement with key officials of relevant agencies at national and FCT levels. My engagement with these officials was valuable, as they informally provided me with insights into the context of the task-shifting policies, and the discourse that ensued before the final version of the first national task-shifting policy was published in 2014.

I made a long list of policy documents relevant to task shifting, human resources for health, and broader health policy in Nigeria and the FCT, which I reviewed by reading through their titles, tables of contents, and executive summaries to confirm their focus and relevance (Bowen, 2009; Morgan, 2022). I checked the policy documents for their authenticity, credibility, representativeness and meaning (see **Figure 4** below) (Morgan, 2022), to ensure their suitability to provide insights about the policy framework for task shifting in primary healthcare facilities in Nigeria and its FCT.

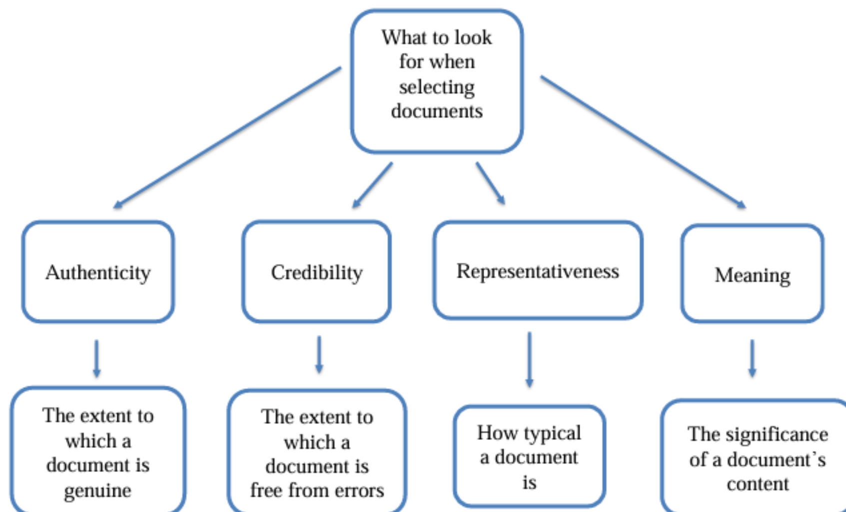


Figure 4 Characteristics to consider in selecting documents for analysis (Morgan, 2022)

From this pool of documents, I purposively selected 11 documents for the documentary analysis. I read each document in detail, to identify sections with content relevant to the research questions. I then uploaded the policy document into the qualitative analysis software NVivo, where I read them severally as part of the documentary analysis process. Following my preliminary reading of the selected documents, I categorised them based on their relevance to either task shifting, human resources for health, primary healthcare and national health system as shown in **Table 3**, following.

FOCUS	DOCUMENT	DESCRIPTION
Task-shifting	2014 National Task Shifting and Task Sharing Policy	The first national policy on task shifting was published in 2014 and provides a framework for redistributing healthcare responsibilities among health workers to address shortages and improve access to care in primary healthcare settings. Focuses on task shifting for maternal child health services, including HIV, TB and Malaria services delivered by doctors, nurses, midwives and community health practitioners.
	2018 National Task-Shifting and Task-Sharing Policy	This was published in 2018, as an updated version of the 2014 national policy. The policy mainly expanded the range of family planning services that can be shifted to community health practitioners. A 2021 addendum to the policy recommended the diagnosis and treatment of NCDs (Hypertension and Diabetes Mellitus) via task shifting.
	2022 National Task-shifting and Task-sharing Policy	This is the most recent iteration of the national task-shifting policy published in 2022, which recommended that CPs and patent and PPMVs should be involved in delivering family planning services at the community level.
	2021 FCT Task-shifting and Task-sharing Policy	The FCT's first task-shifting policy was adapted after the 2018 national task-shifting policy. It makes recommendations for the shifting of maternal child health services, including HIV, TB, Malaria and NCD services delivered by doctors, nurses, midwives and community health practitioners.
Human Resources for Health	2020 National Human Resources for Health Policy	A strategic national document published in 2020 outlining the policy approach for the development, management, and optimisation of healthcare workforce resources to meet national health goals.
	2021 – 2025 FCT HSS Human Resource for Health Policy and Strategic Plan	A policy document published in 2021 outlining the policy and plans for strengthening the healthcare workforce within the FCT across all levels, aligned with broader FCT health system priorities.
	2019 FCT PHC Board Human Resource for Health Policy	A policy document published in 2019, addressing the policy approach to workforce challenges specific to primary healthcare in the FCT, focusing on recruitment, retention, and capacity building.
	2019 FCT PHC Board Human Resource for Health Strategy	A strategy document complementing the FCT PHC HRH policy, detailing strategies for optimising human resources within FCT primary healthcare facilities.
Primary Health Care	2012 Minimum Standards for Primary Health Care in Nigeria	A national document published by the NPHCDA to outline the benchmarks for delivering quality primary healthcare services across Nigeria, ensuring uniformity and accessibility. The document outlines the recommended minimum workforce and infrastructural needs for different grades of primary healthcare facilities in Nigeria.
National Health System	2018-2022 National Strategic Health Development Plan II	A national document published by the Federal MoH in 2018. The document outlines the roadmap for achieving national health objectives, focusing on improving health outcomes through multisectoral collaboration and investment between 2018 and 2022.

	2016 National Health Policy	A foundational document published by the Federal MoH in 2016 that defines the overarching goals, priorities, and strategies for achieving universal health coverage and improving public health outcomes in Nigeria.

Table 3: Documents selected for Documentary Analysis

3.4.2 Interviews

I conducted semi-structured interviews to explore the perspectives of policy-relevant participants who were policy actors directly involved in formulation, review, implementation, or oversight of task-shifting policy and its practice in Nigeria and the FCT. I sampled policy-relevant participants purposively to ensure their relevance to task shifting, aiming at capturing a diverse range of experiences and institutional affiliations. The sampled participants were drawn from government agencies, NGOs, professional associations, and regulatory agencies. I consulted government officials at national and FCT levels, to identify their colleagues who were directly involved with task-shifting policy and oversight of its implementation. I wrote to formally invite potential participants to partake in the study. The sampling of participants working with development partners and NGOs began with identifying the organisations that had been involved in supporting and implementing task-shifting interventions at national and FCT levels. I then wrote formally to them, introducing my study and requesting to interview the most suitable official of the organisation (see **Appendix V** for letter of invitation for interviews). A similar approach of writing formally to organisations was taken to recruit participants from the regulatory agencies and professional associations. I also used snowball sampling, to supplement the initial participant list by identifying additional key informants through referrals from earlier interviewees.

Having approached 28 potential policy-relevant participants directly or through their organisations, ultimately, I interviewed 24 participants across different institutions. Three of the participants (one each from Abuja Municipal, Bwari and Kuje Area councils) were medical doctors working in primary healthcare facilities, with oversight over the other healthcare workers involved

in task shifting practice. The other 21 participants did not have clinical roles but were affiliated with either government agencies, development partners, NGOs, regulatory agencies or professional associations, as outlined in **Table 4** below.

PARTICIPANT CATEGORY	ORGANISATION	NUMBER	PARTICIPANT ROLE
National Policymakers	Federal Ministry of Health	3	National reproductive health activities
			National maternal health and safe motherhood programmes
			National family planning and maternal health programmes
	NPHCDA	2	National emergency maternal and child health interventions
			National maternal and child primary healthcare interventions
FCT Policymakers	FCT Health and Human Services Secretariat	1	FCT human resources for health coordination
	FCT Primary Health Care Board	2	FCT maternal health and safe motherhood programmes
			Planning and coordinating primary healthcare intervention in the FCT.
Development Partners/NGOs	World Health Organisation	1	Designing and supporting human resources for health interventions
	Banyan Global (USAID's Nigeria Health Workforce Management Activity)	2	Overseeing health workforce interventions at national and FCT levels
			Providing technical assistance for health workforce interventions at national and FCT levels
	Pathfinder International	1	Providing technical assistance for health workforce interventions at national and FCT levels
	Jhpiego	1	Overseeing health workforce interventions at national and FCT levels
Regulatory Agencies	Medical and Dental Council of Nigeria	1	Planning and coordinating the regulation of clinical practice for medical doctors
	Nursing and Midwifery Council of Nigeria	1	Planning and coordinating the regulation of clinical practice for nurses and midwives

	Community Health Practitioners Registration Board of Nigeria	1	Planning and coordinating the regulation of clinical practice for community health practitioners
Professional Associations	Association of Medical Officers of Health	2	Senior national level official
			Senior FCT level official
	National Association of Community Health Practitioners of Nigeria	2	Senior national level official
			Senior FCT level official
	National Association of Nigeria Nurses and Midwives	1	Senior national level official

Table 4: Policy-relevant participants recruited for the study

The interviews were conducted following a semi-structured format using interview guides, which structured the interviews but allowed room for flexibility and adaptability with each interview (Turner, 2010). Two interview guides were developed for the medical doctors and the other policy-relevant participant (**Appendix III and IV)** to capture relevant clinical and policy nuances in the interviews. I conducted six pilot interviews to test the interview guides, identify any problems of clarity or scope with the questions, and get a sense of the appropriate interview pace. (DeJonckheere and Vaughn, 2019; Majid et al., 2017; Turner, 2010) I then updated the interview guides based on the feedback I received from pilot testing. Since I started the documentary analysis before commencing fieldwork, some insights from the documentary analysis shaped the interviews.

I provided each interviewee with a participant information sheet (see **Appendix VI**) to give them information about the study. Informed consent was obtained from each participant before the commencement of the interview using a consent form (see **Appendix VII**) signed by the participant. The interviews were scheduled at the convenience of the participants and at their

preferred venues and times. Seven interviews were conducted remotely, due to scheduling constraints or participant preference. For the remote interviews, participants either shared a soft copy of the signed consent form or provided verbal informed consent before the commencement of the interview.

All 24 semi-structured interviews were conducted in English and lasted for about an hour. With consent, the interviews were audio-recorded using a handheld digital recording device and then securely transmitted for professional transcription. During each interview, I noted key points and insights in my fieldwork notebook, which was a complementary source of data for analysis.

3.4.3 Focus group discussions

I conducted seven FGDs: three with nurses/midwives and four with community health practitioners, to prompt shared perspectives and experiences of health workers directly involved in the practice of task shifting for maternal health services within primary healthcare facilities. I addressed the participants for the FGDs as facility-based participants, comprising healthcare workers (nurses, midwives, and community health workers) who were directly involved in delivering maternal healthcare services in primary healthcare facilities. These facility-based participants were drawn from the three area councils covered in my study.

The recruitment of facility-based participants started with receipt of formal permission to engage healthcare workers from the each of the area councils. Afterwards, I engaged facility managers with study posters and flyers (see **Appendix VIII**) to healthcare workers (nurses, midwives and CHWs), giving some information about the study and outlining how they could voluntarily sign-up to participate. With low self-enrolment and given the limited number of potential participants, I identified focal persons within the nurses/midwives and CHWs in each area council, and they assisted with the recruitment of facility-based participants and my communication with them. The

focal persons also coordinated with me to finalise the date, time, and location for the FGDs. Given the shortage of staff in the facilities, I recruited the facility-based participants for each FGD were drawn from two or more primary healthcare facilities, based on their willingness and availability to join the discussions. As such, a convenience-sampling approach was used to recruit facility-based participants. Across three area councils, I recruited 86 facility-based participants (36 nurses/midwives and 50 CHWs) for the seven FGDs. In **Table 5** below, I outline the facility-based participants recruited in each area council.

AREA COUNCIL	NUMBER OF DISCUSSIONS	HEALTHCARE WORKER CADRE	NUMBER OF PARTICIPANTS
Abuja Municipal	3	Nurses/Midwives	12
		Community Health Workers	26
Bwari	2	Nurses/Midwives	12
		Community Health Workers	12
Kuje	2	Nurses/Midwives	12
		Community Health Workers	12
Totals	**7**		**86**

Table 5: Facility-based participants enrolled for FGDs

The discussions were organised as single cadre groups, with all participants for each discussion being either only nurses/midwives or community health workers. I ensured that the two main cadres were involved in the discussions separately, to foster open discussions and enable the identification of shared and divergent viewpoints within and across cadres. In the Bwari and Kuje Area Councils, two FGDs were conducted, one each with nurses/midwives and community healthcare workers separately. In the Abuja Municipal Area Council (AMAC), I conducted three FGDs, one with nurses/midwives and discussions with community health workers in the AMAC. Given this council's expansive nature, I conducted two FGDs for community healthcare workers, to capture the perspectives of health workers in the central and remote parts of the area council.

Each FGD lasted approximately two hours and was conducted in English using a discussion guide (see **Appendix IV**), developed in line with the study objectives and the line of questioning shaped by preliminary insights from the documentary analysis. The discussion guide was pilot-tested to evaluate the clarity and comprehensiveness of the questions (Turner, 2010). I moderated the discussions, observed the group dynamics, and captured non-verbal cues, ensuring a circular seating arrangement during discussions to encourage open conversations and encourage participation. While moderating the discussions, I encouraged all the participants to speak, to ensure optimal participation and made sure dominant participants did not take over the discussions (Krueger and Casey, 2015). The FGDs were conducted either in the area council secretariat offices or in nearby primary healthcare facilities, which were familiar to participants, in order to encourage participation, reduce travel burden, and ensure adequate privacy for open conversations. At the end of each FGD, participants were given light refreshments and a token to cover their transportation expenses. With consent, the discussion was audio-recorded, using a handheld digital recording device, and then securely transmitted for transcription.

3.5 Data Management

I ensured that all data collected for the study was managed in line with the data protection guidelines of the University of Oxford. This data included the audio recordings and transcripts of all interviews and FGDs. After each interview and FGD, the audio recordings were securely stored in the central data repository (Z-drive) of the Medical Sciences Division at the University of Oxford, and subsequently transmitted to trained transcription assistants, for transcription under strict confidentiality agreements. After transcription, transcripts were anonymised and securely stored in a password-protected folder in the central data repository. I ensured that all physical documents with identifiable information (such as physical consent forms) were stored in a locked cabinet that was only accessible to me.

3.6 Data Analysis

I iteratively and simultaneously analysed the data from all the study methods in keeping with the IPA framework, which does not view data analysis as a distinct activity, but rather as a process that occurs throughout the study (Yanow, 2000; Yanow and Schwartz-Shea, 2014). In analysing the data, I aimed to explore the content of policies, the perspectives of study participants, and the meanings, values, interests and assumptions that underpinned the task-shifting policies and their practice. The iterative and simultaneous analysis of the data from the three methods allowed me to compare and synthesise the data across the data sources, instead of analysing the data from each method separately. The data analysis started with the documentary analysis, which was done iteratively (Bowen, 2009). I read the documents severally to understand the meaning and values conveyed through the text and make interpretations, while comparing my analytical deductions with those I was making from interview and FGD data.

Across the documents and transcripts, I identified the words, phrases and ideas that appeared frequently and explored how those words were used in each instance, seeking to interpretively deduce the meaning of those words and establish if the words had been ascribed different meanings by different policy actors in the interviews and FGDs. While analysing the study data, I created vignettes, which are short fictional stories about policy actors and situations relevant to the study. The vignettes I created were drawn from my interpretation of the perspectives of the study participants and my understanding of the study context. The vignettes illustrated key insights, contextual dynamics, and events emerging from the study, thereby enhancing the understanding and interpretation of the findings. (Gourlay et al., 2014; Hughes, 1998)

In keeping with an IPA framework, I sought to identify interpretive communities from my analysis. I read through the data from the three methods, identifying the roles and responsibilities of the different policy actors, as stated in the documents, and noting their views about task shifting,

interpretively making deductions about the groups of policy actors that had similar interests, values and perspectives about task shifting. Using this approach, I identified the interpretive communities relevant to task shifting, noting that the boundaries of these communities were not sharply delineated (Yanow, 2000), as there were some overlapping interests and values across interpretive communities (see Chapter 4). Through further iterations of my analysis, I sought the meanings ascribed to the task-shifting policy by the interpretive communities, and the interpretive symbols that held meaning for them, through a reflexive thematic analysis (Braun and Clarke, 2021, 2019; Byrne, 2022). After reading the documents and transcripts several times, I identified codes and organised them to create themes related to the meanings ascribed to the task-shifting policy, and the influences that shaped task shifting practice. I subsequently merged relevant themes and organised them to answer the research questions as laid out in Chapters 4-6.

3.6 Reflexivity and Positionality

I critically reflected on my identity, positionality, and reflexivity throughout the study, acknowledging that I was not detached from the study, but an engaged participant (Wilson et al., 2022). According to Bourke, 'to achieve a pure objectivism is a naïve quest, and we can never truly divorce ourselves of subjectivity. We can strive to remain objective but must be ever mindful of our subjectivities' (Bourke, 2014, p. 3).

As I became immersed in data collection and analysis, I was mindful of my reflexivity, knowing that my interaction with study participants, the approach to asking questions, and my interpretation of the study data are all influenced by my knowledge, experiences and background. I reflected on my perceptions of the policy and practice of task shifting, and how they might influence my interpretation of data. For example, prior to starting my DPhil, I had the impression that task shifting was a linear process that should work once all key requirements are available. My study exposed me to alternative views: that there are multiple influences that shape task shifting, such

as the values and interests of the policy actors involved in its implementation. As such, I was eager to learn from the perspectives of my study participants, rather than seeking a validation of my prior views.

I also reflected on my identity and positionality throughout the study. For example, admitting to my identity as a medical doctor and policymaker, I built rapport with the nurses/midwives and CHWs before each FGD, and used a conversational approach for the interviews, emphasising that I was eager to learn their views about task shifting. This made the study participants to be receptive and helped me gain their trust, allowing for more honest conversations during the discussions and interviews.

3.7 Ethical Considerations

The conduct of qualitative research presents a set of ethical issues, some of which must be addressed before, during, and after the study, and others which are likely to occur depending on the circumstances of the study (Sanjari et al., 2014). Before the commencement of fieldwork in Nigeria, ethical approval for the study was received from the Oxford Tropical Research Ethics Committee at the University of Oxford (Ref No. – 531-22). Local ethical approval was obtained from the National Research Ethics Committee at the Federal Ministry of Health (Ref No. – NHREC/01/01/2007-20/06/2022) and the Health Research Ethics Committee in the FCT (Ref No. – FHREC/2022/01/96/28-06-22) (see **Appendix IX** for ethical approval letters).

Throughout the study, I followed ethical best practices for qualitative research, such as ensuring informed consent is provided by each participant, and guaranteeing their anonymity (Sanjari et al., 2014; Wiles, 2012). I anticipated potential ethical issues that could arise and took measures to prevent or manage them. For example, I anticipated that internal confidentiality (the expectation that members of a group will not to disclose information from a discussion) may not be guaranteed

within each focus group, as participants will be able to hear the views expressed by one another, and would be able to discuss them outside the group if they wished (Sim and Waterfield, 2019). As such, the possibility of this occurrence was highlighted on the participant information sheet and explained to participants before each discussion.

All participants were informed about the study verbally and through participant information sheets, and they provided informed consent using the consent form (**Appendix VII**) before any interview or FGD was conducted. I also informed the participants that their involvement in the study was voluntary, and they could stop the interview/discussion or withdraw participation at any time. To maintain confidentiality, the audio recordings and transcripts were anonymised before being stored. I ensured that the data from the study were stored in compliance with the UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018, as recommended by the University of Oxford.

3.8 Summary and Conclusion

In this chapter, I presented the methodological framework that guided this study, focusing on the design and approach used to explore the policy and practice of task shifting for maternal health services in Nigeria. I designed a qualitative study, methodologically guided by an IPA framework, aiming to understand the evolution of task-shifting policy and the influences and dynamics of task shifting practice within primary healthcare settings. The study incorporated data from three methods: documentary analysis, interviews, and FGDs. I described the study setting and approach to data collection for each of the methods. I gave an account of the iterative and simultaneous analysis of the study data in keeping with the IPA framework and reflected on how my reflexivity and positionality influenced the research process. I also highlighted the ethical considerations that were relevant to the study.

The interpretive and reflexive methodological orientation of this study recognises that policy formulation and implementation is not a rational process, but a subjective process that is shaped by the meanings, values, experiences and context of policy actors and their institutions. In this chapter, I have demonstrated that the study design and methodological choices align with the research questions, IPA framework and the study context. This methodological approach has laid a foundation for the understanding of the findings reported in the next three chapters. It is noteworthy that, though data for the study was obtained from three methods, the data analysis was done simultaneously across the methods with each of the three findings chapters drawing on insights from all methods. In the next chapter, I present the first of the three findings' chapters to provide insights into the emergence and evolution of task-shifting policies and the interpretive communities ascribing meanings to the task-shifting policy.

CHAPTER 4—FINDINGS I – EVOLUTION AND INTERPRETATION OF TASK-SHIFTING POLICY

4.1 Introduction

Task-shifting policy in Nigeria has undergone several revisions within less than a decade, highlighting its status as a contemporary issue that has garnered the attention of policymakers in the country. As the policy evolved over time, it came to reflect the interests and values of the key policy actors involved in its revision, as well as the meanings they ascribed to the task-shifting policy. This chapter reports on the emergence and evolution of the national task-shifting policy in Nigeria, making sense of how the policy is understood by policy actors at national and FCT levels, and the meaning that different interpretive communities ascribe to the task-shifting policy.

In the chapter, I provide answers to my first research question, that seeks to understand how task-shifting policies emerged and evolved in Nigeria, exploring the influences and policy actors that have shaped its evolution and practice:

i. How did the national task-shifting policy emerge, how has it evolved, and what meaning has been ascribed to it?

Drawing from policy documents, interviews and FGDs, I trace the historical origin and trajectory of the national task-shifting policy and highlight the key changes to the policy content and context between 2014 and 2022. I then identify the interpretive communities drawing meaning from the policy, according to their interests and values and highlight the meanings they ascribe to it and identify the related interpretive symbols (such as objects, acts and language) which hold meaning for these interpretive communities, showing how these meanings reflect their interests and influence their actions (or inactions).

4.2 The Emergence and Evolution of the Task-shifting Policy

In this section, I explore the emergence of the national task-shifting policy, exploring the policy's context, process, content and actors, to understand how different policy actors interpret, negotiate and ascribe meaning to the policy (Yanow, 2000, 1996). Global and regional recommendations that were linked to Nigeria's prevailing challenge of health workforce shortages and high maternal mortality influenced the emergence of the policy, through the actions of several policy actors. Following its 2006 recommendation for task shifting, WHO formally endorsed the extension of task shifting to maternal health services in 2012 (WHO, 2012b). Drawing from these global recommendations, the first task-shifting policy in Nigeria was developed in 2014. In the following sub-section, I outline the Nigerian context before the first task-shifting policy was formulated, and the process through which the national task-shifting policy emerged.

4.2.1 The Nigerian context before the task-shifting policy

In health policy formulation, context helps to explain why policies are developed at a given place and time. Context explores the historical, economic, political and sociocultural factors that influence the emergence and change of policy (Walt and Gilson, 1994). The context within which the task-shifting policy was created closely correlates with the two challenges highlighted in Chapter 1 – the high number of maternal deaths, and the significant shortage of healthcare workers in primary healthcare facilities.

In 2000, Nigeria adopted the Millennium Development Goals (MDGs), of which goals 4, 5 and 6 were focused on reducing child mortality, improving maternal health, and combating HIV/AIDs, Malaria and other infectious diseases. However, as of the late 2000s, not much progress had been made in attaining these health-related goals (Abubakar et al., 2022; Enabudoso et al., 2009). In December 2004, a high-level meeting of senior government officials and development partners acknowledged that health workforce shortages could impact the attainment of the MDGs (Nullis-

Kapp, 2005). Accordingly, Nigeria's inability to meet the health-related MDGs is linked to the health workforce shortage that bedevilled the country throughout the MDGs era (Abubakar et al., 2022). Particularly, the shortage of SBAs hindered access to safe and timely obstetrics and newborn care, before the emergence of the task-shifting policy. As such, some policy actors advocated for CHWs to be trained and supported to bridge service delivery gaps, as indicated in the quote below:

> *'The biggest problem for implementing emergency obstetric and newborn care was the shortage of skilled birth attendants, and skilled birth attendants are basically doctors, nurses and midwives, as defined. Most of the primary health care facilities were manned by community health extension workers who had not been trained to manage emergency situations in obstetrics and had gone through 2-3 years of health technology training, including learning about antenatal care and delivery. But because the midwives are in charge of the labour ward and the antenatal training, it seems like the CHEWS were excluded from learning any skills in the labour ward that could help them manage life-threatening complications of pregnancy and childbirth. And these community health extension workers were employed, and they were seeing pregnant women, even though they had not been exposed to proper training…* ***if we were going to make any change in the reduction of maternal and newborn mortality, the frontline health care workers in this case, the community health extension workers needed to have some basic lifesaving skills, since the nurses weren't going to come to the village and the doctors aren't going to come to the village*** *– so that's why we started the push to start training community health extension workers to manage post-partum haemorrhage, to manage eclampsia with magnesium sulphate, to have safe clean deliveries, to identify post-partum sepsis.'*
>
> *(emphasis added by author)*
>
> *Former NGO Official*

As highlighted above, CHWs were the mainstay of delivering maternal health services in northern Nigeria. However, they were not considered SBAs by health workforce and service delivery guidelines before the task-shifting policy was formulated. The quote above also indicates that before the emergence of the policy, there was advocacy for the training of CHWs to deliver maternal healthcare services, since they formed the majority of the primary healthcare workforce, especially in northern Nigeria.

With a significant shortage of healthcare workers and a high number of maternal deaths, the Nigerian Government was seeking solutions to the health workforce shortage and the high maternal-mortality ratio. The efforts of the government were complemented by several development partners, donor agencies, international NGOs, and civil society organisations interested in reducing maternal mortality and increasing access to essential healthcare services. As such, it was within the context of seeking solutions to the pressing problems of health workforce gaps and a high number of maternal deaths that the task-shifting policy emerged. This context was emphasised in the policy documents I analysed and reiterated in interviews with government officials and development partners.

4.2.2 Process

In policy formulation, ideas and their framing determine how a policy issue is presented, and the potential policy solutions that policy actors will consider (Shearer et al., 2016). The main idea that drove the emergence of task shifting as a strategy was that healthcare workers with lower levels of training and experience could be trained, supervised, and supported to deliver services that would otherwise have been delivered by their more highly-trained and experienced counterparts (WHO, 2006). Another idea was that maternal deaths could be prevented if access to maternal health services increased, especially at the primary healthcare level (WHO, 2012a, 2012b). These two ideas drove most policy actors (such as government official and development partners) at global, regional and national levels to push for task shifting for maternal health services. They viewed task shifting as the 'silver bullet' that could reduce the impact of health workforce shortages, increase access to maternal health services, and lead to a reduction in maternal deaths, as expressed in the analysed policy documents (FMOH, 2014; WHO, 2012a).

The emergence of Nigeria's national task-shifting policy began with the 2006 World Health Report task shifting recommendation (WHO, 2006). Following this, WHO, the United States President's Emergency Plan for AIDS Relief (PEPFAR), and UNAIDS organised a 2008 International Conference on Task Shifting, resulting in the Addis Ababa Declaration, urging countries to adopt task shifting strategies (WHO, 2008b). The African Union's 2009 'Campaign on Accelerated Reduction of Maternal Mortality in Africa' promoted task shifting for maternal health. This was followed by the Human Resources for Maternal Survival conference, and an African Ministers of Health meeting, that endorsed task shifting for maternal healthcare services (UNFPA Ethiopia, 2009). In 2012, WHO endorsed task shifting as a viable strategy for maternal and newborn health services, recognising trained CHWs as SBAs (WHO, 2012b). **Figure 5** below shows a timeline of the global and regional events on task shifting between 2006 and 2012.

Figure 5 Global and Regional Events on Task Shifting between 2006 and 2012

In response to the global and regional developments mentioned above, the policy environment in Nigeria became attuned to and supportive of the concept of task shifting for the provision of maternal and other essential healthcare services. The policy formulation process was spearheaded

by development partners, NGOs, and officials from the Federal Ministry of Health (FMOH), through a series of consultative meetings and engagements. At this time, when the idea of task shifting for maternal healthcare services was gaining momentum in Nigeria, the nurses, midwives and medical doctors expressed reservations about the practice, through their professional associations, as expressed in the quote below:

> *…We started the advocacy in the Ministry of Health. We put the Ministry of Health in the driver's seat and got them to invite stakeholders. I knew that professional associations would be the main stakeholders for us to meet with, particularly the National Association of Nigerian Nurses and Midwives. We got together several meetings, and we discussed. We presented information of the reality on ground. Up to 70% of primary health care facilities are manned by CHEWs in northern Nigeria. We presented the data, and we also presented the data on maternal and newborn mortality. Regional data showed how maternal mortality in the north was ten times what it was in the southwest. So, we presented all that data, and we did say that in the absence of the nurses and midwives, we needed a policy framework that would allow us to train community health extension workers for them to provide better services. We made the point that they were already employed by local Governments, they were already in place, and they were providing these services without being trained.*
>
> ***Former NGO Official***

The quote above indicates that development partners and NGOs kicked off the policy development process, with the FMOH subsequently taking ownership. It also highlights that task-shifting practice preceded the emergence of the policy, as CHWs were already providing maternal health services without being trained. A senior FMOH official provided additional insights into the policy development process, emphasising that between 2012 and 2014, a series of consultations were conducted to inform the development of a task-shifting policy. During these consultations, medical doctors expressed reservations regarding task shifting.

> *What we did was to start discussing the pros and cons of the TSTS policy right from 2012. We started with the National Reproductive Health Technical Working Group. We also advanced it to some workshops and even conferences at the national level. It generated lots of argument and, lots of divergent opinions with very strong opposition coming from the obstetricians and gynaecologists. They felt that it might increase morbidity and mortality because these lower cadre healthcare providers that are going to be trained to*

provide antenatal and delivery services may actually not know their limits. They might not appreciate when to refer. They may want to go beyond what is approved for them and beyond what they were trained to do.

Senior FMOH Official

In March 2014, a Presidential Summit on Universal Health Coverage recognised Nigeria's dire health workforce shortage, and called for concerted efforts to address the human resource gaps (FMOH, 2014). A few months later, the FMOH set up a task-shifting working group that met periodically to draft the first national task-shifting policy, launched in October 2014 and endorsed by the National Council of Health, the highest decision-making body in Nigeria's health sector (FMOH, 2014). The National Assembly and the Presidency also prioritised the health workforce through the 2014 National Health Act, which received presidential assent in December 2014. The enactment of the National Health Act in December 2014 provided a legal framework for establishing the Basic Health Care Provision Fund (BHCPF), an earmarked fund for health. Accordingly, 10 per cent of the BHCPF was set aside for the recruitment and capacity development of the primary healthcare workforce. This was a *symbolic act* as the BHCPF funds for human resources for health were not readily available and accessible to primary healthcare facilities. Further details of this symbolic act will be provided later in this chapter.

Several policy actors influenced the development of the task-shifting policy, acting based on their interests, the beliefs, values and meanings they attached to task shifting, and the issues of health workforce shortage and high maternal mortality rates. The capacity of these policy actors to promote their interests is determined by various influences, including their resources, power, knowledge, and capabilities (Buse et al., 2023; Shearer et al., 2016). Most policy actors involved in developing the task-shifting policy had broad interests in addressing the health workforce shortage in primary healthcare facilities and reducing maternal deaths in Nigeria. However, accounts from interviews indicated that development partners and international NGOs were also

interested in using task shifting to advance service delivery for vertical health programmes focused on HIV/AIDS, TB and Malaria. This interest was because the shortage of health workers impacted the delivery of other essential healthcare services in primary healthcare facilities. Given that the government officials, development partners and international NGOs involved in the development of the policy were not only interested in maternal health services, the task-shifting policy also provided guidelines for the delivery of healthcare services focused on other priorities such as child health, HIV/AIDS, TB and Malaria.

> *For me, I think it [the task-shifting policy] is driven more by partners who are interested in certain interventions. Because Partners have areas where they want to help or support, they would then use the Task-shifting policy as a guide when they observe that there are gaps in human resources for them to be able to implement their interventions. So, they take advantage of the task-shifting policy.*
>
> ***Medical Doctor***

As highlighted in this section, the development of the 2014 national task-shifting policy in Nigeria was influenced by various global, regional, and national institutions, including WHO, PEPFAR, UNAIDS, the African Union, professional associations and the FMOH. The pivotal role of WHO and other development partners in the formulation of the policy is noteworthy. They capitalised on the policy window, created by the shortages in the health workforce and the high rates of maternal mortality, to advocate for task shifting, thereby prompting the FMOH to spearhead the policy development process. This led to the development of a task-shifting policy that was focused on maternal healthcare services and other essential healthcare services that aligned with the interests of development partners and international NGOs.

4.2.4 Content of the 2014 task-shifting policy

The 2014 task-shifting policy document highlighted goals and objectives, justifying the need to address the high maternal-mortality ratio amid the prevailing health workforce shortage. The

policy goal was 'to reduce maternal and newborn morbidity and mortality in Nigeria' (FMOH, 2014, p. 21). The policy objectives related to maternal healthcare services are outlined in Box 2 below.

- Increase access of pregnant women in hard-to-reach areas to skilled attendance at birth
- Outline RMNCH-related tasks that can be performed by different cadres of HCWs attending pregnant women and their babies at PHCs.
- Provide a framework for empowering CHWs (CHOs and CHEWs) and other cadres of health workers to provide quality maternal and newborn care services, health records, and drug management, especially at primary health care and community levels. (FMOH, 2014, p. 21)

Box 2: Maternal Healthcare Objectives of the 2014 Task Shifting Policy

The 2014 task-shifting policy was underpinned by principles emphasising its role as a public health response to address high maternal mortality and workforce shortages. It highlights the importance of strong regulatory systems, ensuring quality of care, and integrating task shifting into existing service delivery and referral frameworks. Sustainability is emphasised through the need for adequate financial and non-financial resources, while adaptability calls for community involvement and tailoring the policy to local contexts. These principles collectively aimed to ensure the effective and context-sensitive implementation of the policy. Although these principles are outlined in the 2014 task-shifting policy, my study data indicated that these principles were mostly overlooked by relevant policy actors with task-shifting practice impacted by several challenges such as inadequacy of resources, poor regulatory oversight and weak referral systems (see Chapter 5).

The 2014 task-shifting policy did not only have content relevant to maternal health services, but also covered other essential services including childcare, HIV/AIDS, TB and Malaria. The policy outlined the cadre of healthcare workers to be involved in task shifting, and the range of services to be shifted/shared between them. The healthcare workers identified for involvement in task shifting included village health workers, CHEWs, nurses, midwives, and medical officers. The maternal health services identified for shifting/sharing by the policy were antenatal care, labour and delivery, postnatal care, post-miscarriage care, and family planning. The policy also recommended that health workforce training, supportive supervision, effective regulation, and robust referral systems should be in place for task-shifting practice.

4.2.5 Evolution of the national task-shifting policy from 2014 to 2022

Following its formulation in 2014, the policy was reviewed in 2018, had an addendum in 2021, and was further reviewed in 2022. It evolved through '*layering*', a process in which new goals and mechanisms are added to an existing policy regime without discarding the previous ones' (Rayner and Howlett, 2009). For a policy to evolve through layering, it is crucial that there is no conflict between the existing policy framework and the new goals and mechanisms being added. Such was the case with the evolution of the national task-shifting policy, as the policy evolution was mainly due to the addition of new services to be delivered via task shifting, and additional groups of healthcare workers introduced to shift/share tasks.

The evolution of the policy was driven by development partners and NGOs, who influenced government officials to make necessary updates to the policy. For example, when CPs and PPMVs were identified as being involved in providing family planning services, some development partners advocated for the task-shifting policy to be updated to cover the delivery of family planning services by these actors as well. During an interview, a participant said:

There was the big move to ensure family planning services are provided by PPMVs who are already coming in. They are not a typical cadre of health workers… but they provide some services in the communities through the drug stores that they operate. So, there was really a big move to enable them to provide some services… I guess we know that most of the time those patients go to these PPMVs or community pharmacists first.

WHO Official

An FMOH official highlighted that the policy was reviewed to increase the participation of the private sector in providing family planning services, saying:

…that is part of efforts to encourage family planning to increase access to modern contraceptives and avert unintended pregnancies. And in most cases, you know, abortion kills people… the Federal Government, through the reproductive health division signalled its commitment to improve primary health care access and to expand family planning by integrating community pharmacies and patent and proprietary medicine vendors through the IntegratE Project... Organisations like the Society for Family Health sought ways to engage the private sector. I know a lot of clients go to the private sector compared to the public.

Senior FMOH Official

As highlighted in the quote above, the development partners and the Government viewed task shifting as a strategy to extend the delivery of additional essential healthcare services through the involvement of different groups of healthcare workers. Through layering, the task-shifting policy evolved, as more groups of healthcare workers were formally allowed to deliver additional services. The policy evolution led to the recognition of CPs and PPMV as part of the workforce that provides family planning services at the community level.

With the rise of NCDs and increased advocacy for their prevention and control in Nigeria, the task-shifting policy was further revised to allow the delivery of services for NCDs in primary healthcare facilities. The revised policy empowered the workforce in primary healthcare facilities to diagnose and treat uncomplicated cases of hypertension and diabetes. Although the policy review expanded the range of essential healthcare services to be delivered in primary healthcare facilities, there was no clear mandate or noticeable effort to expand the health workforce to meet the increased

workload. While CPs and PPMVs may be perceived as an extension of the workforce providing family planning services, their integration into the policy did not increase the population of the facility-based workforce. This is attributed to the fact that CPs and PPMVs operate their premises as private businesses, independent of primary healthcare facilities. As such, the evolution of the task-shifting policy meant that primary healthcare workers had to contend with an increased workload, following an expanded range of services.

In line with Nigeria's health system governance structure, most states adopted the national task-shifting policy, taking up most of the contents, and making necessary adjustments based on their context. In 2021, the FCT adapted the 2014 national policy, using it as a template to formulate its task-shifting policy.

4.2.6 Emergence of the FCT task-shifting policy

The federal system of government in Nigeria empowers the FMOH to formulate national health policies, while state governments adapt national policies to their context and circumstances. In keeping with that, 33 states and the FCT adopted the national task-shifting policy, and are at different levels of implementation (FMOH, 2022). The FCT task-shifting policy was formulated and formally launched in June 2021. Before the FCT policy was formulated, there was no official position on task shifting in the FCT, as highlighted below:

> *In the FCT prior to now, there has been no official position on TSTS policy. However, there has been speculations that TSTS has been happening in some form or shade especially in the rural communities where there is uneven/disproportionate distribution of healthcare workers.*
>
> ***2021 FCT Task-shifting policy***

Adapted from the 2014 national task-shifting policy, the FCT task-shifting policy established a framework for delegating and redistributing responsibilities in delivering essential healthcare

services (encompassing maternal health, child health, family planning, NCDs, HIV/AIDS, TB, and malaria). As a 2014 adaptation, the FCT task-shifting policy did not contain updates from the more recent versions of the national task-shifting policy, such as the shifting of tasks to CPs and PPMVs. It had the same objectives for maternal healthcare as the 2014 national policy, and recognised CHWs as SBAs, referencing that some programmes in the FCT had shown the capacity of CHWs to deliver maternal health services when trained appropriately and proficiently. The institutions involved in developing the FCT task-shifting policy were mainly from the FCT Health and Human Services Secretariat, the FCT Primary Health Care Board, the area councils, regulatory agencies, and professional associations. During an interview, an official of the FCT HHSS indicated that minor revisions were made to the national policy, to create the FCT task-shifting policy.

> *"We had a 3-day meeting with our development partner, and during the meeting, we reviewed the national task-shifting policy because the FCT has a similar nature to the national. We invited three stakeholders: the medical association and other two stakeholders. We reviewed and adjusted certain areas of the national policy document... In the end, no significant changes were made."*
>
> ***FCT HHSS Official***

Having highlighted how the task-shifting policies at national and FCT-level were formulated, I now outline the key policy actors involved in the *practice* of task shifting, and their roles as specified in the task-shifting policies.

4.2.7 Policy actors involved in implementing the task-shifting policy

Following an analysis of data from national and FCT documents and interviews, I identified the key policy actors with roles relevant to task shifting.

Government at national and FCT levels play a central role in leading policy formulation, developing implementation guidelines, and periodically evaluating policy enactment. They oversee the monitoring and supervision of healthcare workers and are responsible for providing

financial resources and infrastructure. Additionally, the government is responsible for strengthening referral systems, recruiting and remunerating healthcare workers, and collaborating with regulatory agencies to develop standardised, competency-based training programmes. They also develop long-term plans to ensure task shifting serves as an interim measure to health workforce shortages, rather than a long-term solution. For example, the FCT policy indicates the role of the Government in providing finances for task shifting. 'The FCT administration, in collaboration with key stakeholders including partners, shall ensure that task-shifting plans are appropriately costed and adequately financed' (2021 FCT task-shifting policy).

Development partners, donor agencies, and NGOs provide critical support for task shifting by offering financial assistance and technical expertise. They complement the Government by improving infrastructure and supplying commodities needed in primary healthcare facilities. These actors also advocate for maintaining quality and safety of care, while encouraging the Government to intensify efforts around recruiting, training, and retaining healthcare workers.

Regulatory agencies are involved in task shifting to ensure safe and quality services. They regulate healthcare worker practices to ensure adherence to expected competencies and are expected to collaborate with government officials to develop in-service training manuals. Regulatory agencies work closely with **training institutions** to update pre-service training curricula and ensure that healthcare worker training is linked to certification, registration, and career progression. They also sanction healthcare workers who deviate from standard protocol or overstep their professional boundaries.

Training institutions ensure that pre-service training equips healthcare workers with the necessary skills and competencies to perform shifted tasks effectively. These institutions collaborate with regulatory agencies and relevant government officials to update training curricula, aligning educational programmes with the requirements outlined in the task shifting guidelines.

Professional associations of healthcare workers play an advocacy role by engaging with Government and regulatory agencies to protect their members' interests. They advocate for fair remuneration and better working conditions while encouraging adherence to professional codes of conduct to ensure the delivery of safe and appropriate healthcare services.

Civil society organisations also advocate for quality service delivery and press the government to prioritise healthcare worker recruitment, training, and retention. They monitor the actions of the government, regulators, and healthcare workers, drawing attention to gaps or issues that may hinder the successful enactment of the policy.

Healthcare workers are responsible for delivering safe and quality care within the limits of their competencies. As outlined in the task-shifting policies, they are expected to work with colleagues across cadres to ensure timely and effective service delivery and provide supportive supervision. Furthermore, healthcare workers are expected to ensure appropriate and timely referral of patients whose conditions exceed their competencies.

Given that the FCT task-shifting policy was adapted after the 2014 task-shifting policy, it only recognised three cadres of health workers to deliver maternal healthcare services. However, the most recent version of the national task-shifting policy recognises four cadres: medical, nursing, CHWs and pharmacists, as represented in **Figure 6** below.

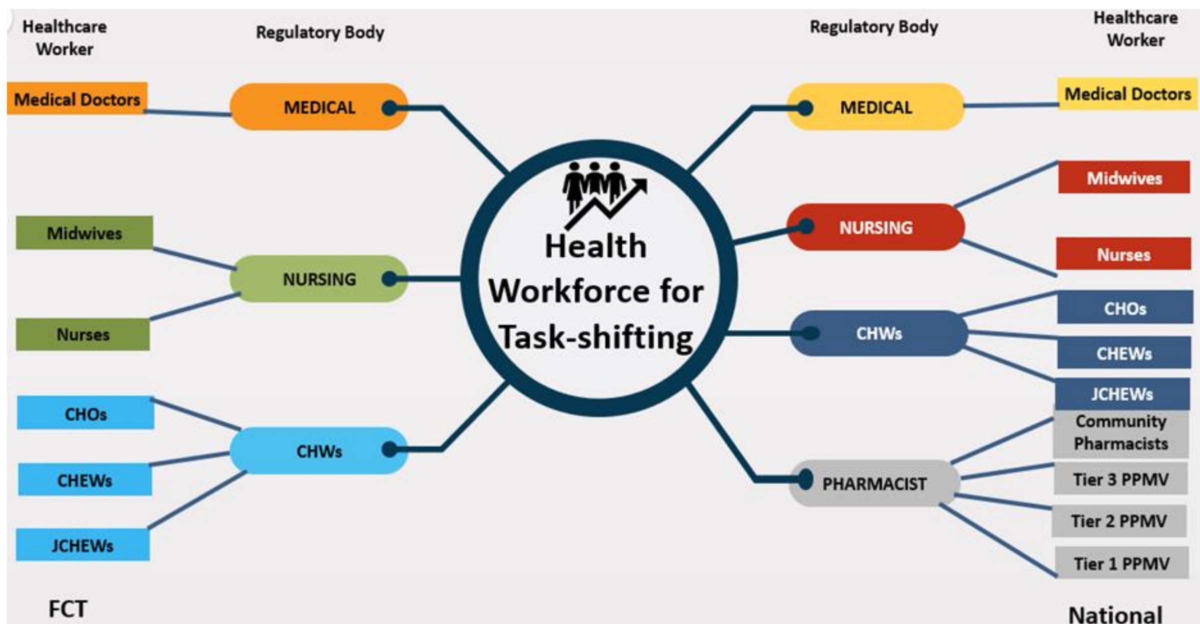


Figure 6: Healthcare workers recognised by the national and FCT task-shifting policies

Having identified the policy actors involved in task shifting above, I now explore how they interpret and ascribe meanings to the task-shifting policy, based on their interests and values. These interpretations and meanings drawn from policy influence how the actors perform their roles and responsibilities (i.e., their actions or inactions) (Yanow, 1996). Based on the interpretation of and meaning ascribed to policy, these policy actors can be grouped into interpretive communities (Yanow, 2000). In the next section, I identify these interpretive communities, their values and interests, and the interpretive symbols that carry meaning for them.

4.3 Understanding Task-Shifting Through the Lens of Interpretive Communities

IPA views the policy space as a social arena, in which human actors can draw meanings and interpretations that are subjective and shaped by social, cultural, political, and economic influences. IPA also acknowledges that the meanings and interpretations of policy words, artefacts, and acts are dependent on the experiences, contexts, prior knowledge, and values of policy actors (Yanow, 2007; Yanow and Schwartz-Shea, 2014). Below, I identify the interpretive communities that draw meaning from the task-shifting policy.

4.3.1 Identifying the interpretive communities

Drawing from Yanow's work, a crucial step in conducting an IPA is the identification of interpretive communities, which are *groups of people or policy actors with a shared interpretation and meaning of a policy*. These communities are not strictly bounded as there could be an overlap of interests or values across them (Yanow, 1996).

Following the iterative approach described in Chapter 3, I identified four interpretive communities interpreting and ascribing meaning to the task-shifting policy, identified below:

i. policymakers
ii. development partners/NGOs
iii. regulators
iv. healthcare workers

To identify the interpretive communities, I noted patterns in the framing of perspectives, and the meaning given to key terms and phrases by different policy actors. I created the interpretive communities following a reflexive thematic analysis of the documents and transcripts from the interviews and discussions (Braun and Clarke, 2019). I noted the comments of the individual actors in the interviews and FGDs and related the implied meaning of words and phrases to their use in the policy documents. I named the four interpretive communities to indicate the dominant perspective of each group.

i. policymakers – *optimists*
ii. development partners/NGOs – *advocates*
iii. regulators – *guardians*
iv. healthcare workers – *practitioners*

I noted that there were points of overlap of interpretation and meaning across the interpretive communities as the community boundaries were not distinct.

4.3.2 The Optimist (Government Policymakers)

The first interpretive community was the government policymakers who are actors from government ministries, departments and agencies at national and FCT-levels. I collectively referred to the members of this community as the '*optimists'*, because of *their shared positive, solution-oriented outlook of the task-shifting policy, viewing it as a practical response to the health workforce shortage*. This community have a shared interest in portraying the Government as responsive. Their perspectives indicate a desire to inspire public confidence and to reinforce the narrative of a 'working government', that can provide needed healthcare services despite the shortage of healthcare workers. For example, a participant in this community said,

> *'The policy is working. The policy is giving positive results.'*
>
> **Official, NPHCDA**

Most members of this community believed that task shifting was working well. However, some of them admitted to some challenges impacting its success as an intervention:

> *'I think everyone believes in task shifting because even from our report, they've seen it. And they believe that the problem is the funding.'*
>
> **Official, FCT Primary Healthcare Board**

The policymakers' perspectives about the task-shifting policy at the national and FCT levels were linked to their position as government officials. Their optimistic outlook made most members of this community overemphasise the potential gains of increased access to essential healthcare services from task shifting, referencing results from pilot task-shifting interventions as evidence that task shifting is working, and more task shifting is needed.

This view informed the layering of the task-shifting policy with additional services that can be delivered via task shifting, each time the policy was updated. The optimists somewhat downplayed

the contextual limitations that impact task-shifting practice. Such limitations include resource constraints, reservations about task-shifting from some healthcare worker groups, and the potential overburdening of healthcare workers as the scope of task shifting expands with each policy review. This community held *quality of care, collaboration* and *efficiency* as their values, expecting task-shifting practice to be a collaborative effort of multiple stakeholders, efficiently managing the available workforce to deliver quality healthcare services. The following, from an senior official of the FMOH further suggests the optimistic outlook for task shifting which was linked to the value of collaboration:

> *'So, there's still a lot to be done, but you know when you are working collaboratively together, and you itemise and prioritise, you can definitely improve as time goes on'*
>
> **Senior FMOH Official**

4.3.3 The Advocates (Development Partners and NGOs)

The second interpretive community consists of actors working for development partners, donor agencies and NGOs, a community I call the '*advocates'*. The policy actors in this interpretive community share the view that *task shifting is working but acknowledge that additional efforts are needed for task shifting to be done better and more effectively. They advocate for increased government support for the practice of task shifting, emphasising the importance of capacity building, adequate funding, and improved infrastructure to ensure the policy's long-term success.* Although the members of this interpretive community also have a positive outlook on task-shifting and shared the optimism of the government actors, they are more pragmatic about their expectations. They are also more upfront about challenges and contextual realities that impact the practice of task-shifting. A member of this community said:

'Regarding the operationalisation of the TSTS policy, I think the government is quite ambitious in making it happen, but I don't think they have done enough to meet what is required to make it work well'

NGO Country Director

Beyond advocating for the government to provide more funding and pay attention to the realities of task shifting, the members of this community are involved in providing financial, technical, and infrastructural support for healthcare workers and primary healthcare facilities, complementing governments' efforts to advance the practice of task shifting. One key interest that the members of this community share is the aspiration to meet the programmatic objectives of the vertical programmes that their organisations prioritise at a given time. Their interpretations of task shifting were grounded in their aspiration to advance equity in access to healthcare services. For example, some members of this community might be interested in improving maternal health outcomes, while others may be championing programmes focused on reducing the prevalence of NCDs. However, they all consider task shifting an intervention that helps them attain programmatic outcomes. As such, they advocate for the advancement of task shifting to the Government, and provide technical and financial support for task shifting. This interest might explain the motivation of members of this interpretive community to fund and implement pilot interventions for task shifting. The values of the members of this community include *equity, collaboration, quality of care,* and *sustainability*, with their views reflecting optimism about the potential of task shifting and an understanding of the systemic and operational challenges that need to be addressed for the practice of task shifting to be improved. Some of these values are expressed below in a quote from a member of the community:

'Essentially, it [task shifting] is about ensuring that there is provision of quality health care to people wherever they live, talking about the ethics and the equity. That's what task shifting is able to do. It is a policy intervention to overcome those challenges' **WHO Official**

4.3.4 The Guardians (Regulatory Agencies)

The third interpretive community comprises actors working with regulatory agencies that have oversight over the different cadres of healthcare workers involved in task-shifting practice in primary healthcare facilities. I collectively called them '*guardians'* for two reasons. Firstly, their interpretation of the policy indicated their positioning as 'protectors' of the clinical practice standards and public safety. Secondly, they stood out to protect and defend the healthcare workers under the purview of their regulatory agency, seeking to preserve the professional identity of their healthcare workers. The perspectives of the members of this community showed that *they viewed task shifting with apprehension, gearing their efforts towards ensuring that healthcare workers deliver safe and quality healthcare services based on the competence that should come with their training and supervision*. Although, the members of this interpretive community regulate the practice of different cadre of health workers, they agree that task shifting is a critical intervention to address health worker shortages. They also express concerns that its practice has not been optimal, because of resource gaps that the Government does not duly address. This indicates some alignment with the views of the interpretive community of advocates. Expressing concerns about patient safety and quality of care, an official of the Nursing and Midwifery Council expressed reservations about the competence of CHWs being trained to deliver maternal health services.

> *The trainings are good… however, you can't use such trainings to convert a midwife to a doctor, no amount of training would do that, and likewise a CHEW to a midwife. …What we tell them at the primary health care level is that there are certain competencies that need to be satisfied before you can be allowed to carry out such tasks comfortably.*

Official of the Nursing and Midwifery Council

The guardians are interested in ensuring that task-shifting practice does not compromise standards of care while advocating for the necessary support systems for task shifting. Given that members of this community are drawn from the same professional cadre of the healthcare workers that they

oversee, the guardians are also interested in preserving the professional identity of healthcare workers. This interest of protecting professional identity aligns with the interests of the interpretive community of practitioners (see next subsection). The values that underpin the stance of the guardians on task shifting include a *strong emphasis on safety*, *quality of care*, *collaboration* and *professional accountability*.

4.3.5 The Practitioners (Healthcare Workers)

The fourth interpretive community comprises of healthcare workers: doctors, nurses, midwives and CHWs, whom I collectively call '*practitioners*'. Their interpretations of task shifting were grounded in lived experience, and reflected the complexities of delivering care within resource-constrained health systems. The members of this interpretive community have a shared perspective that, although the task-shifting approach helps to bridge health workforce shortages, its practice leaves a lot to be desired. *Members of this community viewed task shifting as both an opportunity and a burden. They viewed task-shifting as a useful approach to expand access to essential healthcare services in their communities, but also a source of additional workload, without commensurate recognition and remuneration*. They believe that the Government has not done enough to advance task shifting and are cautiously optimistic about task shifting due to the limited support provided by the Government. In the context of my study, this interpretive community has three sub-groups (doctors, nurses/midwives, and CHWs) that have similar, broad interests and perspectives regarding task shifting. However, the sub-groups differ on issues linked to their cadre-specific interests. For example, although nurses/midwives and CHWs aligned that training for task shifting was inadequate, they had contrasting opinions about the competence of community healthcare practitioners to deliver services as SBAs. Most of the nurses/midwives believe CHWs are not adequately trained to provide maternal health services. Conversely, the CHWs are confident that they have the competencies to deliver safe maternal health services, despite training

gaps. This difference in perspectives about the competence of CHWs is linked to a struggle for financial gains and efforts to preserve professional identity (see Chapter 6).

The key values shared by members of this community are *community service, collaboration, peer learning* and *quality of care.* These values spurred them to learn from each other and collaboratively strive for continued delivery of quality healthcare services for the community, despite differences in their cadre-specific interests (see Chapter 6). The practitioners also share common interests, including gaining more skills from training, the receipt of fair remuneration, and the preservation of their professional identity. The following quotes highlight the value of community service and peer-leaning shared by members of this community.

> *Services are delivered more, and people are attended to timely because there are more available hands who can carry out one thing or the other to ensure the time patients spend in the facility is not longer than necessary. That's why task shifting makes things easy.*
>
> **Nurse**

> *I left school in 2019. I didn't even know anything concerning family planning when I came down to this place (primary healthcare facility). The nurse who is in that unit had to put us (CHWs) through.*
>
> **CHW**

4.3.6 Consensus and Tension between Interpretive Communities

'Policy analysts, in an interpretive approach, take on the role of interpreter between and among interpretive communities' (Yanow, 1996, p. 236). Drawing from Yanow's statement, I further analysed my data to find patterns between and among the interpretive communities. I sought for points of consensus, conflict and tension between interpretive communities. In IPA, consensus refers to a shared or negotiated understanding of certain issues across interpretive communities while tension occurs when interpretive communities have different understanding or interpretation of issues without friction or overt disagreement between communities (Yanow, 2007, 2000). There

were points of broad consensus between the perspectives of these communities: that task shifting that could potentially addresses human resource gaps, and increase access to essential healthcare services, though the different interpretive communities held this view with varying degrees of optimism. Despite this broad consensus, there were a few opposing views expressed by some members of the interpretive community of practitioners, suggesting that task shifting was harmful, as it put patients at risk of harmful and unsafe healthcare services, as indicated in the quotes below:

> *'...this task shifting has caused more damage than good... before you know what is happening you find out the person is destroying instead of helping, so that is one of the things shifting can cause.'*
>
> **Nurse**

> *...but they (government officials) are not in the field, they don't know what is happening. They are giving too much to people than they are capable of handling. ...I'm still saying that they [government official] are giving too much task to these people [CHWs] and this is now making everyone, not to do their work to satisfaction and we are now not delivering quality healthcare.*
>
> **Midwife**

Across all interpretive communities, there was also a consensus on values such as collaboration and quality of care. The interpretive communities acknowledged that task-shifting requires collaboration, and that the healthcare services delivered via task shifting should be high quality. Despite the consensus on values, the actions of the members of some of the interpretive communities opposed their expressed values. For example, although all the interpretive communities indicated that quality of care was a priority, the interpretive community of optimist (government officials) did not provide adequate resources for quality healthcare services to be delivered through the task-shifting approach. As such, healthcare workers were overworked, with poor remuneration and motivation. These impacted the quality of services provided (see Chapter 5). Furthermore, the failure of the government to provide adequate resources can be linked to their view of the task-shifting policy as a symbolic object, signifying Government efforts to address

human resource gaps, without any intentional efforts to advance the practice of task shifting (see next section). The quote below highlights the view that the Government expects healthcare workers to deliver services despite not having commensurate remuneration.

> *I think, if you are expecting somebody to deliver much, then you would be able to remunerate that person well as a motivating factor. So, it'd be nice if community health practitioners get more incentives from the Government and other employers of labour.*

CHW Regulatory Agency Official

There was also tension regarding collaboration, with a difference between expressed values and practice. First, there was a struggle for leadership of primary healthcare facilities between nurses/midwives and CHWs that impacted the degree of collaboration for task-shifting within the health workforce. Tensions over leadership and professional identity were rife, as nurses/midwives considered themselves to be senior healthcare workers and SBAs, while viewing CHWs as 'lower-placed' healthcare workers who were not adequately trained to be to skilled birth attendants or to take leadership roles ahead of nurses/midwives (see Chapter 6). Secondly, there was some misalignment between the work of the Government officials (optimists), development partners (advocates) and regulators (guardians), as they occasionally acted individually to support healthcare workers. This caused tension across these communities, as members of the interpretive community of optimists felt ignored or taken for granted when activities or programmes were organised without their participation or input.

> *One of the partners was the one that led the review of the family planning curriculum for nurses and midwives. Why? It shouldn't be! It is the Government that knows what they want them to do, not their partners. Why will the partner lead the review of a curriculum for the school, and Government itself was not part of it? You'll know that any partner that takes part in that will do that to favour either his product or interest.*

FMOH Official

There was also a tension between the interpretive communities of government policymakers and regulators (nurses/midwives) regarding training healthcare workers. Members from the community of regulators felt they should be responsible for leading training linked to skilled birth attendance. This feeling caused some tension between members of the interpretive community of policymakers and regulators, as expressed in the quote below.

> *'The NPHCDA is mainly made up of doctors. I told them it was best not to interfere with their trainings; what do they want to train the midwives on, did you see a gap in our curriculum or something? Or is there a new skill you think they ought to have? Even then, it is best you consult us first, so we can work together to develop a training programme and know how best to relay the information to them'.*

Nursing and Midwifery Council Official

Above, I have indicated that while there was some consensus among the interpretive communities, there were issues that caused tension between the interpretive communities. In the sub-section below, I delve into identifying the interpretive symbols that were relevant to the task-shifting policy, and the meanings attached to these symbols by interpretive communities.

4.4 Interpretive Symbols Relevant to the Task-Shifting Policy

Interpretive symbols play crucial roles in conveying the meaning of policies to interpretive communities. According to Yanow's work on IPA, symbolic language, acts, and objects serve as means through which policy actors interpret and give meaning to policies (Yanow, 2000). These symbols function as communicative tools that convey values, beliefs, and intentions, thereby influencing how policies are perceived by different interpretive communities. Symbolic language includes written text in policy documents, and spoken words or phrases used by policy actors, which could be interpreted differently by interpretive communities, whereas symbolic objects are physical items which convey different meanings to different interpretive communities (Yanow, 1996). Symbolic acts are actions or rituals which carry meanings for different interpretive

communities (Yanow, 1996). In this section, I explore some of the interpretive symbols related to the task-shifting policy, and indicate the meanings drawn from them to interpretive communities.

4.4.1 Symbolic Objects

The key symbolic object identified following an interpretive analysis of my study data were the national and FCT task-shifting policy documents. The task-shifting policies holds different but somewhat related meanings to different interpretive communities, making them symbolic objects. The **interpretive community of optimist (government officials)** were interested in portraying the Government as *responsive* to the policy issues of maternal deaths and health workforce shortages. To indicate the government's responsiveness, the task-shifting policy was formulated. The policy document was a symbol of action, indicating that the Government was working to tackle the problem of high maternal deaths and a shortage of health workforce. As such, policymakers could refer to the task-shifting policy as a solution, as indicated below:

> *'Its effect [task shifting] has been tremendous, immensely tremendous. In short, on record, we have seen decrease of the maternal death rate; it has come down. [An] increase in ANC uptake, increased postnatal care uptake. ...cases of immediate post-partum complication have reduced, and people that died during delivery have reduced.'*

NPHCDA Official

This view of task-shifting policies as interpretive symbols of Government action may be somewhat responsible for the low prioritisation and financing for task shifting, since the Government may be meeting its intended objective of *being perceived as responsive* following the formulation or review of task-shifting policies.

The **interpretive community of advocates** (i.e., development partners and NGOs) gave a different meaning to the task-shifting policy document as a symbolic object. Members of this community admitted that before the formulation of the task-shifting policy, they trained CHEWs

to deliver maternal health services, especially in the northern parts of Nigeria. This training was not in keeping with the practice regulations at that time, because CHWs were not recognised as SBAs. However, given that most primary healthcare workers in northern Nigeria were CHWs, the development partners and NGOs trained on this to provide maternal healthcare services. With the formulation of the task-shifting policy, members of this interpretive community viewed it as a symbolic object that legitimised their actions of training lower-skilled healthcare workers to deliver maternal healthcare services. The symbolic value the policy document holds for members of the interpretive community of development partners and NGOs is depicted in the following quote.

> *'We don't have enough [healthcare workers] so task shifting is now giving that authority for lower cadres of health workers to provide those services and save more lives. We are hoping that with adequate training and development of skills and competencies by those health workers we would also be able to increase our skilled birth attendance and consequently reduce maternal and even newborn mortality.'*

WHO Official

> *'It [the policy] gave us the legal framework to continue to train community health extension workers to provide lifesaving skills. Those who initially were against it said we were training quacks, but the policy gave us the legal framework to go into some health facilities and identify the only available community health extension workers there, train them over a period of weeks, give them the skills and deploy them'.*

Former NGO Country Director

The **interpretive community of guardians** (officials of regulatory agencies) viewed the task-shifting policy document as a symbolic object that empowered them to review the training curriculum and practice guidelines of healthcare workers to enable them to acquire the skills and knowledge needed to provide safe and quality healthcare services via task shifting.

> *As a regulatory body, the first thing we did was to review our training curriculum to accommodate the knowledge and skills that should be acquired during pre-service training so that community health practitioners to whom tasks are being shifted to will be adequately equipped knowledge and skill wise. So, our curriculum has been reviewed in*

line to have a robust content as containing maternal health, family planning, HIV/AIDS and all those areas that are shifted.

Regulatory Agency for Community Health Practitioners Official

The **interpretive community of practitioners** also valued the task-shifting policy as a symbolic object that legitimised the delivery of services that they had otherwise not been equipped to deliver based on their pre-service training. This was important because, owing to severe staffing shortages, many healthcare workers, especially in rural primary healthcare facilities, had already taken on duties outside their formal training before the task-shifting policy was formulated. As such, the knowledge that a policy on task-shifting existed emboldened them to deliver services beyond the scope of their pre-service training, after receiving training and support to do so. Although the task-shifting policy indicates that healthcare workers should be trained and supported to deliver shifted tasks, many healthcare workers delivered services even though they had not been appropriately trained (see Chapter 5). This might be because of their interpretation that the policy had empowered them to deliver shifted tasks, without them being mindful that training and supportive supervision were stipulated in the policy as essential conditions for task shifting. The quotes below highlight the significance of the policy for the interpretive community of practitioners.

The truth is that before we officially launched the task-shifting policy, most health care workers, especially those lower cadres were already doing it [delivering maternal health services], they were already doing so many of those things beyond what they trained to do. That is why there are so many damages being done, especially in our primary health care facilities. Some people are lucky, while others are not lucky... But with the task shifting, they're now trained; partners have come up with different trainings to make them better at what they are doing already, and we've seen some good changes.

WHO Official

My own view is that the staff at the level of PHC may not really know much about the details of the policy… Some may not even know there is something like that. But in practice, they practise it because when they go for training, the training may not be on the content of the policy document, but the training will go ahead to implement what the policy document is saying, which is 'train this cadre of staff, give them this knowledge for them to go and begin to practice this thing', which is actually task shifting. So it is the

> *policy that gives the backing for such training to be done, but the details of the policy at that level is not their headache.*

Medical Doctor

4.4.2 Symbolic Acts

The provision of 10 per cent of the BHCPF for the development of human resources for primary healthcare care was a symbolic act. Its symbolic meaning was found in its ceremonial purpose – to reflect Government's further commitment to address human resource needs in primary healthcare facilities. I will explore this symbolic act and outline the perspectives of interpretive communities.

4.4.2.1 Establishment of the Basic Health Care Provision Fund

The 2014 National Health Act established the BHCPF which is a statutory health fund comprising at least 1 per cent of the consolidated revenue fund in Nigeria. The National Health Act specifies that 10 per cent of funds should address human resource gaps at the primary healthcare level (Federal Government of Nigeria, 2014). As of 2022, the BHCPF provided resources for about 8,000 facilities, approximately a quarter of the public primary healthcare facilities in Nigeria (Abubakar et al., 2022). **The interpretive community of optimists** consider the establishment of the BHCPF to be a sign of the Government's commitment to tackling human resource gaps at the primary healthcare level. Divergent opinions were voiced by policymakers on the function of the BHCPF provision for human resources in primary healthcare facilities. Some praised it as an essential financing source for addressing human resource issues in PHC facilities, while others criticised its narrow scope, pointing out that its exclusion of more than 75 per cent of facilities diminished its potential influence. One of the policymakers said,

> *'Looking at the situation of things now, the system that this administration is pushing in terms of the basic health care provision fund for our facilities, especially primary health care centres, this problem [resource gaps] will be resolved'*

FMOH Official

Within the same interpretive community, some participants expressed concerns that there were still human resource gaps in health facilities supported by the BHCPF, resulting in low facility utilisation.

> *We have basic health care provision fund for facilities. It is just one PHC per ward that gets BHCPF funding for now. They said later they would extend it to others. Even the facilities that have BHCPF are still complaining. Even those [patients] that registered in BHCPF facilities, they are not even coming to the facility, because when they come, the health workers would not be on ground.*

FCT Primary Healthcare Board Official

The **interpretive community of advocates** (development partners and NGOs) viewed the BHCPF as a symbol of hope for more funds for primary healthcare workforce development. They recognised the BHCPF as a sign that the Government would increase funding for health workforce gaps. However, they expressed reservations about the Government's actual commitment to provide funding to address health workforce shortages. These reservations were because the government seldom funded training for PHC workers, and provided meagre funds for their recruitment, as many of them are neither formally employed nor adequately remunerated (see Chapter 5). The advocates also had concerns about the reach of the BHCPF, as there were structural barriers that hindered easy access of the fund in primary healthcare facilities.

> *'Again, I do think that the Government need to do more than it is currently doing. We are all grateful for the 1% consolidated revenue fund contribution to the basic health care provision fund, but we also do know that in spite of that, there are issues with accessing the fund… All those structural issues need to be addressed for the task-shifting policy to really actualise the desired outcome.'*

NGO Country Director

The views expressed by some policy actors in the interpretive communities of optimists and advocates indicates that the BHCPF has had limited impact of the health workforce situation in

primary healthcare facilities. However, the earmarking of 10 per cent of the BHCPF for the PHC workforce continues to hold a symbolic meaning – reflecting governments' commitment to addressing primary healthcare workforce shortages and capacity gaps.

4.4.3 Symbolic Language

Yanow recommends metaphor analysis as an analytical approach to understanding symbolic language in interpretive policy analysis. She highlights that metaphors can transfer meanings, and show an alternate figurative understanding of policy terms (Yanow, 2000). With respect to the task-shifting policy, a symbolic term that was used in the text and narrative by study participants was 'volunteer health workers', mainly referred to as 'volunteers'. This term appeared severally in most of the interview and discussion transcripts. The term 'volunteer' was particularly mentioned in the task-shifting policies, as seen below.

> *"FCT recognizes that essential health services, if it is to be sustained, cannot be provided by people working on voluntary basis. While volunteers can make valuable contributions on a short term or part time basis, trained health workers who are providing essential health services, including community health workers, shall receive adequate wages and other appropriate incentives as shall be defined by the relevant parties. (FCT HHSS, 2021, p. 7)"*

2021 FCT Task-shifting policy

In literal terms, a volunteer is 'a person who does something, especially helping other people, willingly and without being forced or paid to do it'. (*Cambridge Dictionary,* 2024*)* This literal definition indicates that there is no compulsion nor explicit expectation for payment for work done by volunteers. In FCT primary healthcare facilities, healthcare workers who were engaged without formal contracts were called 'volunteers'. They worked full-time to deliver services in primary healthcare facilities, and were only paid periodic stipends, which were significantly below what they should have been paid if employed. From a metaphorical standpoint, being called 'volunteers' would suggest that these healthcare workers were willing to work for free. However, these

volunteers expected to be paid for their services, though their title suggested otherwise. They did not receive commensurate remuneration for their services and mostly accepted work as a volunteer to avoid being unemployed, an occurrence I titled '*involuntary voluntarism'* (see Chapter 5). The interpretive community of optimists seemed to adopt the literal meaning of the term 'volunteers', presuming that the volunteers were willing to offer 'free' services. This emboldened government officials and facility managers to engage these volunteers to work in primary healthcare facilities without formal contracts and pay them infrequent stipends (see Chapter 5). The literal interpretation of the term 'volunteer' may account for the Government's indifferent stance regarding the recruitment and remuneration of primary healthcare workers. The quote below indicates that volunteers were not paid commensurate remuneration – as the literal meaning of their title suggests.

> *Like in my facility, I have a volunteer who has been working there for over 10 years now. When she started, we told her that she would not be paid. But on our own part as staff and as human beings we sat down and deemed it fit to give her a fixed amount whenever we receive our salaries, despite it not being much.*
>
> **CHW**

> *There were about 13 of them… and they said they were all volunteers; I was shocked. There is one boy I normally see there; he has worked there for over 13 years. He said he was a volunteer; I couldn't believe it. The boy was so dedicated; in fact, if anything was about data, he would be the one who would bring it, and he is a CHEW. Even the one that conducts delivery and the one that performs everything in that facility, all of them they said they are all volunteers. I asked how much they were paid monthly, they said sometimes the in-charge if there's anything extra, he may give them N3000 (£5), or N5,000 (£8) depending on when something comes up, I was shocked! So, you all are volunteers.*
>
> **FCT Primary Health Care Board Official**

4.5 Summary and Conclusion

In this chapter, I drew from Yanow's work on making meaning of policy from text, responses and actions of policy actors, and the identification and understanding of interpretive communities and

symbols. I examined the emergence and evolution of the national task-shifting policy, highlighting the influences that shaped the development of the policy. I identified four interpretive communities: Optimists, Advocates, Guardians and Practitioners, highlighted the policy actors in each community and explored their values and interests. I highlighted points of consensus and tension across interpretive communities. Additionally, I identified certain interpretive symbols to which these communities ascribed meanings and demonstrated how these meanings influenced the actions (or inactions) of policy actors.

In this chapter, I have provided answers to the first research questions, concerning how the task-shifting policy emerged and the influences that shaped its evolution. I have shown that global, regional and national influences triggered the emergence of the task-shifting policy, in response to significant human resource gaps and the high maternal-mortality rates. I have indicated that there were four different interpretive communities, that interpreted and ascribed meaning to the task-shifting policy, showing that its interpretation and the meanings ascribed to interpretive symbols by these interpretive communities influenced their actions regarding task-shifting policy and practice. My findings show that an understanding of the interpretation and meanings ascribed to the task-shifting policy by interpretive communities is vital for the identification of the reasons and motivations behind the actions (or inactions) of policy actors. This understanding is key to improving task-shifting policy and practice, as it enables the exploration of the influences which would not be easily identified from a rational standpoint. In the next chapter, I focus on the influences that shape the practice of task shifting, with particular emphasis to the primary healthcare workforce.

CHAPTER 5—FINDINGS II: HEALTH WORKFORCE COMPETENCE, AVAILABILITY AND MOTIVATION

5.1 Introduction

This chapter examines the health workforce providing maternal health services through task shifting in PHC facilities within Nigeria's FCT. Drawing on my primary data and policy documents review, I identify some of the influences that shape the practice of task shifting and explore how different interpretive communities view these influences. To explore task-shifting practice in detail, this chapter focuses more on the interpretive community of practitioners, providing an understanding of the influences that impact the competence, availability, and suitability of the health workforce to deliver safe and quality maternal health services. I specifically identify the 'who', 'what', and 'how' influencing the health workforce and their impact on maternal health service delivery in PHC facilities. The findings in this chapter provide answers to my second research question:

i. Which influences and actors have shaped the practice of task shifting for maternal health services in the FCT?

Having identified the healthcare workers that are recognised to deliver maternal healthcare services in the preceding chapter, I give some insights into the health workforce configuration within FCT PHC facilities. I explore the PHC staffing gap, indicating that PHC facilities are understaffed, with a sizeable proportion of PHC staff working under precarious employment conditions as volunteers. I explore the influences that shape the competence of the healthcare workforce such as training, supervision, awareness of clinical boundaries and the functionality of the referral system and indicate how they impact on the delivery of maternal health services. Lastly, I explore workforce motivation, emphasising how health workers navigate the existing workforce challenges to sustain maternal health service delivery. I organised my findings into four

themes: the PHC staffing gap; health workforce competence; awareness of clinical boundaries; and health workforce motivation.

Amid the different influences impacting the workforce in PHC facilities, the healthcare workers navigated the challenges and demonstrated resilience, continuing with the practice of task shifting, and ensuring that maternal health services remain available in FCT PHC facilities.

5.2 Healthcare workers involved in providing maternal health services via task-shifting

Based on the national and FCT task-shifting policies, as well as my study findings, doctors, nurses, midwives, and CHWs deliver maternal health services in PHC services in the FCT. This was consistent with the findings of other studies exploring Nigeria's PHC workforce (Aluko et al., 2019; S. C. Okoroafor et al., 2022). Although CPs and PPMVs are recognised by the most recent version of the national task-shifting policy, I did not focus on them, because they are not recognised as part of the PHC workforce by the 2021 FCT task-shifting policy. In Nigeria, the roles of nurses and midwives are not differentiated at the primary care level; therefore, I will refer to them as 'nurses/midwives' in this thesis. Likewise, I will refer to Community Health Officers, Community Health Extension Workers and Junior Community Health Workers collectively as 'CHWs' throughout this thesis.

The FCT faces significant workforce shortages, with only 557 doctors available to provide healthcare services in the FCT across all levels of care in 2022, for a population of over 3.5 million people. This shortage of doctors is more evident at the PHC level, where very few doctors were involved in delivering services across the six area councils (FCT HHSS, 2023). At the time of primary data collection for this study (between late 2022 and early 2023), few doctors, typically two to five, worked across multiple PHCs in an area council. Rather than being permanently stationed in a single PHC, they provided consultation for challenging cases and supervised PHC

healthcare workers across several PHC facilities. There was a similar shortage of nurses/midwives across the area councils. For example, in Kuje Area Council, there were only 14 nurses/midwives serving about 51 PHCs during the data collection period, as reported in an FGD.

Given the limited number of doctors and nurses/midwives, CHWs provided most of the maternal health services in majority of the PHCs in the FCT.

> *'In the entire Kuje area council, we have just 14 nurse-midwives and 121 CHWs at different levels of training that is CHEW, JCHEW and CHO. So, in the provision of health services under maternal health care, the bulk of the work is done by CHWs because we have about 51 primary health care facilities. You find nurses only in about three to four facilities, which means that about 48 of these PHC facilities are manned by CHWs.'*

CHW

The PHC staffing gaps highlighted above aligns with the findings in the 2023 Health Workforce Profile, analysed as part of this thesis, which reported that across the six areas councils in 2022, there were 27 medical doctors, 162 nurses/midwives and 830 CHWs. (FCT HHSS, 2023). The same report indicated low recruitment in the PHC systems over a decade, compared to those working in secondary healthcare facilities (FCT HHSS, 2023). Furthermore, in addition to low recruitment rates, previous research suggests that the shortages can be attributed to a skewed distribution of the health workforce, in favour of secondary and tertiary facilities, and the brain drain of healthcare workers to high-income countries (Adeloye et al., 2017).

Based on employment status, the PHC workers fall into two categories, creating a two-tier workforce. The first category comprises health workers formally employed by the Government, with contracts and inclusion on the government payroll. The second category consists of 'volunteers', who were formally trained staff with relevant qualifications for their respective roles. These volunteers willingly offer to work in PHCs, contributing to maternal service provision and enhancing their clinical skills while waiting for formal employment. However, these volunteers

are not formally employed, not on the government payroll, and not entitled to any benefits. Many volunteers work at the PHCs out of necessity (e.g., to maintain and enhance their clinical skills while hoping for formal employment), rather than pure altruism, as there are no formal jobs, and they receive stipends from PHC managers.

> *'In some areas, you may even see a volunteer who is not an employee. He did CHEW training quite alright, but because the government have not given him or her employment, he's just going there as a volunteer…It's just free will. They are already trained; they have the certificates and have the license to practice. But no employment, so instead of being idle, they go to a nearby place (facility) to be helping, and maybe the person in charge of that Primary Health Centre may give them something (stipends) at the end of the month'*
>
> **CHW Regulatory Board Official**

Notably, in contrast to the common understanding of volunteerism (see Chapter 4), the volunteers in the PHC facilities in the FCT were hopeful that they would be remunerated adequately for their services. These volunteers were mainly nurses/midwives and CHWs. The 2021 FCT task-shifting policy acknowledges the importance of volunteers in providing quality healthcare services. However, the policy suggests that volunteerism should be transient and compensated fairly (FCT HHSS, 2021). In the following sub-sections, I provide more detail about the shortage of healthcare workers in the FCT, including insights into the precarious employment of 'volunteers'.

5.3 The PHC Staffing Gap

The health workforce in the FCT is 57 per cent less than the minimum recommended staffing for PHC in Nigeria, with CHWs making up the bulk of the workforce (FCT HHSS, 2021). Below, I elaborate on the two key findings relevant to the influences that shape the practice of task shifting for maternal health services: the paucity of paid healthcare workers, and the precarious work of volunteers.

5.3.1 Paucity of Paid Healthcare Workers

Only a fraction of the PHC workforce was formally employed and remunerated, in contrasted to the policy recommendation that healthcare workers be officially employed and adequately paid. These formally employed healthcare workers were called 'permanent staff'. A participant said:

> '*There are very few permanent staff. Volunteers are more than permanent staff'.*
>
> **CHW**

Most study respondents (policymakers, healthcare workers, and regulators alike) expressed concerns about the inadequate number of payrolled healthcare workers. They linked the workforce shortages to insufficient financial resources from Government budgetary allocation (Abubakar et al., 2022). Healthcare workers hinted that the workforce shortages and Government's seeming inaction were facilitated by the availability of volunteers who continued to deliver services even without formal employment and commensurate remuneration. While some local and international donor-supported programmes temporarily engage healthcare workers to deliver services in PHC facilities, their employment ended with the programme, as the Government often did not continue their remuneration. Some CHWs attributed the Government's reluctance to employ PHC workers to the low prioritisation of the PHC system.

> *'When it comes to healthcare services in the community, PHC is the foundation, and tertiary healthcare cannot do without PHC. Unfortunately, the government are less concerned about us [PHC workforce]. We are the grassroot. Before the tertiary hospital see some cases, the cases would have come to us.'*
>
> **CHW**

Given that only a handful of healthcare workers have been employed in the FCT for almost a decade, the availability of volunteers helped bridge human resource gaps in PHC facilities. This

protracted delivery of services, without formal employment, diminished the morale of many PHC workers.

> *'We need employment. Yes. If you go to PHC, you meet volunteers as the majority. If you go to secondary healthcare, you meet local doctors and nurses. That is not encouraging. The last employment in the Bwari area council was in 2008, fourteen years ago!'*

Nurse

The shortage of employed healthcare workers cut across multiple cadres, although most formally employed staff were CHWs. Given the shorter training period and lower remuneration, it is unsurprising that CHWs comprised most of the formally employed staff. A policymaker highlighted that the overwhelming response to job advertisements indicated the availability of employable healthcare workers.

> *'I don't know why employing health professionals is a problem… At a time, we wanted to engage midwives… .Just 30 persons were needed. As we advertised it, within three days, about 2000 applications came and when we tried to screen the applications, 850 midwives were qualified, and there were openings for just 30 persons. We invited about 500 of them for exams; 490 came… and we just wanted to engage only 30. So, who said there are no personnel? There are available ones, and they should be employed.'*

FCT Policymaker

According to PHC workers, the shortage of healthcare professionals causes the available workforce for task-shifting to be overworked. They also emphasised that the need to provide various services, including immunisation, antenatal care, childbirth, family planning, and first aid adds to the burden.

> *'In some cases, there is only one permanent staff who does everything from immunisation to family planning and so many other things. These are some of the challenges that would hinder the successful implementation of the task-shifting policy.'*

Medical Doctor

The staffing gaps also forced healthcare workers to perform non-clinical tasks, further increasing their workload.

> *'We lack human resources, and we don't have a lot of cadres. Most of the responsibilities here in the PHC setting are on us. You are the one to make the record and forward it again to the local government level for data collection. And then we have up to eight data tools that you have to present to them at the end of every month, and they are waiting for you to do that work. We are also the ones who go outside the PHC gates to do immunisations.'*

Nurse

All the healthcare workers engaged in the FGDs reported working under pressure due to the overwhelming workload. They noted that the staffing gaps would have had an even greater impact without the support of the volunteers.

> *'Workload is an issue. We don't have enough human resources at the PHCs; we are understaffed. The reason why some people would think that we have some level of workforce is because of volunteers. But honestly, coming to the main staff, we don't have enough. …The human resource gap is affecting task shifting.'*

Medical Doctor

In Box 3 below, I provide a vignette from my data to outline the health workforce shortage and its impact on service delivery.

Box 3: Vignette on health workforce shortage and the delivery of PHC services

Usman is a CHO working at the Dutse-Alhaji Primary Healthcare Centre alongside two other health workers, a midwife and a CHEW who are also formally employed. Formal employment means that Usman and his colleagues receive monthly salaries and allowances from the Bwari Area Council. In the same facility, Usman and his two colleagues work with four volunteers who are not formally employed, and these seven healthcare workers provide primary healthcare services to a population of over 10,000. Usman starts his day at 7:45 am with the ante-natal clinic, which he runs with two other colleagues, and they provide ANC services to over 40 women every weekday. They check the records of the women to ensure they are registered and record that they attended the clinic. For each woman, they record her weight, check her blood pressure, measure her abdomen's size, and listen to the foetal heartbeat to confirm that the baby is fine and growing well. They also discuss with each woman to determine if she has any complaints. Depending on the woman's complaints, they fill out prescriptions for routine ANC medications and any other medications that may be needed. Occasionally, they send women to the mini laboratory in the clinic for routine investigations such as blood and urine tests. While the ANC clinic was running, two other health workers administered vaccines to children under two years and they had to record the vaccines given to approximately 50 children each day, assess them for signs of malnutrition, and inform the parents about their next appointment. At the same time, a different health worker is in the labour ward, assessing two women expected to deliver in a few hours. The health worker in the labour ward had just finished resuscitating a newborn after a woman had successfully delivered her baby.

The health worker had to call Usman to assist her in labour when the woman was just about to give birth, and he returned to the ANC clinic after helping in the labour ward.

Usman and his colleagues finished the ANC and immunisation clinics at 1pm and then started the non-communicable diseases (NCDS) clinic at 1:30 pm. In between, they take turns to go on break for lunch and finally round up the NCDs clinic at 3:40 pm after seeing twenty patients and referring two to Kubwa General Hospital for review by a medical doctor. All day, one of the health workers was attending to emergencies such as cuts that needed to be sutured, children with febrile convulsions, and acute diarrhoea, and was supported by another healthcare worker who spend the whole day providing family planning services. Although most clinics were closed at 3:45 pm, Usman and his colleagues had to stay back for another hour to fill in administrative forms and service delivery records. They needed to update those records and share them with officials of the Bwari Area Council Health Department fortnightly. Finally, at 5:15 pm, Usman and his colleagues closed for the day and had to turn away a woman who had signs of early labour. The clinic was closed and to reopen the next day at 7:30 am. The clinic was closed on most evenings, although it should provide 24-hour services, a feat that could not be achieved by Usman and his six colleagues, who were already feeling drained each day and thus were unable to provide 24-hour services in the clinic.

The vignette above illustrates the difficulties PHC workers face in the FCT due to workforce shortages. These shortages limit the operating hours of PHCs, restricting access to maternal health services such as childbirth, which can occur at any time. Given the prevailing shortage of healthcare workers and overwhelming workload, most PHCs do not provide 24-hour services.

'Another challenge is human resources. Some facilities are dilapidated, some of them that have low manpower, so you cannot ask them to do 24hrs work. Only a few facilities are running 24hrs shifts, it is a big challenge. And most deliveries occur in the night, and most of these facilities don't run 24/7, and you cannot tell one person to run 24hrs.'

FCT PHC Board Official

Some focus group participants expressed frustration that the local government had employed non-clinical staff and posted them to healthcare facilities, despite the critical shortage of clinical healthcare workers. While these new employees may be sent to PHC facilities, their non-clinical backgrounds mean they cannot significantly reduce the clinical workload on the healthcare workforce. This employment decision by the local government suggests poor planning and decision-making in staffing PHC facilities.

'When the area council employs, they don't employ enough health workers. If they say they employ health workers, 20 per cent of their employment will be the health workers. 80 per cent are administrative workers. They don't have schedule. They don't come to the office, and they receive a salary. The admin staff have little workload while health workers are lacking.'

Nurse

Nigeria has faced serious security challenges for over a decade, affecting its health system (Etiaba et al., 2020). Healthcare workers have been attacked, kidnapped, and killed in various parts of the country, particularly the northeast (Olarewaju, 2021), which includes the FCT. Healthcare workers hesitate to work in PHC facilities in communities with significant security concerns (Olarewaju, 2021), further exacerbating existing human resource deficits.

'Some facilities are vulnerable to kidnapping and other forms of danger because they are not fenced. Facilities need to be fenced, and security improved so that people will feel safe to work there.'

Nurse

Inadequate amenities and infrastructure also deter healthcare workers from accepting employment in some PHC facilities.

> *'Lack of social amenities like electricity, water and good access roads discourage new staff. In my facility, we were supposed to have some volunteers, but because the place is not conducive to move around, they did not want to come. Even when they post some people here, they find a way to go back because they can't live around there.'*

Midwife

Thus, despite the availability of qualified health workers for employment, some had reservations about working in PHC facilities with significant security issues and infrastructural gaps. Having highlighted the health workforce shortage in PHC facilities and its impact of the delivery of maternal and other essential healthcare services, I outline my findings on the precarious employment of volunteers in PHC facilities in the FCT.

5.3.2 Precarious Work: Protracted 'Involuntary Volunteerism'

Across my discussions with healthcare workers, they expressed palpable frustration about the precarious engagement of volunteers, with a CHW reflecting on his experience as a volunteer and questioning the feasibility of task shifting under such uncertain conditions.

> *'If I decide not to work today, can you shift to me? Can I be the one to refer the patient even? Will I even consult the patient not to talk of referring him or her? So, it is when we have staff that task shifting will be more effective, not when volunteers are being used and not paid by the government. The facility is giving you stipend to wash your uniform. Every time, you renew your license from that stipend, you feed your family. You transport yourself to work to and back. You are not expected to sell the drugs in the pharmacy and pocket the money. It is that stipend you depend on. Now, how will you shift this task to me? If I decide today that I don't have transport to come to work, nothing will happen. You cannot shift it to me because I will not even come. And of course, you know, I'm a volunteer. I volunteered to help. I didn't volunteer to die. So, we do the little we can do and go, you understand? So, government should employ us. Yes! They should employ us so that we will now do these tasks that are shifted to us.'*

CHW

The above account highlights the disconnection between policy expectations and volunteers' lived realities. It indicates the plight of volunteers who mostly work full time yet are not adequately remunerated and recognised. It also indicates that the reliance of volunteers without formal contracts is not sustainable as they could decide to stop work without notice, further jeopardising the delivery of healthcare services. This narrative brings to the forefront the urgent need for formal employment and recognition for task-shifting initiatives to be both ethical and effective. To illustrate the situation, I used data from my study to develop a vignette about Fatima, a nurse and volunteer in the FCT, given in Box 4 below.

Box 4: Vignette on the precarious employment of healthcare workers

Upon graduating six years ago, Fatima held a deep aspiration to serve her community in Kabusa as a nurse. Unfortunately, her dream was deferred, when she was unable to secure employment from any of the FCT Area Councils due to an embargo on hiring. This period of unemployment caused Fatima unease, as she worried about losing her clinical skills. She felt disappointment and frustration at not being able to fulfil her desire to provide healthcare to her community. Fatima declined a job offer at a private clinic in Masaka due to its remote location and concerns over security. She resorted to undertaking menial jobs in Kabusa and providing basic medical treatment to community members in her home. Fatima continued to hold out hope that the local government would lift the employment embargo.

Fatima received advice from her classmate Abdullahi, who was a volunteer at Kabusa PHC Centre, to apply for a volunteer role with the local government. Within a month, she was stationed at a primary health clinic in Kabusa by the authorities. She didn't have an employment letter or contract, just an introductory letter, so her remuneration was not guaranteed and varied each month based on the facility's revenue. At times, she received no

compensation even though she worked full-time with three other volunteers and two formally employed community health officers. However, within six months, Fatima was entrusted with managing the antenatal care clinic and her responsibilities were amplified, despite being a volunteer. To supplement her sporadic stipends, she resorted to accepting tips from patients, supporting NGO community health programs, and offering healthcare services at home.

Fatima worked for over five years as a volunteer, though she hoped her volunteer status would last for one a few months. Despite the employment embargo, a CHEW was recently recruited and deployed to the facility, which was met with disappointment by Fatima and the other volunteers. They felt let down by the employment of a recent graduate while they were left to continue their work as volunteers without remuneration. The volunteers expressed their discontent regarding the additional costs incurred in renewing their licenses and working full-time without a guaranteed salary. One of the dissatisfied volunteers subsequently resigned, increasing the workload for Fatima and the other health workers. Despite her dissatisfaction, five years after commencing her work as a volunteer, Fatima values the recognition she receives as a nurse in the community. She is grateful for the chance to practice as a nurse, although her role remains unremunerated. Fatima still hopes to be formally employed by either the government or the NGO that occasionally engages her to support their programmes.

The above vignette indicates the plight of many volunteers working in the FCT's PHC facilities without contracts and guaranteed remuneration. The ILO referred to that kind of engagement of workers as precarious employment (International Labour Organisation, 2012) as described by Pulford et al.

> *Precarious employment is often considered to be 'bad work' and is characterised by several undesirable features, including employment instability, low material rewards, erosion of employee rights and protection, non-standard working arrangements, limited*

opportunities for training and employability, erosion of employee representation, and imbalanced power relations. (Pulford et al., 2022)

The engagement of the volunteers in FCT PHC facilities meets that above definition of precarious employment, as they were engaged to work for free by the local government authorities and received meagre stipends from facility managers. Volunteers received stipends courtesy of collective social entrepreneurship through which healthcare workers generate revenue for facility sustenance from informal payments by patients (see Chapter 6). Volunteers were also sometimes paid from voluntary contributions from formally employed staff who wanted to help. 'In my own facility, we have about eight volunteers, and we usually give them a little token from time to time from whatever we get because we know they aren't getting paid' (CHW).

Although I did not interview local government officials directly, accounts from health workers suggested that government officials were aware of the plight of volunteers. To become a volunteer, a health worker writes a formal letter to the local government, expressing interest in offering services without compensation. Local government officials screen prospective volunteers to ensure that they are certified healthcare workers and then consult with facility managers. Afterwards, the applicant is given a letter of introduction to present to the facility manager before starting work. Facility managers (called '*In-Charge'*) are the most senior healthcare workers recognised by the local government authorities. They are responsible for running the PHC facilities where they work and providing resources for volunteers' stipends. The monthly volunteer stipends were derived through collective social entrepreneurship from payments made by patients for drugs and PHC services such as antenatal care, childbirth, and immunisation (see Chapter 6). However, since internally generated revenue may vary with the volume and nature of services delivered, volunteer stipends fluctuate, and at times, they may not receive monthly stipends.

Although volunteers were unhappy with their precarious employment, they kept their jobs for several reasons. Firstly, they wanted to maintain their clinical skills, which could be lost if they were out of practice. Secondly, they derived some satisfaction from working in communities. They were pleased by the recognition, which made them 'visible' as healthcare providers, enabling them to get engaged by NGOs for temporary work or sought by community members to deliver home-based services. Volunteers also looked forward to the meagre stipends paid in PHC facilities and, sometimes, a fraction of the service-related payments from patients (see Chapter 6). Additionally, a significant number of volunteers assumed their roles with the expectation that the experience of working in PHC facilities would facilitate a smoother transition to formal employment within the local government, perceiving that it would be a straightforward transition.

> *'She finished in 2000, I finished in 2001, and we have continued to work as volunteers since then. Imagine the kind of experience we have gotten. The reason why we did not stay at home is just for the experience. You know, you can't just finish from school and want to stay at home. For me, after I finished from school, I chose to start with the government so that I could learn more and also to acquire more knowledge and not forget those things I was taught in school. So that's why most of us volunteer with the hope that we would be absorbed whenever there is an opening for employment.'*
>
> **CHW**

As indicated in the quote above, volunteers always hoped to be formally employed after working without contracts for some time. Their displeasure and frustration about working without formal employment contracts indicated that their engagement in the role was not entirely done for altruistic reasons but somewhat necessitated as employment opportunities were scarce.

Considering the precarious nature of volunteer engagement in the FCT and their dissatisfaction, I created the term '*involuntary volunteerism*', indicating the volunteers felt compelled to continue in their roles mainly because of a lack of alternatives and for other reasons mentioned above. As such, their seeming volunteerism was not entirely voluntary, as many healthcare workers

suggested that they would leave their roles for better opportunities if available. I conclude this sub-section by highlighting that the precarious employment of healthcare workers in FCT PHC facilities significantly impacts the motivation of the health workforce involved in task-shifting for maternal health services, and that staff shortages could be exacerbated if many volunteers move to alternative employment.

In the next section, I highlight how the training and supervision of healthcare workers impact their competence to deliver safe and quality maternal health services.

5.4 Health Workforce Competence

In this section, I present the findings related to the competence of the health workforce based on my analysis of the perceptions and the reported accounts of my study respondents. Health workforce competence is a critical factor that influences the responsiveness of services to population health needs, and impacts the effectiveness, safety and quality of healthcare services (Barbazza et al., 2015). Consequently, the concept of 'competence' featured prominently in the policy documents I reviewed. The 2021 FCT task-shifting policy placed the utmost importance on the competence of healthcare workers as a criterion for determining their suitability to provide services. In addition, my study respondents referred to the 'competence' of the health workforce during interviews and FGDs. For example, an official of the Nursing and Midwifery Council said:

> *When it comes to complex deliveries, we have said it cannot go around to the CHEWs; they are to handle only normal deliveries. In terms of things like suturing of lacerations, which is already happening in the rural areas, the doctors can share that, and the nurses and midwives can do that. Incision and drainage; they can do those because they are in the curriculum. They have the competence to do those things.*

Nursing and Midwifery Council Official

The above quote emphasises the value placed on health workforce competence by the interpretive community of guardians, linking it to curriculum-based training that is available to different cadres

of healthcare workers. Health workforce competencies are defined as: '*essential complex knowledge-based acts that combine and mobilise knowledge, skills, and attitudes with the existing and available resources to ensure safe and quality outcomes for patients and populations'* (Langins and Borgermans, 2015, p. 3).

Training and supervision are essential for enabling healthcare workers to acquire the necessary knowledge, skills, and attitudes to competently deliver healthcare services through task shifting (Adefolarin et al., 2021; Langins and Borgermans, 2015; WHO, 2006). This was supported by my study finding.

> *'The essence of these trainings is to bridge the gap so we can reduce maternal mortality. What we tell them at primary health care is that there are certain competencies that need to be satisfied before you can be allowed to carry out such tasks comfortably. For example, the midwives have to take about 60 deliveries and assist in about 20 emergencies.'*

Nursing and Midwifery Council Official

Across cadres, the healthcare workers had varying views about their competence. Some nurses/midwives had reservations about the competence of CHWs to deliver maternal health services, although they recognised that such competencies could be gained through training and supportive supervision. For example,

> *'One of my worries now is setting of oxytocin. They [CHWs] don't know that you're not supposed to set oxytocin… Some of them don't know the position of the baby whether it is posterior, breech or transverse'*

Midwife

On the other hand, CHWs themselves were confident about their knowledge and skills, citing that they had gained the competence to deliver maternal health services based on their pre-service and in-service training.

'All of us [CHWs] passed through school, and when we passed through school, we were educated. If we talk about anatomy and physiology, it is there we learnt much about the human reproductive organs. After we have done our school maybe for two years, we go for practical. Practical will give us the sense of having experience in different facilities… So that knowledge, we have it. When you come back, you start practising the knowledge. You find out that when you practice, and you do it well, you will be able to continue doing it.'

CHW

The varying positions about competence between the nurses/midwives and CHWs indicate some tension within the interpretive community of practitioners. Despite this conflict, there was consensus across all the interpretive communities that competence is critical for the quality and safety of care. All participants unanimously agreed that quality of care could be compromised, and patients put at risk of adverse outcomes if PHC workers were not competent to deliver maternal healthcare services. It is recognised in the literature that there is an association between the competency of the healthcare workforce, their performance, and the training and supervision provided to them (Adefolarin et al., 2021; Barbazza et al., 2015; Deussom et al., 2022; Oladele et al., 2023). In the sub-sections that follow, I outline my findings about the training and supervision of PHC workers in the FCT.

5.4.1 Health Workforce Training

Building on participants' reflections on training and health workforce competence, I utilise the vignette in Box 5 below, to give an overview of the training-related experiences of PHC workers in the FCT.

Box 5: Vignette highlighting the training-related experiences of PHC workers

Pauline, a community health officer and Rita, a nurse have worked in Kuchingoro PHC centre in Abuja Municipal Area council for the past four years. Two years ago, they went for two-week training on modern family planning methods funded by USAID. They were paid N100,000 (about £100) each as allowances for the training, which was organised by the National Primary Health Care Development Agency. The training allowances which were almost equivalent to a month's remuneration augmented their meagre salary. Given that they had twelve colleagues who could not attend the training due to limited slots, Pauline and Rita were asked to train their colleagues when they return to their healthcare facility to enable them to acquire the same knowledge and skills. However, teaching their colleagues was difficult because of the busy nature of their healthcare facility. Also, some of their colleagues are unhappy that they did not receive training allowances.

Rita recently had a disagreement with a community health extension worker while trying to teach him one of the new family planning methods. He didn't want to be taught by her because he believed that nurses looked down on CHWs. On the other hand, Rita was reluctant to train CHWs because she believed that maternal health services should only be delivered by nurses, midwives, and doctors. The healthcare workers were disgruntled because Pauline had been nominated to attend six trainings over the past two years while they have not had a chance to attend one. They complain that there is no fairness in the selection criteria for training, especially since they also want to acquire new skills and receive training allowances. These health workers did not show up for facility-based training if Pauline was to teach because they felt that Pauline did not have the patience to teach them, and they bore grudges that she was always nominated for training by the facility manager.

The training was expensive for USAID as they had to pay for accommodation, feeding and travel allowances for over fifty participants. The FCT Health Secretariat declared they did not have a funded budget line for training for the past three years so would not be able to fund any training. As a more cost-effective alternative, USAID paid some expert trainers to train PHC workers in their facilities while they worked. Although this approach was cheaper, it was difficult for the trainers because most of the healthcare workers were busy providing services and barely had spare time to be trained. At a training evaluation meeting for stakeholders, a representative of the Nursing and Midwifery Council complained that the Nursing Council was displeased with the training of CHWs on nursing-related tasks because they were not involved in the development of the training manuals and not invited to support the training. An official of the FCT Health Secretariat also reported that only few trainings could be organised due to the associated high costs. She expressed frustration that more than 50 per cent of the PHC workers had not been adequately trained but were still delivering maternal health services.

As highlighted in this vignette, only a few participants could attend trainings, due to the significant costs associated with accommodation, subsistence, and training allowances. These trainings were infrequent because they were funded mainly by NGOs and development partners, since the Government seldom prioritised health workforce training in its budgets. Two facility-based training approaches were introduced to minimise expenses on the high costs of residential training. First was *step-down training*, in which healthcare workers received facility-based training from a colleague in their facility who recently attended a training workshop. The second was the *low-dose, high-frequency approach* in which expert instructors train healthcare workers in their facilities. However, both approaches were impacted by the busy nature of the PHC facilities, as expressed in the quote below.

'As for me, even if you want to do the low dose because they are trying to see how they can train you in your facility to reduce costs, it is fine. However, the person is in the facility while you are giving training, and he needs to do his work. His work is suffering, and you are passing information.'

Midwife

Beyond the workload in facilities, the two approaches to increase the availability of training opportunities were also impacted by other factors. Step-down training was affected by the lack of incentives for teaching and attendance and its effectiveness depended on the teaching skills of the health workers expected to facilitate the training.

'And when they say, okay, this person has gone to training, you are pained that you did not go. So instead of asking questions from the person who went for the training… You are just sitting waiting for the person. And when they call for step down, you are not there…. There are some people that cannot represent. You cannot tell somebody to go for a training that will come but will not tell you anything. If you go for training, you must give the feedback. That is the problem.'

CHW

On the other hand, security risks (such as the possibility of being killed, kidnapped, or robbed) in some communities prevent instructors and supervisors from visiting facilities for low-dose, high-frequency training, thus impacting the training of healthcare workers and their competence to deliver safe and quality healthcare services.

Given that facility managers were responsible for selecting participants to attend residential training workshops, the healthcare workers complained that the choice of participants was arbitrary and influenced by the facility managers' bias and preference. As such, some health workers had an unfair advantage and attended multiple training workshops. Occasionally, some facilities managers nominate themselves to participate in training workshops because of the attached financial benefits. Consequently, healthcare workers proposed a rotation system for those

attending residential training workshops to minimise bias and ensure equitable access to training opportunities for those involved in delivering healthcare services.

> *'There should be shuffling and reshuffling of staffs because sometimes a particular person can be going for a particular training…and that alone can also affect the way we work. Let's say if this set is going for this training, when the other time is coming, there should be another set, so that other people can hear from the horse's mouth. There should be reshuffling of staff when it comes to training. If you go today, another time, another person should go.'*

CHW

The rivalry between nurses/midwives and CHWs impacted training. According to the participants, this rivalry stemmed from several factors, such as the long-standing contest for leadership of PHC facilities, the competition for financial gains and the contention about services linked to the professional identity of nurses/midwives (see Chapter 6). The rivalry affects training, because tensions between nurses/midwives and CHWs made it difficult for them to be trained together, sharing training facilities and spaces like the labour ward.

> *'When we trained CHEWs, we took them for general practicals. When we got there, some of the nurses were not happy. They said, 'why are we bringing these people and giving them access to everything?'. But then when we explained, they were okay with it, but without knowing that some of them were not happy. Some of them refused to explain somethings when the CHEWs asked them questions.'*

FCT PHC Board Official

Nurses/midwives also expressed concerns about their jobs being taken over by CHWs. As such, they felt training CHWs would mean empowering their 'competitors'. These concerns are somewhat linked to the struggle for financial gains as nurses/midwives viewed CHWs as rivals who would reduce their likelihood of making financial gains from the delivery of healthcare services (see Chapter 6).

> *'One of the worries is that they [CHWs] don't even accept that they don't know it, they don't even accept that it is not their field. But they want to prove to you and probably the*

patient that they are nurses, and then they jump into doing things that they are not trained to do. Just as we have all rightly said, if you want to be a midwife, go to school and study midwifery; if you want to practice as a nurse, go to school and practice nursing.'

Nurse

Furthermore, nurses/midwives expressed reservations about the experience of CHWs and the duration of their training. They suggested that the training for CHWs was not long enough to give them the required competencies to deliver maternal health services.

'You cannot say what you learnt for two and a half years, plus your experience while working, is what someone [a CHW] will be able to effectively do in just one week of training.'

Midwife

Despite these tensions, some government officials highlighted that many CHWs already provide advanced maternal health services, such as conducting deliveries without proper training, underscoring the necessity for adequate training for CHWs.

'When a CHEW that has not been trained on how to conduct delivery is already doing it, it is like task shifting, but they were not trained. So, they can be doing the wrong thing.'

FCT PHC Board Official

Weighing in on the tensions, regulators believed that there was poor coordination between policymakers and regulatory agencies in curriculum design, training module development, and policy formulation for task shifting.

'The NPHCDA is made up of mainly doctors. I told them it was best not to interfere with their (nurses/midwives) trainings. What do they want to train the midwives on? Did you see a gap in our curriculum or something? Or is there a new skill you think they ought to have? Even then, it is best you consult us first, so we can work together to develop a training programme and know how best to relay the information to them [nurses/midwives].'

Nursing and Midwifery Council Official

There was also poor coordination between the policymakers, as highlighted by an official of the NPHCDA:

> *There's a communication gap between the policymakers, that is, the FMOH and the NPHCDA. It would surprise you to know that we did not know of this review of the TSTS policy until we were in the states. We had already printed the version of the TSTS policy we knew, and we took it to the state to disseminate… the states were then telling us that they were in Abuja reviewing the TSTS policy.*

NPHCDA Official

This perceived poor coordination and communication between policymakers and regulators has implications for the training of healthcare workers involved in task-shifting. It highlights the need for clearer guidelines and collaborative frameworks, to ensure that training is aligned with both policy intentions and regulatory expectations.

5.4.2 Health Workforce Supervision

The WHO recommends supervision as an indispensable instrument to improve health workforce competence (WHO, 2006). Task-shifting policies emphasise the need for supportive supervision and mentoring for optimal workforce performance and recommend that supervisors have the necessary competence to provide adequate support (FCT HHSS, 2021; FMOH, 2022). Many respondents agreed that supervision was essential and linked to health workforce performance: '…you will see that supervision is key. No matter the amount of training you give to a health worker, if you don't supervise them, you will not achieve your goal as they tend to perform better when they know that they are being supervised.' (FCT Policymaker)

According to the participants, supervision in the FCT was either internal by senior healthcare workers in the same facility or external by government or NGO officials who visited facilities to assess how health workers performed. Healthcare workers, policymakers, regulators and NGO officials agreed that there were gaps in the supervision available to the primary health workforce.

'For me, one of the biggest challenges for task-shifting is supervision. So, when we agree that we would task shift or task share, we are supposed to take responsibility to ensure that people work within the regulations they have been told to work. But unfortunately, supervision is very weak and poor.'

Medical Doctor

Participants reported that one of the reasons for these gaps was the shortage of experienced healthcare workers with supervisory skills, and the lack of vehicles to enable the few supervisors available to get around all the facilities.

'Another thing again is the poor supervision of this task shifting in facilities, and it is because of inadequate manpower, I mean supervisors, we don't have enough. Even when we have, those you have who would have done some supervision will still be hindered because we don't have the ability to move; we don't have a single vehicle for transportation.'

Medical Doctor

The limited availability of financial resources from the Government also impacted the supervision of healthcare workers, as supervisors required funds for transportation to facilities. During interviews, policymakers complained that the Government seldom funded external supervision, as NGOs and development partners provided most funds. Supervision was also impacted by workforce rivalry, as nurses/midwives reported that some CHWs refused corrections.

'It is the nurses that most times do the supervision. They correct the CHEWs when they are doing the wrong thing. Sometimes some will take correction, some too may not listen. Some may be too big to take correction and still continue with that wrong thing they're doing.'

Nurse

An official of the Nursing and Midwifery Council suggested that CHWs did not want to be supervised by nurses/midwives:

'We found out in practice that sometimes the community health extension workers say they don't need the supervision of the midwives… Some professionals have been groomed to believe that they can take up a task, but they don't need to be supervised.'

Nursing and Midwifery Council Official

In contrast, CHWs did not directly hint that they did not want to be supervised by nurses/midwives. Instead, they complained that their superiors were not courteous in their approach to supervision.

'Our superiors correct us in an embarrassing way and make us feel ashamed even in the presence of patients. I recommend that they change their manner of correcting us when we make mistakes and stop treating us like quacks as if we don't know what we are doing. Nobody is perfect.'

CHW

Although both nurses/midwives and CHWs had reservations about the approach to supervision, the CHWs were more vocal about it, complaining that the supervision they received was far from supportive. This made some CHWs evade supervision. Echoing the voices of several healthcare workers, a CHW expressed concerns about the approach to supervisions.

'Most of the supervision today is more of fault finding than supportive. What do we mean by supportive? If we are in a facility and you see me not doing something well, you should guide me and teach me better ways of doing it than shouting at me and looking down on my capacity, because nobody was born with that capacity. If the person keeps making mistakes, keep teaching. It is supportive supervision!'

CHW

Security concerns such as the fear of kidnapping and theft also affected supervision as external supervisors mostly avoided healthcare facilities in communities with significant security issues. Consequently, healthcare workers in these facilities were left without external supervision for extended periods:

'But as of now, most of our facilities have security problems… especially Kuje area council, security is compromised. You dare not go there for supervision, even in daytime in some of these facilities.'

The findings outlined above indicate that gaps in the training and supervision of healthcare workers impact the ability of healthcare workers to deliver safe and quality maternal health services via task shifting.

5.5 Awareness of Clinical Boundaries

In Chapter 4, I indicated that medical doctors and nurses/midwives expressed reservations about task shifting through their professional association, mentioning the concern about other healthcare workers exceeding clinical boundaries beyond the range of tasks shifted to them. In the literature, similar concerns were reported about some healthcare workers crossing clinical boundaries while delivering services via task shifting, resulting in resistance to task shifting or tension within the workforce (Ebenso et al., 2020; Nzinga et al., 2019). Clinical boundaries refer to the 'scope of practice' of healthcare workers based on the cadre, training and experience. Scope of practice encompasses the tasks that licensed health professionals are authorised to carry out, with these tasks being defined by state laws or regulations set by the relevant licensing authority (AMA, 2022).

The accounts of respondents during FGDs indicated that many of the nurses/midwives and CHWs were not clear about tasks that were supposed to be shifted to or shared with them. This uncertainty about tasks to be shifted/shared leaves room for disagreements between nurses/midwives and CHWs regarding which tasks can be performed. The responses during discussions also showed that some healthcare workers cross clinical boundaries, delivering services beyond the scope of practice. In the sub-sections below, I outline the findings related to the health workforce certainty of the policy-recommended tasks/roles that can be shifted, the encroachment of clinical boundaries

by some healthcare workers, and how the referral system impacts task-shifting for maternal health services.

5.5.1 Role Certainty

Following an analysis of my data, I describe 'role certainty' as the clear understanding and confidence that healthcare workers have in performing duties that align with their defined scope of practice, as outlined by regulatory guidelines and institutional policies.

The doctors and nurses/midwives I engaged in my study indicated that their roles were not explicitly stated in practice guidelines. Instead, they knew the roles they were expected to perform based on what they had been taught from their pre-service training:

> *'From our training, we know what we can do and what we should not do. We know our limits.'*
>
> **Nurse**

> *'We (nurses/midwives) were trained to a certain level, but no standing order to refer. We refer when it is above our limit, but it is not written as a standing order. Every nurse was trained to a limit, if it reaches this limit you refer, if you have a medical officer, you call a medical officer, if not you refer.'*
>
> **Midwife**

CHWs, on the other hand, had their roles explicitly stated in practice guidelines, known as 'standing orders'. These standing orders outlined the typical symptoms and stepwise approach to treating diseases within the scope of practice of CHWs (Ibrahim, 2016). According to some CHWs,

> *'I would say that right from school, everybody, like we the CHWs have something we call the 'standing order' which directs us on what to do.'*
>
> **CHW**

> *'We have standing orders and the standing orders are just like the principles that we operate with. With it, we should know our boundary. Yes, you should know where to reach and stop and look for help.'*
> **CHW**

Accounts from the healthcare workers indicated that there was some disagreement between the nurses/midwives and CHWs about what roles could be shifted and shared between them.

> *'You know that you have nurses and midwives at the primary health care. There are also community health extension workers at the PHC. There are also community health officers. How should the task be shared? What should be the limit of each of those people? As I said, the standing orders clearly spell out that the CHWs can conduct delivery, but the nurses come and say I am the midwife who has been legally trained to conduct delivery. So, when they meet at the labour room, the question is who is not eligible and who is?'*
>
> **Medical Doctor**

These disagreements about roles and shifted tasks between nurses/midwives and CHWs created discord and negatively impacted service delivery, training, and supervision. For example, based on the conviction that the roles of CHWs did not include supporting labour and childbirth, some nurses/midwives were reported to have denied CHWs access to the labour ward either to deliver services or for training:

> *'...in the area of delivery, we [CHWs] are having a lot of issues. Some of them [nurses/midwives] will come to the labour ward. They will say to go out, because they are midwives or nurses, and you are not supposed to handle a delivery.'*
>
> **CHW**

This would indicate that some nurses/midwives believe that CHWs are not expected to be involved in labour and childbirth, yet in contrast, the 2021 FCT task-shifting policy and standing orders for CHWs stipulate otherwise.

5.5.2 Recognition and Encroachment of Clinical Boundaries

The healthcare workers I engaged in discussions admitted to having a sense of the boundaries of their clinical work, which were either tacit (as was the case with doctors and nurse/midwives) or stated (as was the case with standing orders for CHWs). As indicated in the quote below, many

healthcare workers claimed to know the limits of their clinical competence and the point at which they should refer patients to more experienced healthcare workers.

> *'You know, in our field, you have a limit. When you conduct a labour and you find out there's a complication that you cannot handle, you refer immediately. Most of the labours that are complicated, we refer them, we don't keep them, because if you are keeping them, you are keeping the person at risk of harm.'*

CHW

Similar to the scope of practice describe previously, clinical boundaries are set based on the competence that policymakers and regulators expect from different health workforce cadres, based on their expected knowledge and skills derived from pre-service and in-service training (AMA, 2022). As stated in the 2021 task-shifting policy, whether clinical boundaries are implicit or explicit, all healthcare workers in PHC settings are expected to know them and ensure that they do not deliver services beyond the scope of their training.

> *'The roles and the associated competency levels required will be defined both for existing cadres that are extending their scope of practice, and for those cadres that are being newly created or assign additional/new tasks under the TSTS policy approach. These standards should be the basis for establishing or reviewing recruitment, training and evaluation criteria.'*

2021 FCT Task-shifting policy *(*(FCT HHSS, 2021, p. 6)

The task-shifting policy recommends that healthcare workers refer patients to more experienced colleagues or secondary healthcare facilities when they encounter clinical conditions that are beyond the scope of their training. This recommendation was acknowledged by healthcare workers.

> *'Sometimes you see in task shifting that people are overstepping their boundaries. We are trying to put an end to that. We have tried to correct them so that everybody should not go beyond their boundary. When you need to, you call for help. Everybody needs to identify what their scope of duty is when it comes to task shifting.'*

Medical Doctor

Many healthcare workers in the FGDs admitted that some colleagues occasionally exceeded clinical boundaries. Some healthcare workers were either uncertain about their clinical limits or deliberately encroached on known clinical boundaries to provide services beyond their expected competence. Reflecting on the overstepping of clinical boundaries by healthcare workers, a CHW blamed this occurrence on the weak regulatory system.

> *'I stand to be corrected, the majority of health workers are overstepping their boundaries and that is happening because the law in Nigeria itself is even broken by the lawmakers themselves. That is why you see everybody [healthcare workers] doing as they like and over-stepping their boundaries.'*

CHWs

With the emerging perception that many healthcare workers crossed their clinical boundaries while delivering healthcare services, I sought to understand the motivations behind these actions, regardless of whether they exceeded their clinical limits deliberately or unintentionally. Drawing from my analysis, I created **Figure 7**, to outline why FCT PHC workers exceeded their clinical boundaries. These reasons are further discussed below.

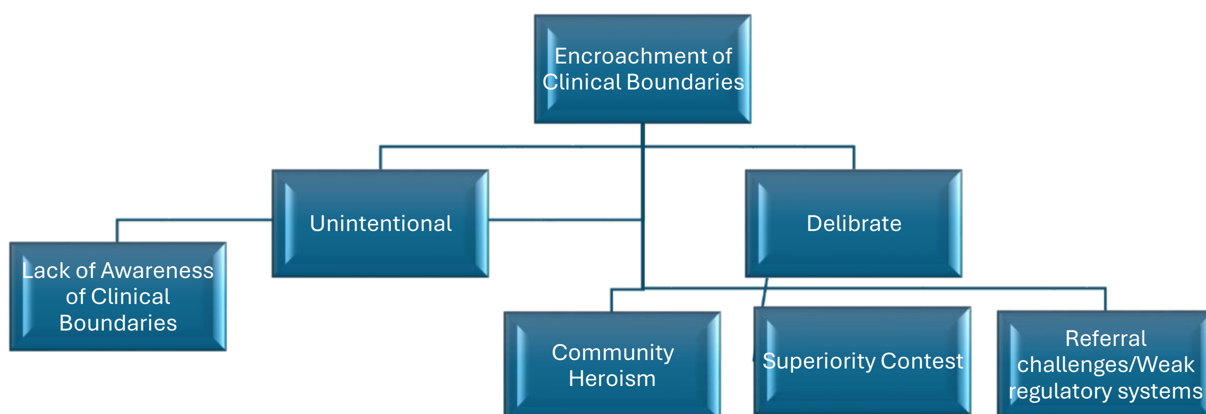


Figure 7 Factors influencing encroachment of clinical boundaries

The most common reasons for the deliberate encroachment of clinical boundaries include the desire to appear as the 'helper' of the patient, and the loss of faith in the referral system by patients and healthcare workers, as indicated below.

> *'A woman came with placenta baby, see placenta out, she was holding the cord. I said, 'Please go to general [hospital]'. She started shouting. She said, 'I prefer to die here, than to go to general [hospital]'. I said, 'See the cord outside. This baby will not be alive. The cord is already outside, and the baby was inside.' She said, 'Hajiya, I prefer to die in your hand than me going to general hospital.' This woman refused…..I delivered her, but the baby was still bad because the cord was outside for more than an hour before they took her in. See bleeding! When she delivered, I asked her what happened. She said, 'Hajiya, the way they [general hospital staff] treat us, the way they beat us, the way they shout at us, the way they behaved to me, I prefer dying somewhere else than me going there to see that thing.'*
>
> **CHW**

The above account from a CHW about a discussion between them and a patient indicates that sometimes patients refuse to be referred for several reasons, including the fear of poor treatment in secondary healthcare facilities. This causes healthcare workers to handle complicated cases that should be otherwise referred.

Since most of the healthcare workers in PHC facilities are members of the community within which they work, they tend to have a reputation as providers of life-saving services and community heroes/heroines who help community members with their health challenges. Seeking validation of this status drives some healthcare workers to over-step their clinical boundaries. This quest for validation spurs healthcare workers to accept the need to 'help' patients when they refuse to be referred, causing them to provide services beyond the scope of their training.

Below, a nurse suggested that some CHWs deliberately crossed clinical boundaries to prove their competence to patients and expressed concerns that patients may be at risk of harm from such practices.

'…what marvels me is that you know quite well that this is not your field; instead of you to call on those in that field, they [CHWs] will not. They want to prove to the patient that they know, and they can do it, and if this kind of practice continues, it is the patient that is on the receiving side of things.'

Nurse

Another nurse gave an account of her discussion with a CHW who failed to refer a patient, because he wanted to appear 'competent' to the patient and community.

'I had a scenario, when I entered the ward, I said, 'But this is not our case again, why are you keeping this patient'. He said, 'If I refer this patient, they would not believe in me again, and they will now say I don't know what I am doing.' I was like my God! Because of your selfish interest to show that you are jack of all trade master of none, you would not refer. Because they want to prove to their community, their tribe, their brothers and sisters that they went to school and they are now doctors and nurses or health workers, they want to perform that magic to tell them that they can do it, and they know it all, and most at times we get to lose these patients.'

Nurse

In addition to demonstrating their competence to patients, some healthcare workers also tried to showcase their competence to colleagues from other cadres in a superiority and competence contest. Consequently, they occasionally disregarded advice from other healthcare workers regarding the referral of patients. This occurrence is linked to the rivalry between nurses/midwives and CHWs (see Chapter 6).

'Even when we tell them [CHWs] to refer the patients, it seems we are not allowing them carry out the procedure. Meanwhile it is not under their expertise. Most of the cases, by the time you follow it up and you go to the secondary health facility and see the outcome, you will feel so embarrassed because a lot of damage has been done.'

Nurse

'…these challenges will continue because we have one thing that we are having problem with. Some people (referring to nurses) think they are superior and in the medical setting, nobody is an island.'

CHW

Another reason some healthcare workers do not hesitate to overstep their clinical boundaries is the weak nature of the regulatory systems at the PHC level. As such, healthcare workers who overstep their clinical boundaries are seldom penalised. As quoted below, some healthcare workers recommended penalties to discourage their colleagues from overstepping their clinical boundaries:

> *'So, they should know their boundaries, and if they go beyond their boundaries, they should be penalised.'*
>
> **CHW**

> *'Let there be a penalty… Like a disciplinary committee that checks that people work within their scope of work and if you cross your boundary, you pay a penalty fine. I think it would help everybody to sit up and keep everybody in check.'*
>
> **Midwife**

Many study respondents suggested that healthcare workers overstepped their clinical boundaries because of the challenges with the referral system connecting primary and secondary healthcare facilities. Sometimes, patients reject referrals and appeal that PHC workers 'do their best' to help them. In other cases, healthcare workers expressed their reluctance to refer patients, because of the presumption that they might be not given attention in secondary healthcare facilities due to limited bed space.

> *'When there was a woman in labour that needed to be referred, the CHEW informed the woman's husband and then referred them to the nearest general hospital. On getting to the general hospital, they were told that there is no bed. They return to the PHC, the CHEW then referred them to another general hospital, the next general hospital repeats the same thing; 'no bedspace', and they move around to different general hospital, far and near… At this time, the woman's and child's lives are already at a risk.'*
>
> **Medical Doctor**

> *'If you refer a patient to Kubwa General Hospital, for instance, once they find out that the case is coming from PHC, they will start insulting the patients. They make it look like people working in the primary health sector don't know anything, like we are all quacks. They will even say it in the presence of the patient, that he or she is not supposed to go to*

a PHC centre, making them feel like visiting PHC centres is a suicide mission. At the end of the day, they will tell the patient that they don't have bed space. Even if the person is at the point of death, they will tell the person they don't have bed space.'

CHW

In the quote above, the CHW indicates that when patients are referred, they are not guaranteed to receive services in secondary healthcare facilities. Instead, secondary healthcare facilities staff castigate patients for visiting PHC facilities, giving the impression that healthcare workers in PHC facilities are incompetent.

Drawing from my study data, I identified some reasons that delayed or prevented the referral of patients, potentially causing healthcare workers to overstep their clinical boundaries. I categorised them into patient, health workers and systemic reasons, shown in **Table 6** below.

Table 6: Reasons for difficulties with the referral systems for task-shifting

Patient Reasons	The perception that their treatment would be more complicated and expensive in secondary healthcare facilities.
	Concerns that healthcare workers would not treat them respectfully in secondary healthcare facilities.
Health Worker Reasons	PHC workers seeking validation as 'community heroes/heroines' if they successfully deliver services for 'complicated cases'.
	PHC workers seeking to prove their competence by handling complicated cases.
	PHC workers fear of being insulted and described as incompetent by colleagues working in secondary healthcare facilities
Systemic Reasons	Limited bed spaces for referred patients in secondary healthcare facilities.
	The high workload in secondary healthcare facilities which limits the attention given to referred patients.
	Poor communication and feedback channels between primary and secondary healthcare facilities.

	Inadequacy of appropriate transfer services and infrastructure (e.g. ambulances) to move referred patients to secondary healthcare facilities.

The encroachment of clinical boundaries by healthcare workers is a significant concern, as such practices could lead to maternal morbidity and mortality if healthcare workers deliver services beyond their scope of practice. As indicated above and highlighted in the quote below, healthcare workers are faced with tough choices in the practice of task shifting, as they navigate the gaps in the PHC system to deliver maternal health services, sometimes putting patients at risk.

> *'If you are the only CHEW in a health facility, you may have to do the work of a doctor because the demand will come, and a lot of the time, they are in despair. When you even have someone who wants to stick to the guidelines, the environment does not allow such a person to stick to the guidelines. So, it is a difficult situation.'*
>
> **Medical Doctor**

In the next section, I highlight how health workforce motivation impacts the practice of task-shifting for maternal health services.

5.6 Health Workforce Motivation

Motivation in the work context can be defined as an individual's degree of willingness to exert and maintain an effort towards organisational goals (Franco et al., 2002). It is a crucial determinant of performance recognised in the literature (Franco et al., 2002; Mbachu et al., 2022; WHO, 2006). Drawing from FGDs with nurses/midwives and CHWs, and some interviews, my data suggests that workforce motivation influenced task-shifting for maternal health services in the FCT. In this sub-section, I outline my findings about the motivation of the health workforce and highlight how it impacts the delivery of maternal health services. I developed a short vignette from my data to highlight how motivation of the healthcare workers in FCT PHC facilities, presented in Box 6 below.

Box 6: Vignette showing the influences impacting the motivation of healthcare workers

Gloria is a CHEW working as a volunteer in the Kuje PHC Center for four years. She is happy that she can serve the community and help deliver clinical services, working full-time five days a week. However, she is unhappy that her stipends are meagre and not paid regularly. She is sad that she has not been sent to attend any training workshop for the past 18 months despite overseeing the family planning unit. She feels this way because she wanted to gain new skills and looks forward to the training allowances. She recently sympathised with a formally employed colleague, Sarah, a nurse who complained of not being promoted for over three years and had not received uniform and shift allowances in the last two years.

Gloria and Sarah lamented about the dilapidated structures in their facility and how the lack of some basic infrastructure made their work more difficult. They wished they were working in the nearby private clinic with modern equipment. They also expressed frustration about the pothole-ridden road leading to their clinic and worried about security in their clinic, which was not fenced. Sarah told Gloria how sometimes she felt unhappy coming to work because her salary was very small, and she was owed several allowances. She admitted that she sometimes took her frustrations out on her patients and mentioned that she had a heated argument with a patient, mainly because of a mood swing caused by recalling that her promotion had been delayed for three years.

The vignette above illustrates how various experiences, and contextual elements shape the motivation of the FCT primary care workforce. From my data, some of the experiences that healthcare workers found to be motivating include their recognition as *'community heroes/heroines'* because of the services they delivered and the fulfilment they gained from their clinical work. The healthcare workers expressed that despite their motivation to help others and get recognised for it, their overall motivation was low:

'There are no motivations. Wherever you work, there are some things that you should look to as a worker. There are other little additions. Incentives that go a long way to help you and make you happy.'

Nurse

'They should appreciate everybody; with the little they are giving us; we need to be appreciated so that we can be motivated to do more.'

CHW

The data showed that multiple work and system-related influences impacted the motivation of the health workforce and caused them to be dissatisfied with working in PHC facilities. These factors include paltry salaries, which were occasionally delayed, lack of formal employment despite working as volunteers for prolonged periods, poor interpersonal relations within the health workforce, and delayed staff promotion. Other factors include poor supervisory support, limited training and career advancement opportunities, staff shortages with overwhelming workload and a lack of requisite infrastructure for service delivery.

Volunteers complained that they were demoralised because they did not have employment contracts and were often not prioritised for employment when opportunities arose. Employed staff were also discouraged by their meagre wages, citing that their pay did not match their workload.

'To be sincere with you, the midwives spend virtually 24 hours working… either taking delivery or doing antenatal or family planning. Sadly, we are paid next to pennies. I see nurses as the slaves of health workers when you think of the services they render and the remuneration.…We have not gotten there yet, both in salary and incentives. Probably, if the remuneration is even better, it will reduce the height of what I would do to get extra money in my pocket.'

Nurse

In the above quote, the nurse suggests that the remuneration for nurses/midwives should be increased, given the enormity of their work. She hinted at possibly going to extreme means to

augment her income, which resulted in nurses/midwives and CHWs struggling for financial gains from the delivery of maternal healthcare services (see Chapter 6).

Healthcare workers reported delays in promotions, with some waiting for months to years. When promotions did arrive, salary upgrades were not immediate, and promotion arrears were often not paid. They also complained of not receiving salary arrears and statutory allowances. These delays and non-payment of emoluments and allowances were described as demotivating by the PHC workforce in the FCT.

> *'Even as we are talking, our arrears and allowances have entered voice mail. I think even the salary is not paid on time, it is always delayed. So, it is not encouraging at all. Then for the promotion, before your promotion gets implemented, it would take almost two years, then you talk of arrears, those ones are in voice mail.'*
>
> **CHW**

Some healthcare workers, particularly nurses/midwives, expressed dissatisfaction with the professional dynamics and rivalry within PHC facilities. They complained that they sometimes encountered negative attitudes and behaviours from CHWs. This made the work environment tense and hostile. Consequently, some nurses/midwives mentioned that they preferred to work in secondary or tertiary healthcare facilities if given the opportunity so some of their colleagues did not want to work in PHC facilities. The tussle for leadership of PHC facilities (see Chapter 6) was also considered dispiriting and unnecessary by nurses/midwives and CHWs, as the resulting tension within the health workforce sometimes limited inter-cadre collaboration (see Chapter 6).

> *'Even some of our nurses do not want to work in PHCs because of the remuneration and the kind of motivation. They don't want to come down to this place where nobody respects them and at the end of the month, what is gotten is nothing to write home about. Also, our facilities are not well equipped, and this affects how services are delivered. All these can scare people away from the PHCs. So, if we can get good motivation, monetary and other aspect, I think more nurses would be willing to come down to PHCs. A lot are even travelling out of this country because the remuneration is too poor.'*

Nurse

Healthcare workers also reported low motivation, because of limited in-service training and career progression opportunities. Another major factor that demotivated the nurses/midwives and CHWs alike was the shortage or lack of basic infrastructure and equipment needed to deliver services, especially in remote and rural facilities. They also complained that many healthcare facilities had bad roads, so commuting to work was a hassle. Some healthcare facilities were not enclosed by fences, which raised security concerns, especially in communities with significant security issues.

> *A big challenge concerning those remote areas that we have our facilities is security; that is why some of the nurses, when you post them to such units, they would not want to go because of lack of safety, though we know that security has been a general problem in the country. But if adequate arrangement is made for people going to such areas to make sure that they are safe, it would really go a long way.*

Nurse

Some healthcare workers also complained that the highhandedness of some of their supervisors and superiors was discouraging.

> *So, for you to tell them, thank you, you are really trying, it will motivate them to do more and put in more effort in doing their job. But when bosses shout and yell at subordinates, it will bring down the spirit. Nobody wants to put their best in such an environment. This results in an attitude of 'after all, it is not my father's work'.*

CHW

Low motivation and poor job satisfaction among healthcare workers can adversely impact the delivery of maternal health services (Franco et al., 2002; Mbachu et al., 2022; WHO, 2006). As shown above from my study data, low motivation made some health workers dissatisfied with their jobs – and, in some cases, direct their frustration and anger towards patients. Despite the satisfaction many healthcare workers derived from the social recognition they got from their work,

their motivation was undermined by the absence of formal employment contracts, inadequate financial compensation, and infrastructural gaps.

5.7 Summary and Conclusion

In this chapter, I have examined some influences that impact the health workforce involved in task-shifting for maternal health services. I highlighted the shortage of healthcare workers, stressing that the healthcare workers delivering maternal health services are numerically inadequate, and that most of them have precarious employment, without contracts and guaranteed remuneration. I explored the competence of the health workforce, emphasising that although training and supportive supervision available to healthcare workers is not optimal, they continue to deliver services as best as possible. I examined the awareness of clinical boundaries within the health workforce, indicating that healthcare workers are unclear about what tasks should be shifted/shared, and that they unintentionally or deliberately deliver services beyond their scope of practice. I also highlighted how challenges with the referral system cause healthcare workers to deliver services beyond their scope of practice, instead of referring patients. I have also indicated that the health workforce is not optimally motivated.

I conclude that, although task-shifting is happening in the FCT, the workforce delivering maternal health services is doing so by navigating the challenges they face and is not based on the seemingly 'straightforward' provisions of the task-shifting policy. The practice of task shifting has been influenced not just by systemic gaps in the PHC facilities, but by the actions (and inactions) of all policy actors involved. The government's failure to prioritise the PHC system and the poor coordination between regulators and policymakers further heightened the systemic gaps that have impacted the practice of task shifting. This chapter has shown that although the nurses/midwives and CHWs shared some common broad interests as part of the interpretive community of practitioners, there was tensions between the two cadres. This indicates that while interpretive

communities could have sub-groups with similar broad interests and values, there is a possibility of misalignment between sub-groups when they have to protect interests or values that are specific to the sub-groups. This chapter has also spotlighted the role of healthcare workers as street-level bureaucrats, not practicing task shifting 'rationally' as depicted in the policies, but rather based on their interpretations of the policy, their interests, context, and the resources constraints they had to contend with in PHC facilities.

In the next chapter, I present additional findings on the influences that shape the practice of task shifting, with a particular emphasis on the interactions among healthcare workers, elucidating how these interactions sustain the delivery of maternal healthcare services in PHC facilities, despite prevailing resource constraints.

CHAPTER 6—FINDINGS III: HEALTH WORKFORCE DYNAMICS AND COLLECTIVE SOCIAL ENTREPRENUERSHIP

6.1 Introduction

I use this chapter to provide additional answers to the research question that sought to comprehend the influences that shape the practice of task-shifting for maternal health services in PHC settings in the FCT. In the preceding chapter, I outlined that the practice of task shifting is shaped by the interpretation of policy by different actors particularly the healthcare workers. I showed that the actions of nurses/midwives and CHWs as the key cadres involved in the practice of task shifting is influenced by their cadre-specific group interests and values. In this chapter, I zoom into the interactions between these healthcare workers, emphasising on how nurses/midwives interrelate with CHWs, and how healthcare workers interact to sustain the delivery of maternal healthcare services, despite resource constraints in PHC facilities.

Drawing from my primary data and the policy documents I reviewed, I examine the interactions between nurses/midwives and CHWs, highlighting the synergistic and antagonistic elements. I indicate that although these healthcare workers are in the interpretive community of practitioners, tensions exist between them. These tensions are linked to struggles to preserve professional identity, a scramble for financial gains, and the competition for leadership positions within PHC facilities. I show that, despite the tensions within the interpretive community of practitioners, the shared interest of the healthcare workers causes them to work together to keep facilities functional through collective social entrepreneurship. I highlight further how resource gaps impact the practice of task shifting, describing how, through the collective action of healthcare workers and leveraging collective social entrepreneurship, a ‘facility sustenance fund’ was developed to sustain the functionality of PHC facilities.

6.2 Health Workforce Interactions in Task-shifting for Maternal Health Services

6.2.1 Interactions within the health workforce

The delivery of maternal healthcare services in PHC facilities requires the completion of different tasks that usually require more than one healthcare worker:

> *'... task shifting is sharing responsibility with each other. You cannot hold the responsibility alone, but you share with your colleagues, so you work as a team.'*
>
> **CHW**

For example, the running of an ante-natal clinic involves different tasks, such as taking records of the expectant mothers on arrival at the PHC facility; a health education session for all the pregnant women; a one-on-one session, to see if they have any complaints and review any laboratory results; and a prescription of medicines for each woman. Different healthcare workers interact to achieve the goal of providing ante-natal care services through this sequence of tasks. The delivery of most maternal health services, like childbirth, is often more complex than running an ante-natal clinic and mostly requires two or more healthcare workers. Hence, the interprofessional collaboration of healthcare workers is essential for the delivery of healthcare services, and any influences that can impact cohesion within the health workforce can disrupt the delivery of healthcare services (Schot et al., 2020).

Narratives from FGDs suggested that delivery of maternal healthcare involved 'health workforce interactions' – work relationships and exchanges between healthcare workers. Depending on the nature of the interactions, they could foster collaboration between healthcare workers, enabling them to share knowledge and coordinate efforts to ensure that services are delivered. Conversely, these interactions could lead to tension within the health workforce and negatively impact the delivery of healthcare services. Accounts of the healthcare workers indicated that health workforce interactions typically occur during routine service delivery activities, such as antenatal

consultations, labour and delivery support, and postpartum care, as well as during staff meetings, informal conversations, and training sessions.

> *'We are running shifts; they mix nurses and CHWs. They mix nurses and midwives. We are doing collective work. There's no specific group attending to any case because by the time a patient is presenting himself/herself, you cannot tell the patient that the person that will attend to him/her is not around or something. So, you do whatever that is in your capacity to do while you wait for a helping hand to take over the case. But we work together.'*
>
> **CHW**

> *'Yes, it [task shifting] does enhance better interaction between different cadres. Because CHWs, nurses, midwives and doctors, if you are learning from them, they will definitely call you, talk to you, put you through, which has really enhanced better communication within us. We are free to each other.'*
>
> **CHW**

> *'Well, it [task shifting] can cause tension. Like, okay, maybe if the in-charge [facility manager] is doing family planning, and the nurse midwife posted today has gone for a training on family planning. If you don't relate properly, it may cause tension, because the in-charge may say, 'I will be the one doing all the family planning cases that come' and maybe the nurse would say, 'I am also trained'. But if both of them can make a balance and understand each other, I don't think that should be a challenge.'*
>
> **Nurse**

Accounts from healthcare workers above indicated that interactions within the health workforce predominantly involved CHWs and nurses/midwives, as they were mainly responsible for clinical services in PHC facilities:

> *'Most of the facilities in the area councils don't have doctors, so our work is mainly with nurses and midwives.'*
>
> **CHW**

Following the analysis of the interview and discussion transcripts, I categorised the health workforce interactions in PHC facilities into two: *intra-cadre* and *inter-cadre* interactions.

Intra-cadre interactions were between healthcare workers of the same cadre. From accounts during discussions, healthcare workers suggested that they found it easy to work and cooperate with co-workers from the same cadre, as they felt more supported by colleagues with similar educational background, training and work experience.

Inter-cadre interactions were between healthcare workers of different cadre (e.g., midwives working alongside CHWs). These inter-cadre interactions were either cooperative or antagonistic. Some of the healthcare workers reported that their interactions across cadres was cooperative as they viewed themselves as partners who needed to collaborate for the common objective of providing services for patients. For example,

> *'In this facility, the nature of our work is cordial; there is no segregation. We work as a team except in an area where some groups are not well trained. In such area, only the well-trained personnel do the job.'*
>
> **Midwife**

This inter-cadre cooperation helped to improve supervision and peer learning across cadres as some health workers had mutual respect and accepted being supervised and taught by persons from other cadres, provided they were more experienced:

> *'So, it is the nurses that most times do the supervision. They correct the CHEW when they are doing the wrong thing. Sometimes, some CHEWs take correction, and some too may not listen.'*
>
> **Nurse**

Although the narratives from the healthcare workers suggested cases of cooperation or cordial inter-cadre interactions, the cooperation between the healthcare workers was not always guaranteed, as sometimes there was tension within the workforce. These tensions were linked to

rivalry between CHWs and nurses/midwives (see next sub-section). For example, one CHW commented:

'In some health facilities, there is no cooperation, especially in an instance where there's monetary gain. Only one person can go away with the money, while others do not even have transport fare back home.'

CHW

They [CHWs] have almost the same training as nurses. So, there is that rivalry between these two professional cadres…. Irrespective of these professional inclinations, there has been very good working relationship in many settings and that comes down a lot to interpersonal communication skills.

Medical Doctor

The health workers suggested that most intra-cadre interactions were cooperative – with less tension and more collaboration between health workers. Depending on the understanding and communication between healthcare workers, inter-cadre interactions were either cooperative or antagonistic. Antagonistic interactions made the work environment tense and were associated with less collaboration and negative or hostile dynamics between healthcare workers.

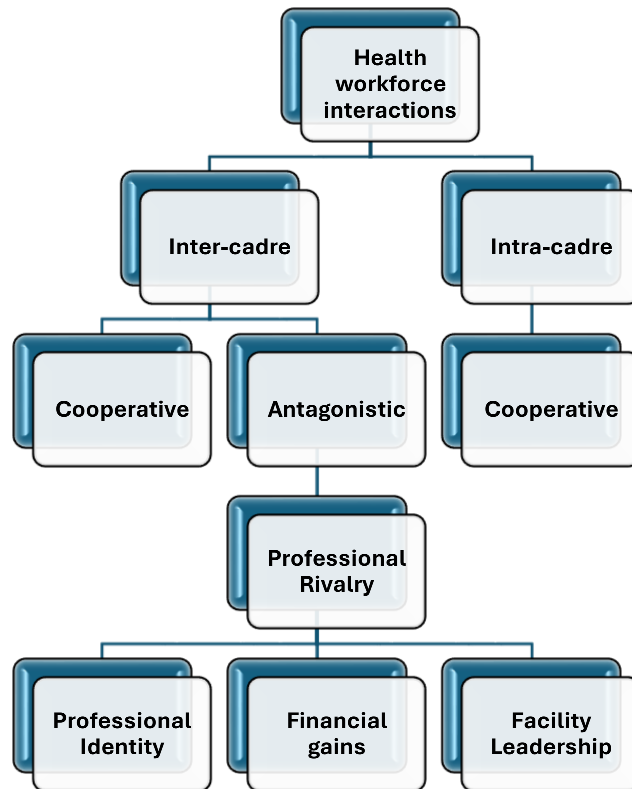
There has always been cadre rivalry. If the CHEW is an in-charge [facility manager] and doesn't know how to manage well, there will always be a clash with the nurse. But then what can we do! The CHEW and the nurse must work in the same place. We try to talk to them, and we try to follow the hierarchy as much as we can.

CHW

My analysis of the data from the interviews and discussions indicates that inter-cadre antagonistic interactions were linked to professional rivalry, which resulted from a competition for professional identity, financial gains, and facility leadership. In the next sub-section, I make the connection between the professional rivalry and competition between nurses/midwives and CHWs. The schema in

Figure 8 below shows my categorisation of the interactions between the health workers in FCT PHC facilities.

Figure 8: Health Workforce interactions in FCT PHC facilities



6.2.2 Professional rivalry and task shifting

Professional rivalry between healthcare workers in Nigeria has been reported in the literature, with studies highlighting that it causes poor cooperation between healthcare workers and impacts the delivery of healthcare services (Adigwe et al., 2023; Mohammed, 2022; Omisore et al., 2017). Accounts from the healthcare workers in my study indicated that there was professional rivalry within the health workers within PHC facilities. The vignette in Box 7, following, hints at reasons for this professional rivalry.

Box 7: Vignette highlighting drivers of professional rivalry in the PHC workforce

Sadiya and Halima are midwives working in a PHC clinic as volunteers and they have admitted a pregnant lady into the labour ward for a vaginal delivery. The government has not provided IV fluids and consumables to the facility for over a year. To address this resource gap, the facility manager buys essential commodities to facilitate service delivery and ensure that commodities are available when needed. The midwives on duty use materials (IV fluids, medicines, pads, etc) worth N8,000 (£5) to help the patient deliver her baby. After the successful delivery of the baby, they ask the patient to pay N24,000 (£15) as the 'delivery fee' to cover their services and the materials used. To generate revenue internally, the clinic has a 50-50 sharing formula that allows healthcare workers to split the 'profit' from delivery services between themselves and the facility's joint account. The revenue raised is used to support the running of the facility and pay monthly stipends to volunteers. Sadiya and Halima have N4000 (£2.5) each after the delivery and go one to have another delivery before the end of their shift, making N8000 (£5) each on that day. This financial gain motivated healthcare workers like them to take as many shifts as possible, because it gave them more opportunities to earn additional money aside from their monthly stipends.

During a recent facility staff meeting, the midwives insisted that they are the custodians of the labour ward and that CHWs should not be allowed to support childbirth. The midwives also said CHWs should focus more on other services because they were not 'well trained' to handle complications in the labour ward. The CHWs did not accept the proposition, insisting they were recognised as SBAs by the task-shifting policy and their standing orders. The CHWs wanted to support childbirth so they could also get additional income to augment their stipends. The facility manager was a nurse, and she took sides with the midwives, and said CHWs should not take deliveries.

The CHWs felt they were not treated fairly and reported the matter to the Area Council PHC Authority. The CHWs argued that the nurses/midwives refused to allow them to deliver childbirth services because they wanted to have a monopoly over the financial gains that come from providing such services as SBAs. They also accused the facility manager of taking sides with the midwives because she was a nurse. They also said she gave nurses/midwives an unfair advantage by allowing them to attend more residential training workshops than CHWs. As such, the CHWs requested that one of them should be appointed as the facility manager, since most of the clinical staff in the facility were CHWs. The Area Council authorities promised to address the matter, but did not intervene for over six months. Within that time, the CHWs and nurses/midwives had a tense relationship, with CHWs delivering childbirth services whenever the nurses/midwives were not on duty and lobbying at the Area Council Authority for a CHW to be appointed as the next facility manager.

This vignette highlights the drivers of professional rivalry within the PHC workforce: professional identity, financial gains and facility leadership. It shows that healthcare workers make personal financial gains from the delivery of maternal healthcare services, which they use to augment their meagre remuneration. The vignette also shows that nurses/midwives and CHWs compete for these financial gains, with nurses/midwives seeking monopoly over the delivery of maternal health services based on claims that CHWs were not SBAs – a position that the nurses/midwives link to their professional identify. The vignette also shows the authority of facility managers and suggests that healthcare workers are more favoured if the facility manager is from their cadre. Lastly, the vignette highlights that the nurses/midwives and CHWs compete to have someone from their cadre as facility manager.

Below, I provide details of the three main sources of professional rivalry and tension between nurses/midwives and CHWs.

6.2.2.1 The professional identity element

Healthcare professionals draw their professional identity from their training, workplace setting, experiences, and roles. The knowledge, skills and recognition accrued from learning and qualifications also contributed to professional identity (Cornett et al., 2023). In the context of my study, I view *professional identity* as '*the sense of self that healthcare workers hold, both as individuals and as a professional group, shaped by the specific roles and responsibilities they are trained for and socially recognised to perform*'. For example, midwives often view assisting childbirth as a defining element of their identity – an act that distinguishes them as midwives. When other cadres like the CHWs take on such roles, it may be perceived by midwives as an encroachment of their identity-defining roles, and a threat to their shared identity. In the context of task shifting, the shifting of tasks that are viewed as 'identity-defining' roles may cause some healthcare workers to push back, and resist the shifting/sharing of such tasks in a bid to preserve their professional identity and ensure that only those who are members of their cadre are able to perform such identity-defining roles. To illustrate how professional identity contributes to the rivalry between nurses/midwives and CHWs, I highlight the symbolic value that nurses/midwives attached to skilled birth attendance and the labour ward/room.

Prior to the formalisation of task-shifting for maternal health services, only doctors and nurses/midwives were authorised to deliver child delivery services as SBAs. The key workplace setting linked to this professional identity was the labour ward/room. Also, the key skill and knowledge expected from SBAs was the ability to support women with safe childbirth services. During discussions, nurses/midwives suggested that delivery services and the labour ward/room were meant for them. For example, comments from a midwife and a medical doctor:

> *'Delivery is strictly for midwives. I think that is the standard; once a midwife is there, she takes responsibility for delivery.',*

Midwife

'Midwives believe they are the owners of labour and delivery, so if they see anybody coming into the labour room, it is a problem.'

Medical Doctor

The perception of professional identity for nurses/midwives as being connected to skilled birth attendance and working in the labour ward/room is linked to their pre-service training – in which doctors and nurses/midwives were trained to be SBAs, and given access to the labour ward/room. However, with the emergence of the task-shifting policy, CHWs have become recognised as SBAs following training and supervision. This development has not been well received by the nurses/midwives; they considered CHWs lower in the hierarchy, and more involved with immunisation and other community-based services. One CHW comments:

'Personal interest from the health workers, that is, the nurses and the midwives, is a problem. Like in my own facility, they believe that CHEWs are responsible for immunisation only'.

CHW

The nurses/midwives were uncomfortable with CHWs delivering childbirth services, as many of them suggested that the training and supervision they had received was inadequate for them to deliver childbirth services competently.

'…one of the CHOs called me that there is a delivery that the woman is already 6cm that I should come. On getting there, he said he was setting up. I told him to hold on for me to check. On checking, I realised the woman was not even up to 4cm. So, in such an instance, if I was not there, it would have resulted in complications. I just put him through and told him what to do next time.'

Midwife

‘For you to finish as a midwife, do you know what it takes? And it is a very sensitive aspect, and once you miss any of the procedures, you are either putting the mother or the child in danger. ...if they want to do midwifery or nursing, let them do that.’

Midwife

Although the nurses/midwives expressed concerns about the training and competence of CHWs as SBAs as depicted above, it appeared that they were also concerned about ‘sharing’ their professional identity with CHWs. As such they occasionally prevented CHWs from delivering childbirth services. One nurse commented:

‘If nurses are there, CHEW does not take delivery. And nurses are always there. We are six in our facility, so we don’t lack nurses though we need more hands. But we don’t allow them [CHWs] to take delivery.’

Nurse

As depicted above, skilled birth attendance and the labour ward both have symbolic value for the nurses/midwives, as they see these as ‘their service’ and ‘their territory’. This was shown in the reports of some nurses/midwives refusing to support the training of CHWs or admitting them into the labour ward. This refusal to support or train CHWs was done to frustrate efforts to facilitate the recognition of CHWs as SBAs. The nurses/midwives also wanted to protect jobs for people in their cadres, by trying to prevent CHWs from performing all the services that nurses and midwives usually delivered.

‘So, protectionism is key in the argument. People want to say, if this is the profession and there are people licensed to do this, why would we allow somebody else who isn’t licensed to do it? That’s protectionism… They feel that they need to protect jobs for their own cadre. They are protecting their likes. They are telling you, ‘Employ us, we will not allow you to shift this task because if we allow you to shift this task, that means you would not find us useful.’

Medical Doctor

Furthermore, the nurses/midwives wanted to preserve their professional identity by ensuring patients knew the difference between both cadres. They expressed concerns that their professional identity was being eroded, as patients sometimes mistook CHWs for nurses. The nurses/midwives suggested that patients could assume that CHWs were nurses or midwives because many CHWs were not always explicit about their identity and in some facilities, they did not wear uniforms that distinguished them from nurses and midwives. As such, they expressed concerns that CHWs were taking up their professional identity.

> *'As we are all in different cadres, we are supposed to have different uniforms for the different cadres to differentiate us so that when patients walk into the facility, they can easily identify. In FCT area councils, it is not so and that is not good enough because patients cannot even tell who they are communicating with per time.'*

Nurse

> *'I have never seen a CHEW recognise himself as a CHEW. They will say they are nurses. In my facility, when I hear them say that I quickly correct them, 'Let them know who you are'. There was a day a patient was speaking with her husband on the phone to send money for treatment and she gave the phone to the person on duty. The CHW introduced himself to the man on the phone as the nurse on duty, I diplomatically corrected him. We need to do this, so that workers in health facility do not continue to assume positions.'*

Nurse

On the other hand, the CHWs were happy to be recognised as SBAs, and to provide childbirth services. They resisted the actions of the nurses/midwives to prevent them from training and working as SBAs. One CHW commented:

> *'We are all trained, not that we have to watch somebody do before we learn what we are supposed to do. So, we are trained.'*

CHW

The CHWs argued that their standing orders and the task-shifting policy empowered them to deliver services as SBAs. As such, there was tension within PHC facilities due to the nurses/midwives resisting their delivery of services as SBAs:

'In everything we do, there is a standing order that would guide and assist on what to do. By following the guideline of standing orders, we are able to touch a lot of things and cover a wide range of illnesses.'

CHW

The reservation about the status of CHWs as SBAs was also expressed by a Director at the Nursing and Midwifery Council of Nigeria. He indicated that the Nursing and Midwifery Council did not approve the training given to CHWs before they were considered SBAs. He compared the rigour and duration of the training received by nurses and midwives with that received by CHWs and adjudged it inadequate:

'A skilled birth attendant is defined as a medical doctor, a midwife or a nurse trained to proficiency in caring for pregnant mothers and their babies. Just two to three weeks of training is not enough to make a community health extension worker a skilled birth attendant.'

Nursing and Midwifery Council Official

Conversely, a representative of the Community Health Practitioners Registration Board of Nigeria argued that CHWs are well-equipped as SBAs, because their training curriculum was updated to cover knowledge and skills needed for skilled birth attendance. As such, all recently qualified CHWs were competent SBAs. He also said in-service training of CHWs helped them update their skills to deliver maternal health services. Furthermore, he suggested that nurses/midwives prevented CHWs from delivering services because they were trying to protect their 'territory'.

'I don't think it is because of skill. Like I said, when our curriculum was reviewed, the maternal and child health area was adequately made to be more comprehensive. I think what they may be doing is more of being territorial, trying to protect their so-called

territory. That, 'This is for us. Why should somebody come and be struggling for our role?' That may be their orientation, but I think that is wrong because, as health workers, our primary target should be to improve the health status of the people, not who does what.'

Official of Community Health Practitioners Registration Board of Nigeria

The perspectives articulated by the members of the interpretive community of guardians (regulators) and practitioners (healthcare workers) show that the existing rivalry between nurses/midwives and CHWs is partly caused by the efforts of the nurses/midwives to prevent CHWs from 'sharing' their professional identity.

6.2.2.2 The scramble for financial gains

Another source of the rivalry between nurses/midwives and CHWs was the scramble for financial gains from delivering maternal health services. As depicted in the vignette on professional rivalry (see Box 7), many PHC facilities were run in a manner that enabled healthcare workers to receive direct personal financial benefit when they delivered maternal healthcare services.

'Me, as a midwife, I think beyond that, as much as I am a Nigerian who likes money; I think the life of my patient is more important than the money. But everybody now, whether doctors, nurses, midwives, and so on, would centre on this finance. They now see that the aspect of maternal and child health is the one that is regular and follows a pattern. It is arranged in a way that you will always see clients, so everybody's eye is on it (maternal and child health services). It is the financial aspect everybody is seeing. So, I think that is one of the aspects that is making everyone just look at the maternal side, it is that they get more money.'

Midwife

This scramble for financial gains came about because informal user fees are paid for maternal health services in most PHC facilities, and healthcare worker(s) directly involved in delivering those services may receive a fraction of the monies paid by patients. *'You know, the government are not bringing drugs to the facilities. They don't supply drugs except once in a while. Sometimes, they bring drugs like paracetamol just to indicate they have dropped something. They're not bringing drugs to the facilities. So, each facility depends on their in-charge [facility manager]. When they [facility managers] see that people are coming for treatment, they can gather the little money the facilities have, to buy drugs in order to treat patients. Facilities end up buying their own drugs when they see that people coming...'* **CHW**

Facility managers (or individual health workers) bought these needed commodities and asked patients to pay for them, plus an additional service charge to raise money for the healthcare facility. Occasionally, patients were asked to buy additional commodities needed if not available in the facility.

> *'Another thing about the money thing, there is no imprest. There is no provision for the consumables to be used. So, like family planning and even sometimes in the delivery aspect, the client has to buy delivery items. But sometimes we have to start sourcing it.'*

Midwife

These informal payment for maternal health services allowed facilities to raise revenue, and healthcare workers to make extra money to augment their monthly salary/stipends. This incentivised healthcare workers to deliver maternal health services, causing them to occasionally struggle to deliver more services in a bid to increase their supplemental income.

> *'In some places where we don't have midwives, even though there's a specific amount we charge for labour, the CHO who takes delivery has their way of getting money from patients, such a way that they have some amount to pocket without affecting the expected charge the patient is supposed to pay. Since we don't have a midwife, the person who takes the role of a midwife at that time can find a way to have monetary gain. This monetary gain could be from getting delivery items for patients who come without their delivery items.'*

CHW

Both nurses/midwives and CHWs admitted that they were incentivised to provide maternal healthcare services for financial gain, and these caused some tension between both cadres. They viewed these financial gains as supplemental income that augmented their meagre remuneration, highlighting that the additional income was particularly useful for volunteers who received paltry stipends.

> *'The issue is that there is a fixed amount of money that patients pay for delivery, and the amount differs in every facility. In my facility, the amount is five thousand naira (N5,000), but somebody might be charged ten thousand naira (N10,000). The person who received*

the money will only remit a part of the money and pocket the remaining. And, of course, she needs it. She may even tell you, after all, I am a volunteer; I don't earn salary; what do you want me to do, I can't just work and go like that without having my own share.'

Nurse

The accounts from both nurses/midwives and CHWs suggested that in some facilities nurses/midwives attempted to monopolise the delivery of services linked to skilled birth attendance.

'And then some of our nurses too. It's not that we are hundred per cent good, no. Some of our nurses too are so money-conscious. Yes, they want to hijack everything. What would they [CHWs] do – if you're not there, they'll try in as much to do and clean the place. But when you carry them along about everything, they are seeing it. You bring it to the table, you share. In fact, your own shouldn't be major. Their own should be major because they don't have salary.'

Nurse

Although these nurses/midwives indicated that their main reason for preventing CHWs from delivering services linked to skill birth attendance, they also admitted that there was also a financial incentive for their actions, justifying financial gains as compensation for the hazards associated with their job. During a FGD with nurses/midwives, I asked a follow-up question seeking to know if they had a financial incentive to deliver services as SBAs and a midwife said:

'My thoughts are that, yes you are correct to an extent, but they don't see the other side of where a midwife is soaked with blood, all the infectious diseases we are exposed to, nobody sees it.'

Midwife

The nurses/midwives also mentioned that some CHWs delivered maternal healthcare services beyond their competence because of monetary gains. They revealed that the meagre remuneration of healthcare workers might entice them to get involved in fraudulent activities just make ends meet. For example, nurses/midwives noted that money was an incentive, linking it to their meagre remuneration:

'…The majority of them [CHWs], their services are centred on money, that is why they are carrying out tasks that are not meant for them. Because if it is not centred on money, they would not be going off their limits.'

Midwife

'Probably, if the remuneration is even better, it will reduce the height of what I can do so I can get something in my pocket.'

Nurse

While acknowledging that volunteers needed supplemental income, the nurses/midwives suggested that actions of the volunteers were unprofessional as they over-charged patients, provided unneeded services, and prolonged the duration of some services to justify higher patient payments:

'But the challenge is that some of them [volunteers] are greedy, and because of that, they want to overcharge to take care of all their financial problems because they're not being paid. So, it's a big challenge.'

Nurse

'This volunteering thing should be looked into. Nurses should be recruited, or the CHEWs – make them staff, so that they can have the mind to do the work the way it should be. Not that a procedure for six hours to be dragged into 12 hours because you want to make money. So, they (government) should look into volunteer of a thing and recruit permanent staff. It will help us.'

Nurse

During the FGDs, both nurses/midwives and CHWs acknowledged that the scramble for financial gains was a common occurrence in many PHC facilities. However, some healthcare workers indicated that there was minimal competition for monetary gains in their facilities, because of the approach that was adopted to collect informal payments from patients. Accounts from the healthcare workers suggested that competition for financial gains was driven by the fact that monies they received from delivering maternal health services were individual gains. Individual

gains arose in scenarios where healthcare workers were permitted to retain a portion of the fees paid by patients for services rendered. This arrangement was prevalent in many facilities, leading to heightened competition among healthcare workers to deliver services. For example, some CHW said,

> *'If you take labour, you are entitled to N1500, so that one is your own. So, if you take delivery. N1000 is for matron, N1500 is your own.'*

CHW

> *'Let's say I'm on night duty or I'm on evening duty. Your wife delivers. After telling you her delivery items or after bringing her delivery Items, she delivers, She wants to go. Your charges now are N11,000 or N12,000. I give N2000 to the government; the remaining N10,000 goes to my pocket.'*

CHW

In some PHC facilities, the facility managers mitigated the pursuit of individual financial gains by structuring the system to prioritise 'collective gains'. To achieve collective financial benefits, these facilities established a facility collective pool, which aggregated all payments received for service delivery. On a monthly basis, the funds within this collective pool were distributed among all healthcare workers, and utilised for procuring facility commodities and infrastructure, as determined by the facility manager. Although this approach had the potential to discourage active involvement in service delivery, it was mitigated by the facility manager deciding the amounts to be paid to each healthcare workers monthly from the collective pool. As such, healthcare workers contributed to the delivery of services, knowing that their stipends would be paid based on their monthly performance, as determined by the facility manager. These actions highlight the enterprising nature of some facility managers, which was key for the collective social entrepreneurship that supported facility functionality (see next section).

'…there are cases of struggling for money, but it's not in every facility. Like our facility, it is not in existence because we have central accounts, so all revenue generated enters into a particular purse, which is why we don't have the issue of fighting for money.'

Nurse

'Please, the monetary aspect. It's not always that a patient pays to a nurse or midwife that render the service. Most times, like in my own facility, its one-pocket. Yes, it's one pocket. We have a cashier that collects the money. Even if it is delivery, once the patient delivers. We don't charge the woman. We write the bill on the card, and we tell them to pay to the cashier. That is how it is done in my own facility. Maybe it's because it's a doctor who is in charge of the facility that has helped us. I don't know. Maybe that is why it is working.'

Nurse

'It's almost the same thing. The in-charge [facility manager] is the one who decides the drug to buy and from there she would generate money to give stipends to the volunteers; an amount that is based on her own decision. The stipends are not the same across all the facilities because it's determined by the in-charge of each facility.'

CHW

Although facility managers reduced the scramble for financial gains in most PHC facilities, some of them engaged in fraudulent activities, utilising resources in the collective pool for their personal benefit.

'My facility is different. Like in my facility, what I noticed there is, it's like a family business because like my in-charge [facility manager] where he sees that money is coming, that's where he puts his family members – the laboratory, the delivery room and the pharmacy. That's where he keeps his people. They're watching like CCTV camera from him, and he has eyes in every money that comes into that PHC.'

Nurse

As depicted above, having a facility collective pool reduced the struggle to deliver maternal health services. Neither nurses/midwives nor CHWs would have an advantage if either cadre delivered the services. Instead, the idea of having collective gains made the healthcare workers cooperate more, when they realised that their gains at the end of each month were linked to the amount of

money they could accrue in the facility collective pool. This difference in approach to managing financial gains in PHC facilities highlights the actions of facility managers and healthcare workers as street-level bureaucrats (Lipsky, 1980), as they organised themselves to deliver maternal health services and handled incoming financial gains differently across facilities.

6.2.2.3 The leadership contest in PHC facilities

Another source of rivalry between nurses/midwives and CHWs was the contest for leadership within PHC facilities. PHC facilities are usually led by the most senior healthcare worker (the facility manager), who is to oversee the administrative and clinical operations of the facility.

> *'At the level of the PHC centres, we usually have an officer-in-charge who is usually the most senior officer of the facility, posted by, and must report to the PHC department. Such a person could be a nurse, a midwife, a community health officer (CHO) or a CHEW, depending on the availability of staff. It is the duty of this officer in charge to make sure that all various cadres of staff work together in harmony within the primary health centre.'*

Medical Doctor

Most PHC facilities were led by either CHWs, or nurses/midwives along with CHWs. The leadership within PHC facilities significantly impacts the cohesion of the health workforce, as facility managers are tasked with coordinating and overseeing the activities of healthcare workers. As hinted below, the leadership capabilities of facility managers are crucial for the effective operation of PHC facilities, ensuring they function with minimal issues:

> *'Some places [facilities] are lucky to have a good leader, who is a good human resource manager and able to manage all the cadres, but some places don't have a good manager and are having issues.'*

Medical Doctor

The facility managers (or the 'in-charges', as they are commonly called) are also responsible for overseeing the day-to-day operations of the PHC facilities. They have many powers, as they are

responsible for controlling the facility's finances, engaging and paying volunteers, and interfacing with government authorities. They also nominate healthcare workers for training workshops and engage with development partners and NGO officials that support service delivery at the PHC level. Accounts from healthcare workers highlighted the high level of influence that facility managers have and the potential for them to make decisions in favour of their cadre.

> *'You know right from the inception of OPD there has been that rivalry between the CHWs and the nurses and for the fact that most of the facilities are being manned by the CHEWs and by the CHOs. So definitely, if you have a colleague working with you, you want to give your colleagues preferential treatment above others. So that is exactly what is happening. If the CHO and CHEW is manning a facility, definitely he'll want to favour his colleagues over the nurses. So that is exactly what is happening.'*

Nurse

With the potential for facility managers to give preferential treatment to healthcare workers from their cadre, nurses/midwives and CHWs competed to see that individuals from their own cadre were appointed as facility managers.

> *'Again, the issues of leadership between the nurse and the CHEW usually come up if unfortunately, the CHEW is the in-charge [facility manager] and the nurse is not. There have always been cadre rivalry. If the CHEW is an in-charge and doesn't know how to manage well, there will always be a clash with the nurses. But then what can we do? The CHEW and the nurse must work in the same place. We try to talk to them, and we try to follow the hierarchy as much as we can.'*

Medical Doctor

There was tension within the health workforce about the issue of leadership in healthcare facilities. The struggle for leadership was centred on the issues of seniority and ownership of the healthcare facilities. This is relevant, because seniority and qualifications are key determinants of who becomes the facility manager. Some nurses/midwives indicated that the seniority problem might be connected to the peculiarity of the FCT administration which employs nurses/midwives and CHWs on the same level and salary scale. For example:

'The level with which we are employed is the same. That is one of the problems.'

Midwife

'…it's only applicable here in FCT LGAs. In Kogi state, where I studied midwifery, nurses and CHEWS are different. I wonder why they are the same here.'

Midwife

The nurses/midwives said that before task-shifting, they considered themselves senior to the CHWs and should not have CHWs leading them. The nurses/midwives suggested that CHWs claimed 'ownership' of the PHC facilities, and believed doctors and nurses/midwives should be working in secondary and tertiary healthcare facilities.

'What our counterparts believe is that they are the owners of primary health facility because they call them 'community health extension workers', so that 'community' is in their name, and the fact that the primary health facility is in the community gives them that power. They said even doctors, nurses and midwives are not meant to work in primary health care… That is the major thing causing problems, they never believe that other cadres of health are meant to work in primary health care.'

Nurse

A medical doctor also highlighted the perception that CHWs viewed themselves as the custodians of PHC facilities:

'The community health practitioners have come to feel or trying to assert that primary health care is for them alone and that every other person is an intruder. That they can do everything in a primary health care facility, and they should be heading the primary health care facilities.'

Medical Doctor

These arguments about seniority and 'ownership' of the PHC facilities caused tension and mistrust between the healthcare workers. The healthcare workers reported incidences of biased decision-making by facility managers, in favour of their cadre. This bias was reported to occur regardless of whether the facility manager was a nurse/midwife or a CHW:

'So, the disparity between CHEWs and nurses in my own place, it is the in-charge that is bringing it in.'

Nurse

Some of the nurses/midwives believed that some CHWs had the backing of government officials and, as such, were appointed to be facility managers even though they were more junior than the nurses/midwives in the PHC facilities.

'Most of them [CHWs] have connections with the superiors in the office. They are able to manoeuvre their way to securing the position using such connections. That leads to a situation where a CHEW is heading a facility even when there is a B.Sc. Nursing holder in such facility.'

Nurse

A medical doctor in Abuja Municipal Area Council alluded to the leadership struggle and said that local government authorities tried to minimise it, by making facility manager appointments based on the seniority of the healthcare workers working in a facility.

'There is clarity of appointment if one is a senior. By default, seniority, and then again qualification. If we have a CHEW and a CHO in the same facility, you can't make the CHEW the head over the CHO, because the CHO has more qualification that makes him/her ahead to head a facility than a CHEW.'

Medical Doctor

The doctor indicated that, although this approach was objective, there was still some tension in the workforce, as some healthcare workers did not understand the 'seniority approach' used to appoint facility managers. Instead, they keep pushing to have someone from their cadre appointed as the facility manager, hoping to get favours linked to remuneration, training and day-to-day facility operations for themselves.

In this section, I have explored the interactions within the health workforce and indicated how these influence task-shifting for maternal health services. In the next section, I outline how

collective social entrepreneurship came about in PHC facilities, amid the somewhat tense relationship between the healthcare workers.

6.3 Collective Social Entrepreneurship for Task-shifting

In the preceding sections of this thesis, I alluded to the resource constraints affecting the provision of maternal healthcare services in PHC facilities within the FCT, as reported by participants during interviews and discussions. Despite these resource gaps, the PHC facilities remained functional with healthcare workers delivering maternal healthcare services. In this section, I further elucidate the resource gaps in PHC facilities and examine how these facilities remained functional despite these challenges.

6.3.1 Resource gaps in PHC facilities

The delivery of healthcare services in PHC facilities requires an adequate mix of resources. These resources include healthcare workers, infrastructure, and essential commodities and medicines. Some of the infrastructure needed for PHC facilities to function include electricity, water supply, and road network (Oyekale, 2017). The 2012 Minimum Standards for Primary Health Care in Nigeria stipulates the least amount of human resources, essential drugs and infrastructure required to deliver services at different levels of PHC facilities in Nigeria (NPHCDA, 2012). Despite the clear specifications set by policymakers and regulators regarding these minimum standards, most PHC facilities in the FCT failed to meet the minimum standards of staffing and infrastructure (FCT HHSS, 2021). In Chapter 5, I showed that there were notable health workforce gaps in FCT PHC facilities,

> *'…The reason why we struggle is because of lack of manpower; if there is manpower even in ward, we can handle the labour. We need employment because there is a shortage of manpower in the PHCs.'*
>
> **CHW**

A substantial proportion of the available workforce were not salaried and depended on stipends paid from revenue raised through the collective efforts of the healthcare workers under the leadership of facility managers. The PHC workers also reported that the delivery of services was impacted by gaps in infrastructure, including medical equipment, security, electricity, and water supply.

> *'Like in my own facility, when I was posted there, there was no MVA kit. I had to buy it with my money when I started work. I used my N50,000 naira to buy it, because you cannot work in labour ward without an MVA kit and ambu bag. So, I used my money to buy an ambu bag. I told the in-charge [facility manager] to note that any day I am posted out of this facility, I'm going with my ambu bag, see my receipt. Also, there is no water in my facility, we will be looking for where to buy water. I mean, the thing is too poor.'*

Midwife

Although the task-shifting policy recommends that government provides resources needed for services delivery in publicly owned PHC facilities, limited government funding for PHC, as highlighted by several study participant, resulted in resource gaps in PHC facilities. These resource gaps adversely impacted the delivery of maternal health services. Most of the time, healthcare workers had to improvise, request patients to procure necessary consumables, or purchase essential equipment using their personal or facility funds.

> *'We get our drugs ourselves; it is a challenge. Because had it been we have them in our facility, it will be easier for patients. Now, when the patient comes… especially in the delivery aspect… we write out a list for them to buy a delivery kit. But you would still get to those ones that want to go to buy the kit tomorrow, and the labour started today, and they will now come empty-handed. If you don't have one yourself, you would now be in a crisis, especially during midnight. So, it is a big challenge.'*

Midwife

6.3.2 Group interests, collective action and collective social entrepreneurship

From my interaction with the healthcare workers during the interviews and FGDs, it was clear that they had intrinsic motivation to deliver healthcare services, as they enjoyed the fulfilment of adding social value to their communities by providing healthcare services.

> *'You know, when you meet one person, do almost everything, you satisfy the patient. He goes out there to claim that this hospital is not just this person. He analyses it. 'I like your services. I love everything that you do.' So, it brings glory to all of us.'*
>
> **CHW**

The healthcare workers were also driven by personal goals and incentives that sustained their commitment to the facilities. These individual goals and incentives were associated with their desire for financial compensation, and personal recognition within the community. In addition to the individual goals and interests, the nurses/midwives and CHWs had their group-related (i.e., cadre-specific) goals and interests. The nurses/midwives were particularly invested in safeguarding their professional identity. Both groups wanted to maintain group cohesion and ensure that their members were given opportunities for employment, remuneration/financial gains, leadership in the facilities and community recognition. They competed for these opportunities, as highlighted in the preceding sections regarding professional rivalry. Despite competing for their cadre-specific goals, they recognised their shared interests, and took collective action – working together without coercion, to deliver healthcare services.

Both groups were interested in adding social value to their communities through the delivery of maternal healthcare services, based on their intrinsic motivation to help address the social challenge of limited access to healthcare services. They also valued the recognition that the delivery of maternal health services gave them within the community.

'When you live in a community, and you know what you're doing in the community, and those people in the community they know you, and they like you, and you know your job, even though you're in London they will follow you. Let me give an example in my facility and the nearby community. I know people travel who from far to reach or to assess our facility. Once they come, they will get what they want.'

CHW

The healthcare workers recognised that their remuneration was linked to the functionality of the facilities, as a portion of their income was derived from direct payments made by patients. Irrespective of cadre, these healthcare workers were motivated to attain shared goals – namely, the social value, recognition, and remuneration associated with providing maternal health services.

Despite the presence of rivalry, group-specific interests, and resource gaps, they collaborated to ensure the continued functionality of healthcare facilities and attain their shared goals, while simultaneously pursuing their individual and cadre-specific goals.

'It's all of us. We're not picking only the same nurses or doctors. By the time when there are no doctors or when there are no nurses, who is going to take care of those who are within? So, we are doing teamwork. That is why we have been saying 'health team, we are doing teamwork'; both nurses, doctors, midwives and whatever. We are running shifts; they mix nurses and community health. They mixed nurses and midwives... We are doing collective work.'

CHW

The collaborative efforts of the healthcare workers to attain their shared goals, while striving for their individual and cadre-specific goals, are in accordance with the tenets of collective action theory. Collective action theory focuses on how individuals in small groups with shared interests work together to achieve collective goals, despite potential barriers, such as rivalry (Olson, 1989). The theory alludes to group goals and incentives that drive cooperation within small groups without coercion. The figure below shows the collective action between the nurses/midwives and CHWs toward meeting their individual and group goals and interests.

Figure 9: Collective Action for Maternal Health Services

As represented in the figure above, the healthcare workers (either nurse, midwife or CHW) had personal goals of ensuring they were receiving income from their work in PHC facilities and were recognised for their contributions to the community through the delivery of healthcare services. Within the healthcare facilities, they grouped across their cadre, and now had cadre-specific goals of employment, remuneration/financial gains, leadership in the facilities, and community recognition. While both groups made efforts to attain their cadre-specific goals, it caused competition and professional rivalry that resulted in tension between both. Despite the tension, the nurses/midwives and CHWs worked together (collective action) to meet their shared goals.

The attainment of the shared goals of the nurses/midwives and CHWs depended on the functionality of the PHC facilities, which was threatened by the gaps in human resources, infrastructure and commodities. As such, the healthcare workers were driven to develop innovative approaches to address the resource constraints in a bid to keep their facilities functional. This drive to address the gaps and challenges that impacted the delivery of services through collective action caused them to become *entrepreneurial*. Entrepreneurship involves discovering new ways to combine resources within a firm or a business (Sobel, 2008). Considering the not-for-profit nature

of service delivery in public PHC facilities, it was evident that ‘social entrepreneurship’ was the type of entrepreneurship that would be applicable to address resource gaps in the PHC facilities. In the context of the PHC system in the FCT, the social problem that the healthcare workers sought to address was the limited access to maternal healthcare services. Addressing this social problem aligned with the shared goals of the healthcare workers.

Social entrepreneurship recognises the place of a ‘social entrepreneur’ who is responsible for managing resources to address social problems (Nteere, 2021). However, the entrepreneurial efforts of the PHC workers were a collaborative and not the actions of an individual ‘social entrepreneur’. Rather, the healthcare workers acted as a collective group with shared interests, adopting an entrepreneurial approach to the addressing a social problem, thereby engaging in collective social entrepreneurship. Montgomery et al. emphasised the importance of collaborative action between policy actors and organisations in addressing social problems (Montgomery et al., 2012). They define collective social entrepreneurship as ‘collaboration amongst similar as well as diverse actors for the purpose of applying business principles to solving social problems’ (Montgomery et al., 2012, p. 376).

From my analysis of the study data, it was evident that the PHC workers in the FCT employed the principles of collective social entrepreneurship to maintain the functionality of PHC facilities and tackle the social challenge of limited access to maternal health services in PHC facilities. Through collective social entrepreneurship, the healthcare workers managed available resources and generated more revenue, addressing the prevailing resource gaps in their facilities. Facility managers played a central role in the collective social entrepreneurship with the health workforce, as they provided the leadership and coordination needed to mobilise and manage the financial resources in the PHC facilities.

'They said it is the in-charge [facility manager] that finds a way to make little money to buy some drugs and manage the facility. So, at the end of the month, whatever the PHC generates is what they will use for maintenance.'

CHW

'After buying their own drugs, they can start to treat patients, and that is how the facility generates their own money. And at the end of the month, from the money generated, the in-charge [facility manager] can decide the amount to be paying volunteers. If not, you will see that in a health facility as big as this, some patients will come but will not receive treatment, because there is no drug in the store at all. And that is why they decide to get their own drugs, from which they get the little money they are able to give volunteers as stipends.'

CHW

As part of their managerial role, facility managers were responsible for decisions regarding the engagement of healthcare workers as volunteers in liaison with the local government authorities. The facility managers were also responsible for managing the facility's financial resources to pay volunteer stipends, and provide the essential infrastructure and commodities needed to deliver PHC services.

'Every facility depends on how the in- charge wants to do it. Whatever profit the in-charge [facility manager] makes on what is not the business of the government.'

CHW

In each facility, the in-charge [facility manager] decides the amount to pay volunteers. And on how are they get the money. You know, the government are not bringing drugs to the facilities.., So each facility depends on their in-charge and can decide. When they see that people are coming for treatment, they can gather the little money the facilities have to buy drugs in order to treat patients. After buying their own drugs, they can start to treat patients and that is how the facility generates their own money. And at the end of the month, from the money generated, the in-charge can decide the amount to be paying volunteers If not, you will see that in a health facility as big as this, some patients will come but will not receive treatment.

CHW

Notwithstanding the prominence of facility managers as the 'visible social entrepreneurs', the clinical healthcare workforce contributed to the success of the collective social entrepreneurship that enabled the delivery of PHC services, through their collective action. The intrinsic motivation to address the social problem of limited access to maternal health services drove them to work, seeking to add social value to their communities. The collective resolve of nurse/midwives and CHWs to attain their shared goals facilitated the collective social entrepreneurship that kept healthcare facilities functional.

Accounts from the healthcare workers during the discussions indicated that the collective social entrepreneurship in PHC facilities was an adaptation of the drug revolving fund (DRF). DRFs involve selling medications and medical supplies at their cost price, plus a markup, with the profits going towards restocking inventory while maintaining affordability for those in need (Uzochukwu et al., 2002). The DRF was set up following the 1987 Bamako Initiative, which recommended that the use of government and patient contributions to finance the running costs of PHC facilities and support the unhindered provision of essential medicines and commodities (Uzochukwu et al., 2002).

> *'It depends on what was generated in the month. The revenue generated is shared among volunteers. We operate with the DRF, so that the markup is what we use to pay the volunteers.'*

Nurse

The collective social entrepreneurship that was applied for the delivery of maternal health services was hinged on the concept of the DRF. Health workers mentioned that patients paid user fees at the point of care as part of the DRF. These payments were to offset the cost of drugs, while the government provided the remuneration for healthcare workers, and the infrastructure and commodities needed for service delivery for PHC facilities. To raise additional financial resources

in the healthcare facilities, the DRFs were adapted, with a substantial increase in the user fees paid by patients while accessing healthcare services. As such, patients paid higher user fees than the costs that would have covered the cost of medications and medical supplies. The user fees paid under the collective social entrepreneurship were much higher to cover the cost of essential medicines, commodities, and volunteer stipends. The user fees were also used to cover the costs of basic infrastructural needs and expenses such as payments for electricity, water, and security. Overall, the funds raised from these increased user fees were prioritised for the sustenance of PHC facilities. This revenue was used to ensure that the facilities continued running by addressing the existing resource gaps in manpower, infrastructure and commodities.

Consequently, the term 'DRF' evolved into the *'Facility Sustenance Fund'*, a term I devised, to signify that the revenue generated was *intended to maintain facilities and ensure their continued operation*. The fund was managed by facility managers, who were responsible for ensuring the appropriate allocation of resources. This included guaranteeing the availability of necessary commodities and ensuring that funds were available to pay volunteers' stipends and cover any additional overhead expenses. For instance, facility managers ensured that they accepted only the number of volunteers for whom they could provide stipends, based on the financial resources anticipated to be generated by the facility.

> *'They said it is the in-charge [facility managers] that finds ways to make a little money to buy some drugs and manage the facility. So, at the end of the month, whatever the PHC generates is what they will use for maintenance. So, if they take too many volunteers, they won't have money to pay them, and the old volunteers will be complaining that their money is low.'*

Nurse

Given that the facility sustenance fund resulted in higher user fees being paid by patients, the collective social entrepreneurship in the workforce had implications for equity in access to

maternal healthcare services as the rise in user fees could potentially hinder access to healthcare for individuals unable to afford these costs. In some area councils, such as Abuja Municipal, government officials tried to regulate fees by fixing prices for PHC services. However, many healthcare facilities did not comply with the benchmarked fees, as they aimed to raise substantial resources to enable them to keep facilities running.

> *'We set up a committee and put a benchmark on charges, but like I said, how many are we to be able to supervise these PHCs on regular basis? There are still some PHCs that charge more than the approved benchmark for the cost of these services. When a PHC is reported, we investigate, and if we confirm it is true, we sanction it. But when there is no report, we won't know. So, there are still some PHCs that go behind to charge more than the approved cost of these services because they want to make enough money to be able to offset their bills. If you see the bill that PHCN [electricity company] give to our facilities, you will weep for this country. Some facilities are billed N28,000 a month. That is small facilities. Big ones are expected to pay N30,000, N40,000 or even N50,000 every month for electricity alone.'*

Medical Doctor

As highlighted above, the facility sustenance fund was instrumental in ensuring the continued operation of PHC facilities; however, this was accomplished by transferring increased financial burdens onto patients seeking services in PHC facilities. **Figure 10**, below, illustrates the way the pursuit of both individual and collective interests by healthcare workers culminated in collective action. This, in turn, facilitated collective social entrepreneurship through the establishment of a facility sustenance fund, ultimately facilitating the attainment of health workers' collective goals of adding social value to the communities, receiving community recognition, receiving remuneration, and gaining intrinsic satisfaction.

Figure 10 Collective Social Entrepreneurship for Maternal Health Services

As outlined in this section and shown in the figure above, health workforce interactions led to collective action of healthcare workers to attain their shared goals. This was accomplished through collective social entrepreneurship, which resulted in the establishment of the facility sustenance fund, which was used to keep PHC facilities functional.

6.4 Summary and Conclusion

In this chapter, I have examined additional elements that influence the practice of task-shifting in maternal health services at PHC facilities in the FCT. I highlighted existing gaps in human resources, infrastructure, and essential commodities, and how these gaps shape the interactions among healthcare professionals, fostering collaboration and spur the health workforce towards collective social entrepreneurship.

I highlighted that interactions between healthcare workers in primary facilities impact the delivery of maternal health services. While collaboration was key, relationships between nurses/midwives and CHWs were occasionally collaborative, but mostly antagonistic. These non-collaborative interactions stemmed from professional rivalry, as nurses/midwives sought to protect their professional identity, while competing with CHWs for financial benefits and leadership within facilities. Despite the tense nature of the interactions in the healthcare workforce, they collaborated – driven by a shared vision to address the social challenge of limited access to healthcare services, gain recognition and get remuneration.

I highlighted how the collective action of the healthcare workforce culminated into collective social entrepreneurship that helped address the resource gaps in facilities and keep healthcare facilities functional. The collective social entrepreneurship was steered by facility managers but accomplished through collaboration within the health workforce. I also highlighted how the facility sustenance fund was created to raise resources for healthcare facilities. I indicated that although the facility sustenance fund was beneficial and provided resources for volunteer stipends, needed commodities, and facility overhead costs, it also caused user fees to increase.

Therefore, while antagonistic interactions persist within the health workforce, the overarching goal for collective gains drove healthcare workers to ensure that maternal health services are delivered and sustained through collaborative efforts. This chapter has thus demonstrated that task-shifting for maternal health services is influenced by systemic gaps in PHC facilities and interactions between healthcare workers, with collective social entrepreneurship sustaining the delivery of maternal health services, despite the professional rivalry between nurses/midwives and CHWs.

CHAPTER 7: DISCUSSION

7.1 Introduction

I embarked on my DPhil study to understand the policy and practice of task shifting in Nigeria, focusing on its application for delivering maternal healthcare services within PHC facilities in the FCT. To do this, I designed a qualitative study, underpinned by an IPA framework and used three methods – documentary analysis, interviews and FGDs to generate data which I analysed interpretively. Following a review of the literature in Chapter 2, I identified gaps which led me to specifically design my study on examine the emergence and evolution of task-shifting policies in Nigeria and understand the influences and actors that shape task-shifting practice in FCT PHC facilities. In Chapter 3, I outlined three research questions, listed below:

i. How did the national task-shifting policy emerge, how has it evolved, and what meaning has been ascribed to it?

ii. Which influences and actors have shaped the practice of task shifting for maternal health services in the FCT?

iii. How can the practice of task shifting for maternal health services be improved within the FCT and across Nigeria?

Following the methods outlined in Chapter 3, I made several findings which I outlined in Chapters 4, 5 and 6. In this penultimate chapter, I critically interpret the study's findings in relation to the research questions and offer an informed perspective on task shifting for maternal health services in Nigerian primary healthcare settings, grounded in the evidence and insights generated through this study.

I start this chapter by summarising the study findings and showing the connections between the key elements in the finding's chapters. I interpretively draw from the findings chapters to provide answers to the research questions above, then highlight my broader interpretations of the findings. I finish the chapter by outlining the original contributions of my study, indicating its strengths and limitations; reflecting on my research methods and reflexivity; and proposing potential areas from further research.

7.2 Summary of Findings

In **Chapter 4**, I explored the emergence and evolution of task-shifting policies in Nigeria, identifying key policy actors and their interpretations of the policy. The policy emerged in response to high maternal-mortality rates and health worker shortages, influenced by global recommendations and national efforts, led primarily by government officials and development partners. I identified four interpretive communities: policymakers (optimists), development partners/NGOs (advocates), regulators (guardians), and healthcare workers (practitioners). Each community had its own values and interests that shaped their interpretation of the policy, though the borders of the interpretive communities were not distinct, as there was an overlap of interests and values across them. I also highlighted interpretive symbols relevant to the task-shifting policy and explored how these symbols were ascribed meanings by different interpretive communities.

In **Chapter 5**, I focused on the PHC workforce delivering maternal health services via task shifting in the FCT. I indicated that CHWs form the bulk of the workforce, with few doctors and nurses/midwives in PHC facilities. Many healthcare workers were 'volunteers' without formal contracts or adequate pay. I reported a shortage of healthcare workers with formal employment, the precarious nature of volunteer's engagement, and the low motivation of the workforce. I also highlighted gaps in health workforce training and supervision. Furthermore, I showed that some

healthcare workers were unclear about their roles, and encroached on clinical boundaries for several reasons, some of which are linked to the weakness of the referral system.

I used **Chapter 6** to outline how healthcare workers interacted to deliver services amid limited resources and inter-cadre tensions. I explored the dynamics between nurses/midwives and CHWs, highlighting professional rivalry, including competition over professional identity, financial gains, and leadership roles. Despite these tensions, healthcare workers engaged in collective social entrepreneurship to keep facilities functional through a facility sustenance fund. In this chapter, I emphasised the role of shared interests and collective action in sustaining healthcare delivery despite systemic challenges.

Together, the three findings' chapters reveal an interplay of policy actors' understanding of task shifting, and how their actions (and inactions) influence the task-shifting policy in Nigeria and its practice in the FCT. The practice of task shifting is influenced by the values and interests of the interpretive communities, and impacted by systemic issues, including inadequate resources, workforce shortages, and professional rivalries. Task-shifting practice is often undermined by the realities such as insufficient training, poor supervision, and lack of motivation for healthcare workers. However, healthcare workers demonstrated resilience and innovation through collective social entrepreneurship, adapting to resource constraints, while navigating tensions between cadres. While the healthcare workers managed to sustain service delivery despite resource constraints, the quality and safety of care remained questionable due to unaddressed challenges such as inadequate training, limited supervision and the weak referral system. As such, although collective social entrepreneurship played a key role in sustaining service delivery, it did not ensure adherence to the quality and safety standards articulated in the task-shifting policy. These findings suggest that **task shifting is not being implemented as envisaged in the policy**. Rather, its practice is shaped by need to provide life-saving services, the interests of different policy actors,

the contextual realities that PHC healthcare workers faced and their agency to adapt task shifting to available resources.

Figure 11 below is a schema I developed to represent my understanding of the connections between key elements related to task shifting for maternal health services, based on the findings of my study. The schema indicates that the **four interpretive communities** related to **task shifting for maternal health services in the FCT** have some connections, due to an overlap of some of their interests and values. The interpretive communities interpret and make sense of the policy based on their **interests, values,** and the **meanings** they ascribed to **interpretive symbols**. The **action and inactions of policy actors** are influenced by their interpretation and meaning drawn from policy. These actions and inactions affect **the workforce** (paid staff and volunteers), their **training and supervision**, their **awareness of their roles,** and the **referral systems** for task shifting. Policy actors' interpretation and ascribed meanings of policy also influence the **prioritisation and financing of the PHC system.** In turn, these impact health **workforce employment and remuneration** and the availability of **infrastructure** and **commodities** in PHC facilities. Consequently, prevailing resource constraints cause healthcare workers to collaborate through **collective social entrepreneurship** and sustain the delivery of services through the **facility sustenance fund**.

The arrows in the schema are not intended to be rigid or unidirectional, but to give a sense of my understanding of how the key elements relevant to task shifting are related, and how they shape task-shifting practice. Although the schema appears to indicate a linear relationship between the elements, my study indicates that their relationship is influenced by several considerations, such as differences in meanings, tensions, rivalries and varying interests.

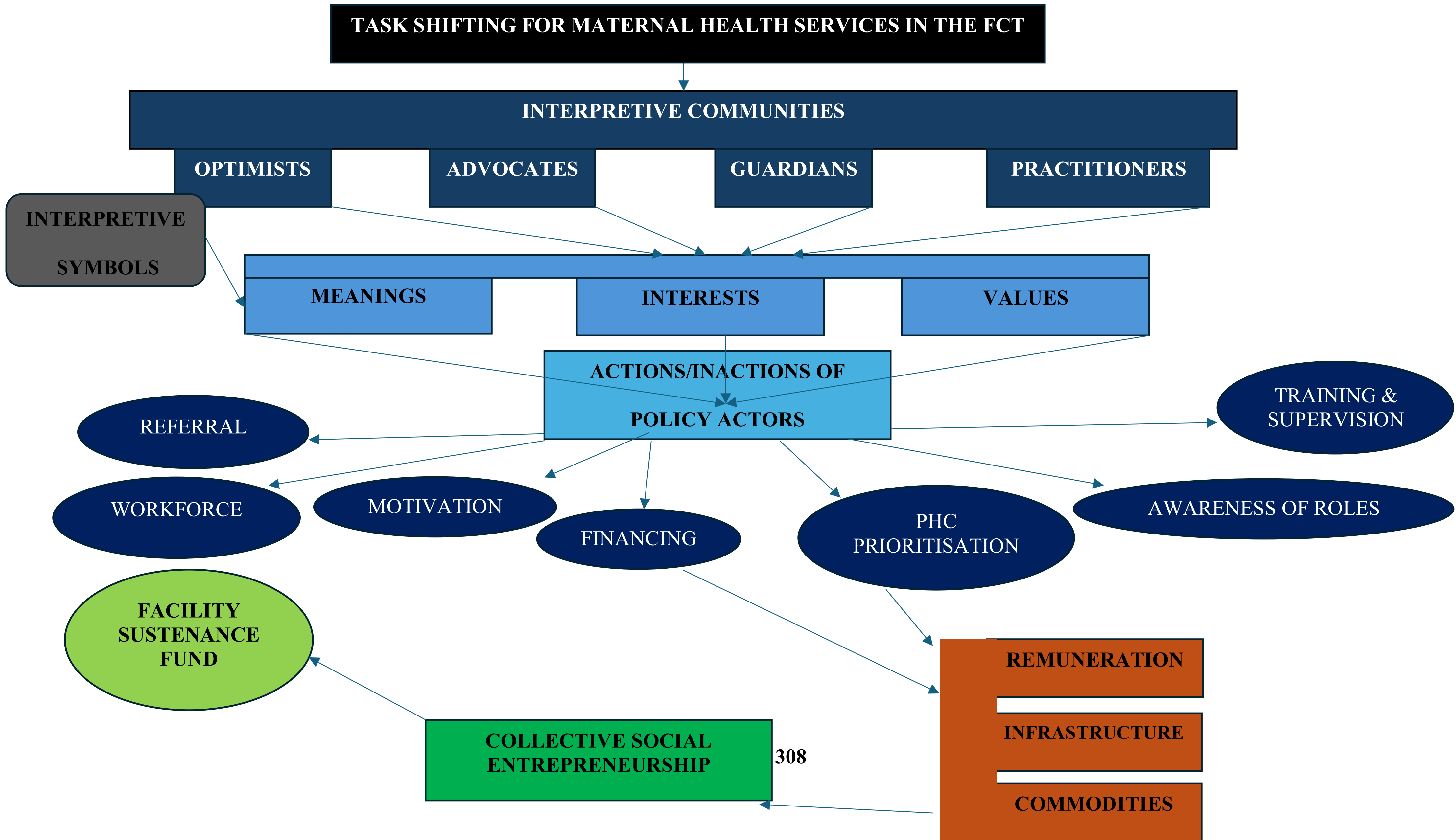


Figure 11: Schema of key elements linked to task shifting for maternal health services

Having presented a summary of the study's key findings, I now draw from my study findings to provide answers to the research question for the study.

7.3 Addressing the Study Research Questions

In this section I provide answers to the first two study research questions, and I provide answers to the third research question in a latter section that is focused on policy recommendations.

7.3.1 Understanding the emergence and the evolution of task-shifting policies

7.3.1.1 Understanding the emergence of the task-shifting policy

This study indicates that the emergence and evolution of the task-shifting policy was a process that involved negotiations across the interpretive communities over time. The global and Nigerian context of high maternal mortality and significant health workforce shortages shaped the discourse before the emergence of the policy, as most policy actors appeared driven to address these two challenges. There were interactions between the interpretive communities as negotiations were being made to justify the need for task shifting and a policy framework to guide its implementation. The dynamics across the interpretive communities showed that the emergence of the policy was resisted by some members (doctors and nurses/midwives) of the interpretive community of practitioners, while the evolution of the policy involved its adaptation to the local context and changing health sector priorities.

Although there was evidence about the limited health workforce and the high maternal mortality in Nigeria, the task-shifting policy did not emerge from 'evidence' alone, but through negotiations, contestation and framing of the problem between interpretive communities. In the context of the limited health workforce and high maternal mortality, task shifting was framed as a rational solution by the interpretive community of optimists (government officials) and advocates (development partners/NGOs), with emphasis on the need to increase efficiency of

the available healthcare workforce, in a bid to increase access to maternal healthcare services. However, some members of the interpretive community of practitioners (healthcare workers) and guardians (regulators) had a slightly different view. Though they agreed with the need for increased access to maternal health services, they viewed task shifting through the lens of patients' safety and quality of care, expressing concerns about the competence of other healthcare workers to deliver shifted services. They also made efforts to prevent the encroachment of clinical boundaries and protect the professional identity of specific healthcare workers (e.g., nurses/midwives). However, other members of the interpretive community of practitioners and guardians did not see task shifting as a threat to patients' safety and quality of care. These members (mainly CHWs) felt 'empowered' by the idea of extending their scope of practice to include services that had been traditionally delivered by doctors and nurses/midwives. As such, they aligned with the views of the interpretive community of optimists and advocates, supporting the idea of task shifting and the subsequent emergence of the policy.

The dynamics between the policy actors in their interpretive communities reflected the influence and power wielded by some of the policy actors, and how these shaped the emergence of the first task-shifting policy. The role of WHO was central to the emergence of the task-shifting policy, as it wielded soft power over healthcare systems policy and priorities in several countries (Kickbusch and Liu, 2022). The influence of WHO began with the publication of the 2006 World Health Report that recommended task shifting and continued through the convening of regional meetings and conferences of task shifting, culminating in its in-country engagement with national level health policymakers in Nigeria. The emergence of the task-shifting policy also highlights the soft power of other development partners and donors who appear as 'external actors', but exert significant influence on decisions made in the health

sector, by embedding technical advisors within government ministries of health, and providing funding for programmes and interventions that they consider to be priorities (Anderson, 2018). In the context of task shifting in Nigeria, actors like WHO, USAID, JHPIEGO and UNFPA were central to the emergence of the policy, as they cited the evidence, nudged national policy actors to action, and funded pilot task-shifting interventions to showcase it as the solution needed to address the healthcare workforce crisis in Nigeria's PHC system (FMOH, 2014). It is also worth mentioning that in several donor-funded vertical programmes being implemented in Nigeria (Abah, 2022), the shortage of healthcare workers impacted their success. Therefore, development partners and donors viewed task shifting as an intervention to improve the operations and outcomes of their vertical programmes.

At the national level, the power play between the policy actors also shaped the emergence of the task-shifting policy. The power structures within the health system were not balanced, as the FMOH had both convening and decision-making powers. The interpretive communities of optimist and advocates wielded significant power through the influence of the FMOH and the development partners, donors and NGOs, formulating the Nigeria's first task-shifting policy despite resistance from some members of the interpretive community of guardians and practitioners. This resistance manifested within task shifting practice, as nurses/midwives tried to protect their professional identity and continued to express reservations about the competence of CHWs, citing gaps in training and patient safety as their main reasons.

7.3.1.2 Understanding the evolution of the task-shifting policy

The evolution of the task-shifting policy was not linear but shaped by the policy actors in interpretive communities exerting their influence based on their interests. As with the emergence of the policy itself, its evolution was mainly driven by the interpretive community of optimists and advocates, as they exerted their influence and identified additional health

sector priorities that could be hinged on task shifting. These priorities included family planning and treatment of NCDS, which were layered onto the task-shifting policy as it evolved. Despite bearing the brunt of an 'expanding' task-shifting policy with increased workload amid resources constraints, the interpretive community of practitioners could not do much to resist this layering of the policy, given their comparatively weaker influence. This indicates the likelihood of further layering of the task-shifting policy in the future by the interpretive community of optimists and advocates.

The evolution of the national task-shifting policy and its adoption in the FCT further highlights the influence of the FMOH on policy directions in the states, as the FCT task-shifting policy was a close mirror of the 2018 national task-shifting policy. This adoption of national policy across the states could be considered advantageous, as it fosters policy coherence across the national health system. However, if policy actors at the sub-national level do not critically appraise national-level policy recommendations before adoption, they may face challenges implementing some policies in their context.

7.3.1.3 Understanding how the task-shifting policy worked for the interpretive communities

Based on the interpretations and meanings ascribed to the task-shifting policy by different policy actors, I reflected on how the policy worked for different policy actors. The interpretive community of optimists (government officials) were interested in showing that the Government was responsive and taking action to address the problems in the health sector. As such, the task-shifting policy worked for the Government, as a symbolic object indicating its response to the health workforce crisis. With that impression created, the Government could afford to do very little regarding the actual implementation of task shifting as suggested by its limited provision of resources for the practice of task shifting in PHC facilities which was highlighted in Chapters 5 and 6. The layering of the task-shifting policy with additional tasks may have

been primarily symbolic to reflect the government's actions to tackle limited access to family planning and NCDs treatment. The layering of the task-shifting policy also suggests that the government believes there is some 'progress' with the task-shifting policy, hence a need to expand its scope and the range of services covered.

The task-shifting policy worked for the interpretive community of advocates, because it legitimised their training of healthcare workers to deliver their services of interest. The task-shifting policy also enabled the development partners and NGOs to report progress to their global offices, as the emergence and evolution of the policy signalled progress towards increasing access to specific healthcare services in Nigeria. This explains the intent behind the technical assistance and pilot interventions on task shifting for specific healthcare services, which usually have limited scope and duration. Once pilot interventions were successfully implemented, the development partners exited the scene, creating an operational, technical and financial vacuum they expected to be filled by the Government. Unfortunately, the Government did not do much to continue task-shifting pilot programmes implemented by development partners and NGOs, thus driving the healthcare workers to do what they could to address the resource gaps in the PHC facilities.

The task-shifting policy yielded both beneficial and somewhat adverse outcomes for the interpretive community of practitioners (healthcare workers). On the positive side, the implementation of the policy legitimised the provision of services by healthcare workers who had, out of necessity, been performing shifted tasks before its formal adoption. The policy also enabled healthcare workers to add social value to their communities, as they potentially increased access to essential healthcare services. In addition, the healthcare workers were able to provide a wide range of healthcare services via task shifting, potentially increasing their opportunities to make formal and informal financial gains from their work. Conversely, the

formulation and enactment of the task-shifting policy negatively impacted the healthcare workers, as it created more room for inter-cadre rivalry. It also increased their workload significantly, since the expansion of services to be delivered via task shifting was not accompanied by a commensurate increase in the number of healthcare workers to meet the increased workload.

Overall, the task-shifting policy worked for the interpretive community of optimists, advocates and practitioners, though it negatively impacted the healthcare workers. Given that the policy evolution has been driven by government officials and development partners/NGOs who gained from the policy, and that the healthcare workers had limited influence, it is likely that the policy will continue to evolve and expand the range of services to be shifted. This may cause the status quo of resource constraints and other challenges to remain, with the healthcare workers continuing to bridge the resource gaps as much as they can, though at the expense of the quality and safety of healthcare.

7.3.2 Influences and actors that shaped the practice of task shifting in the FCT

Reviews of task-shifting literature consistently identify a set of essential prerequisites such as policy guidelines, competency-based training, clear role definitions, supportive supervision, functional referral systems, reliable financing, and effective regulation as critical for task shifting practice. (Baine and Kasangaki, 2014; Colvin et al., 2013; Deller et al., 2015; Leong et al., 2021; Munga et al., 2012; Sunny C. Okoroafor and Christmals, 2023a; WHO, 2012a, 2008a) However, empirical evidence such as the findings of this study and other literature on task shifting indicate that these enabling elements are rarely fully present in LMIC contexts, often undermining the safety and effectiveness of task-shifting interventions.(Ajisegiri et al., 2023; Akeju et al., 2016; Baine and Kasangaki, 2014; Mijovic et al., 2016; Munga et al., 2012; Nzinga et al., 2019; Sunny C. Okoroafor and Christmals, 2023a)

Given that the ideal prerequisites for task-shifting are rarely present in LMICs such as Nigeria, task-shifting practice is frequently shaped by the actions of relevant policy actors and several context-dependent influences. In this section, I discuss the influences and actors that shaped the practice of task shifting for maternal healthcare services in FCT PHC facilities. I start by discussing the actors and then move on to the influences that shaped task shifting.

7.3.2.1 Actors that shaped the practice of task shifting in the FCT.

The practice of task shifting in the FCT was influenced by several actors, which I have categorized as government policymakers, development partners/NGOs, professional associations, regulators, and frontline health workers. I will discuss them briefly below.

Government Policymakers: These are government officials at both the national and FCT levels. They were the primary drivers of the emergence and evolution of the task-shifting policy. Their enthusiasm for the policy was evident in their efforts to institutionalise task shifting through policy documents and strategic plans. As outlined in the task-shifting policy, they are expected to provide the resources required for task shifting in PHC facilities. As members of the interpretive community of optimists, they perceived task shifting was 'working', yet they failed to provide adequate resource to cover the recruitment and remuneration of adequate healthcare workers, and to provide needed infrastructure and commodities. At the Area Council level, government officials influence the practice of task shifting by engaging with facility managers to recruit volunteers, supervising the practice of healthcare workers, and overseeing the operation of PHC facilities, including the appointment of facility managers.

Development partners and NGOs: These actors influence the practice of task shifting by providing technical assistance for the emergence and review of the task-shifting policy, thus shaping practice guidelines. They provide funding for health workers' remuneration and

training and provide commodities to support the practice of task shifting through pilot programmes. They are members of the interpretive community of advocates, and advocate for government to increase prioritisation and funding for the PHC system. They influence task shifting policy and practice evolution in line with the objectives of their organisation and the services they are interested in, reinforcing the vertical approach to the delivery of healthcare services in PHC facilities.

Regulatory Bodies: Officials of regulatory agencies (such as the Nursing and Midwifery Council of Nigeria and the Community Health Practitioners Registration Board of Nigeria) are members of the interpretive community of guardians. They influence task-shifting practice by servicing as the gatekeepers of the practice for each cadre, and have authority to define scopes of practice, accredit training programmes and institutions, and enforce professional standards. However, there is weak coordination between them and the Government regarding the training of healthcare workers, resulting in some regulators questioning the competence of healthcare workers from other cadres after training. They work closely with professional associations to advocate for provision of resources needed for the delivery of essential healthcare services and expressed their concerns about task shifting regarding quality of care and encroachment of professional boundaries. Their weak regulatory capacity impacted task shifting, as their inability to adequately regulate the practice of healthcare workers was outlined as one reason some healthcare workers deliberately crossed clinical boundaries in their practice.

Professional Associations: These are formal groups of healthcare workers (such as the Association of Medical Officers of Health; National Association of Nigerian Nurses and Midwives; and National Association of Community Health Practitioners of Nigeria). They are part of the interpretive community of practitioners and have influenced the emergence and

evolution of task shifting, with some of them (nurses/midwives and doctors) resisting the idea of task shifting, based on concerns about quality of care and professional identity.

They are cadre-specific and protect the cadre-specific interests of their members, while collaborating among themselves to jointly advocate on issues related to their shared interests such as better conditions for healthcare workers, and for the provision of infrastructure and commodities for PHC facilities. They engaged with frontline healthcare workers, informing them about the policy direction of the government, while getting information from them to shape their advocacy meetings and engagements. They also engage with Government policymakers and regulators to influence scope-of-practice decisions, training curricula, and supervisory structures for PHC workers.

Frontline Healthcare Workers: These actors, particularly CHWs, nurses, midwives and doctors were central to the practice of task-shifting in the FCT, as they were the active interpreters of what task-shifting means in real-world settings. They acted as 'street-level bureaucrats', practicing task shifting based on the meanings they ascribed to it, and the resource constraints in their healthcare facilities. They influenced task-shifting practice through their altruism, interested not only in their remuneration, but also in the social value they added to the community, and the attached community recognition. They had cadre-specific interests which often led to competition and rivalry, impacting their practice, training and supervision. However, they had broader shared interests which were impacted by resource constraints in PHC facilities, causing them to act collaboratively to sustain the delivery of services through collective social entrepreneurship. Although they didn't exert much influence on how the task-shifting policy emerged and evolved, they were the lifeblood responsible for task-shifting practice and sustained service delivery in PHC facilities. However, the services they delivered

through by managing available resources were not guaranteed to be safe and of optimal quality since foundational challenges of training, supervision and workload remained unaddressed.

Overall, government officials and development partners were key influencers of task-shifting policy as they formulated policy, provided some resources, and shaped the evolution of the task-shifting policy. Frontline healthcare workers mainly influenced task-shifting practice on the ground as they innovated out of necessity to sustain the delivery of maternal healthcare services.

7.3.2.2 Influences that shaped the practice of task shifting in the FCT

Below, I outline the key influences that have shaped the practice of task shifting based on the findings of my study:

Health Workforce Altruism: This was a key influence that fostered the practice of task shifting. The altruistic ability of healthcare workers to act in best interest of patients and prioritise the needs of patients over self-interest (Sajjad et al., 2021) was evident from their desire to contribute to their communities through the delivery of maternal healthcare services. The altruism of the health workforce is reflected through their intrinsic motivation to ensure that the functionality of PHC facilities was sustained. Further, this altruism made healthcare workers innovate and address prevailing resource constraints through collective social entrepreneurship. This intrinsic motivation to assist community members and patients also explains the finding that healthcare workers were exceeding their scope of practice to help patients *before* the formulation of the task-shifting policy. Health workforce altruism also explains the finding that some healthcare workers overstepped clinical boundaries to help patients, due to the weakness in the referral system. This recognition of health workforce

altruism is consistent with the findings of a systematic review, which identified altruism as a source of intrinsic motivation among healthcare workers (Muthuri et al., 2020).

While healthcare workers were also motivated by the remuneration and recognition associated with providing maternal healthcare services, their altruistic disposition enabled them to endure challenging working conditions and resource limitations. The extrinsic motivation of the healthcare workers was low due to poor working conditions, prevailing resource constraints, meagre remuneration and overwhelming workload. However, their intrinsic motivation drawn from their altruism prompted them to prioritise service delivery and increase access to maternal healthcare services in their communities.

Resource Gaps in PHC Facilities: Task-shifting practice was impacted by resource gaps and the lacklustre attitude of the Government towards PHC in the FCT. Task shifting was practised in resource-constrained settings, an occurrence which was at variance with the policy which recommended that 'essential' requirements for task shifting, such as staffing, remuneration, infrastructure, referral systems and commodities should be in place. Task-shifting practice was impacted by shortage of healthcare workers, limited financial resources for the recruitment and remuneration of healthcare workers, gaps in infrastructure such as water, electricity and security, and limited availability of commodities such as medicines and medical consumables. These resource gaps demotivated the healthcare workers, impacted their training and supervision, and made the work environment less conducive for them.

Healthcare Workers Discretion as Street-Level Bureaucrats: The practice of task shifting was influenced by the discretion of healthcare workers who acted based on their context, interests and interpretation of the task-shifting policy. Task-shifting practice enabled them to add social value to their communities through the delivery of healthcare services and provided

them with a source of livelihood. Driven to attain their individual and group interests, the healthcare workers made task shifting 'happen' by delivering services as best as possible, managing the limited resources at their disposal, and innovating as needed. They navigated the limited workforce by engaging more volunteers, raised financial resources through the facility sustenance fund, circumvented the weak referral system by crossing clinical boundaries, and continued the delivery of services despite gaps in their training and supervision.

The healthcare workers acted as street-level bureaucrats, navigating the complexities of implementing the policy in PHC facilities amid resource gaps, tension and rivalry within the workforce and uncertainty of roles. They were not mere passive implementers of policy, but active agents who shaped how task shifting was practiced and how care was delivered (Lipsky, 1980). The street-level bureaucracy in the health workforce caused healthcare workers to adopt varied approaches to practice task-shifting in different facilities, improving their approach based on their experiences and shared learning. As such, the practice of task shifting was partly guided by the policy framework, but mainly shaped by the healthcare workers adapting to their local context and acting as street-level bureaucrats, as described by Lipsky (Lipsky, 1980).

Professional Rivalry and Hierarchical tensions: These impacted the practice of task shifting as they created a tension between the healthcare workers. The policy did not anticipate that professional rivalry within the workforce would follow the implementation of task shifting, as the policy suggested that healthcare workers would, without hesitation, work together and shift/share roles following policy recommendations. Although healthcare workers managed to collaborate, their competition for cadre-specific interests impacted their practice. For example, in a bid to protect their professional identity, nurses/midwives sometimes prevented CHWs from delivering maternal health services, thus impacting service delivery, and the training and supervision of the CHWs. The practice of task shifting was also shaped by hierarchical tensions

between the workforce, especially between nurses/midwives and CHWs. While CHWs viewed themselves as custodians of PHC facilities and suggested the nurses/midwives should be working in secondary healthcare facilities, the nurses/midwives viewed that they were higher in the health workforce hierarchy than CHWs, and as such should neither be led by CHWs nor regarded as peers.

Meaning-making by interpretive communities: The interpretation and meanings ascribed to the task-shifting policy by the interpretive communities were central influences that impacted the practice of task shifting as it shaped the actions (or inactions) of the policy actors. The interpretive communities of optimists viewed the task-shifting policy as a symbol of Government action to handle the health workforce crisis, but they did not prioritise the financing of the PHC system. The Government did not pay much attention to the *practice* of task shifting, since the formulation and periodic review of the policy had signalled that they were 'making efforts' to improve access to essential healthcare services. Likewise, the interpretive community of advocates (development partners/NGOs) mostly limited their efforts to pilot programmes that signalled they were making efforts to advance access to specific healthcare services. These actions and interpretations impacted the practice of task shifting, as there were inadequate resources available, causing healthcare workers to practice task shifting in resource-constrained healthcare facilities.

Some healthcare workers viewed the task-shifting policy as a symbolic object that legitimised an expansion in their scope of practice. This perception prompted some healthcare workers to extend their scope of practice despite lacking the requisite training and supervision. The periodic review of the task-shifting policy was a symbolic ritual, which further kept the discussion about task shifting at the forefront, signifying the Government's continued interest in addressing health workforce shortages through task shifting. The review of the policy also

helped to meet the interests of the development partners and NGOs, as they facilitated the addition of more services to the 'task shifting vehicle' used to facilitate the delivery of the specific services they were interested in. While there might be some genuine interest for Government and development partners in increasing access to maternal and other health services, I found no accounts of the Government or development partners looking into *how task shifting was actually working*. Rather, the policy continued to evolve, layered with additional healthcare services, without much attention being paid to the healthcare workers expected deliver the shifted tasks. This focus on expanding access to services through task shifting without an assessment of how task shifting was actually working resulted in widening resources and the delivery of services whose quality and safety could not be guaranteed.

Collective Action and Collective Social Entrepreneurship: The ability of the healthcare workers to collaborate to address resource constraints influenced the practice of task shifting. To actualise their shared interests, healthcare workers worked together to raise resources, creating a facility sustenance fund via collective social entrepreneurship. This fund was key to the running of most PHC facilities, as it was used to engage volunteers and pay their stipends, procure essential commodities, and provide the basic infrastructural needs of PHC facilities. Without the facility sustenance fund, the delivery of maternal healthcare services via task shifting would have been significantly hindered, as the workforce, infrastructure and commodity gaps may have been too dire. Although the facility sustenance fund facilitated the practice of task shifting, it also raised the cost of the healthcare services, potentially limiting access to healthcare services for those who could not afford to pay. The higher cost of healthcare services delivered via task shifting could potentially slow progress towards universal health coverage; the overarching goal of the Nigerian healthcare system (Abubakar et al., 2022). Furthermore, collective social entrepreneurship for task shifting expanded access to

healthcare for those who could afford to pay user fees but did that at the expense of the quality and safety of services provided. Although, collective entrepreneurship managed to circumvent the resource constraints in primary healthcare facilities, several fundamental challenges that were key determinants of quality and safety of care such as training, supervision and regulation remained unaddressed.

7.4 Implications for Task-Shifting Policy and Practice

Having discussed the emergence and evolution of the task-shifting policy, and highlighting the influences and actors shaping its practice, I now outline the implication of my findings for the delivery of maternal healthcare services. I have shown in this thesis that the *interpretation*, the *meanings* ascribed to the policy, and the *interests* of policy actors influence the policy and practice of task shifting, shaping their actions and inactions regarding task shifting.

Previous studies have explored other considerations for task shifting in conceptual and implementation frameworks (Das et al., 2024; Sunny C Okoroafor and Christmals, 2023; Orkin et al., 2021; van Schalkwyk et al., 2020). Van Schalkwyk et al. highlight that expanding health worker roles, reallocating tasks and adopting technological innovations would foster task shifting, and stressed the significance of governance, task-shifting evaluation, and patient-centred care to ensure quality and equity (van Schalkwyk et al., 2020). Das et al. propose the SHIFT-SHARE framework, highlighting the importance of stakeholder engagement, ethical considerations, and clinical safety in ensuring that task shifting enhances healthcare quality and access systematically (Das et al., 2024). An implementation framework tailored to the African context emphasises that stakeholder mapping, evidence generation, policy development, training, and monitoring were key for task shifting (Sunny C Okoroafor and Christmals, 2023). (Orkin et al., 2021) stress the need for contextual factors (such as health system readiness and workforce composition) to be considered for the design, implementation, and evaluation of

task-shifting programme. While all these frameworks highlight crucial considerations for task shifting, they have not noted the significance of interpretations, meanings and interests of interpretive communities in shaping task-shifting practice, a key perspective that my study adds to the literature on task-shifting and human resources for health.

Below, I reflect on what the study findings mean for the policy and practice of task shifting within PHC settings in the FCT and Nigeria.

7.4.1 Task-shifting policy evolution, and the disconnect between policy and practice

As the task-shifting policy evolved between 2014 and 2022, the key change in the national task-shifting policy was the expansion of the range of tasks that could be shifted in PHC facilities. However, there was no commensurate effort to increase the human resources required to deliver this expanded range of services. Additionally, there were persistent gaps in the infrastructure, and commodities needed to provide maternal healthcare services in PHC facilities. As such, though the policy evolution had the positive intention of increasing access to services for family planning and NCDs in PHC facilities, it consequently increased the workload for the PHC workforce, as additional healthcare workers were not engaged to meet the increased services offered. This occurenece indicates a disconnect between the evolution of the policy and the on-the-ground realities of task-shifting practice. This increased range of services without a corresponding increase on manpower and other resources had a negative impact on the delivery of maternal health services. It could potentially cause the existing health workforce to deprioritise some maternal health services and/or spend less time on them to meet other service demands, with implications for quality and safety of care.

7.4.2 Training, supervision and role clarity

The findings revealed significant gaps in the training and supervision of healthcare workers involved in task shifting. As highlighted in Chapter 5, there are several reasons for these gaps, including limited funding for PHC in Nigeria, the inadequacy of health workers in PHC facilities, professional rivalry (particularly between nurses/midwives and CHWs), the approach to training and supervision, and the high cost of health workforce training. Inadequacy in the training and supervision of the PHC workforce undermines the competence of healthcare workers, negatively impacting the quality and safety of the maternal health services they deliver.

Given the overlapping roles between nurses, midwives, and CHWs, some uncertainty about roles and the encroachment of clinical boundaries were evident from my study, and these caused tension between the healthcare workers. Ajisegiri et al., 2023 report that, regarding task-shifting for NCDs in Nigerian PHC settings, there was no clarity in the approach to delivering services, as there were variable interpretations of standing orders by CHWs, even though they all had the same document. There is a likely association between the inadequacy in training and supervision of the PHC workforce and the encroachment of clinical boundaries. This association is predicated on the assumption that if healthcare workers are trained appropriately and supervised effectively to deliver services via task-shifting, they will likely have more clarity on their roles and clinical boundaries. Although my study data indicated that some healthcare workers intentionally encroach on professional boundaries, it is likely that with appropriate supervision, such encroachment on professional boundaries would be minimal.

7.4.3. Health workforce shortage, involuntary volunteerism and workforce demotivation

My study showed that the number of health workers (payrolled personnel and volunteers) in PHC facilities was inadequate, relative to the demand for maternal and other essential

healthcare services. This causes the healthcare workers to be overworked, impacting the quality and safety of healthcare services delivered. Aside from the pressure of being overworked, a sizeable proportion of PHC health workers were working under precarious conditions as volunteers, mostly for protracted periods. Although these volunteers were part of the health workforce, they could potentially quit if offered a more guaranteed role elsewhere. If a significant number of volunteers decide to stop work for personal reasons or better opportunities, the delivery of services in PHC facilities would be hampered, as they constitute a significant proportion of the PHC workforce. The possibility of volunteers quitting was evident from my study, as some study respondents explicitly expressed their intention to cease 'volunteering' should they secure better employment opportunities. A study by Okoroafor and Christmals also reported that the shortage of PHC workers was impacting task-shifting in Nigeria's PHC settings (Sunny C. Okoroafor and Christmals, 2023a).

Given that the motivation and job satisfaction of healthcare workers are critical determinants of their performance and retention, my study findings indicate that their low motivation could impact the performance of the PHC workforce. The study found that poor working conditions, inadequate and infrequent remuneration, and the non-contracted nature of volunteer engagement often demotivated healthcare workers involved in task shifting. Inadequate commodities and poor amenities (such as electricity, water, roads, and security) also impacted their motivation. The demotivation of the health workforce could significantly affect the delivery of maternal health services.

7.4.4. Referral system dysfunction

One key finding of this study is the dysfunctional nature of the referral system between primary and secondary healthcare facilities in the FCT. Task-shifting of PHC services requires robust referral systems to enable the timely transfer of patients with complicated cases. Effective

referral systems are also needed for patients whose clinical conditions have deteriorated beyond the competence of the workforce or the resources available in PHC facilities. For example, an anticipated vaginal delivery could become a case of obstructed labour, requiring immediate caesarean section to keep the baby and mother alive. In such a situation, the pregnant woman would need to be immediately referred to a secondary healthcare facility. Another example is a situation in which a mother has severe primary postpartum haemorrhage and requires a blood transfusion. Such a case would require immediate referral to a secondary healthcare facility. My study found that the referral system in the FCT was dysfunctional, due to several issues highlighted in Chapter 5.

Given the potential for some maternal healthcare conditions (such as childbirth complications) to result in maternal death if not appropriately managed, the dysfunctional nature of the referral system poses a huge risk to service users who access maternal health services in FCT PHC facilities. As such, there is a risk that task-shifting of some maternal healthcare services could result in maternal deaths when complications arise. A recent study on task-shifting for NCDs in PHC settings in Nigeria also found weak referral links between primary and secondary healthcare facilities (Ajisegiri et al., 2023).

7.4.5 Healthcare team dynamics and professional rivalry

A mix of cooperation and antagonism characterised interactions between nurses, midwives, and CHWs. While there were instances of collaboration, antagonism stemmed from unclear roles, professional rivalry, and scramble for financial gains from user-fees paid by patients. Nurses and midwives often view CHWs as encroaching on their professional territory, leading to conflicts and power struggles. CHWs viewed nurses/midwives as intruders into PHC facilities, who should be working in secondary healthcare facilities instead, leading to a struggle for leadership between both groups of healthcare workers.

The professional rivalry between nurses/midwives and CHWs caused conflict and tension within PHC facilities and impacted services delivery. These groups of healthcare workers were reluctant to support one another while working within facilities, and the underlying tension impacted their training, supervision, and the broader inter-cadre interactions needed for service delivery. However, they also found common ground to work collaboratively to sustain the delivery of services through collective social entrepreneurship. Similar findings about professional rivalry and tensions linked to task-shifting in Nigeria's PHC facilities have also been reported in the literature (Okereke et al., 2019; Sunny C. Okoroafor and Christmals, 2023a).

7.4.6 Task-shifting, Resource Gaps and Collective Social Entrepreneurship

Healthcare workers need adequate human resources, infrastructure, and commodities to effectively meet the needs of service users at PHC facilities (Sunny C. Okoroafor and Christmals, 2023a). Inadequacy of these resource, combined with professional rivalry in the workforce and limitations in their training, supervision, and motivation have the potential to cause many PHC facilities to become non-functional. However, despite tensions and rivalry, there was collective social entrepreneurship in most PHC facilities, with nurses, midwives, and CHWs working together to sustain service delivery in the face of resource constraints. The concept of collective social entrepreneurship involves collective action and innovation to address social challenges (Montgomery et al., 2012), underscoring the resilience and creativity of healthcare workers acting as street-level bureaucrats. By leveraging their collective strengths and resources, the healthcare workers navigated their differences and resource gaps to ensure that maternal health services were provided. Collective social entrepreneurship is linked to healthcare workers' interest in adding social value to their communities, remaining employed to earn remuneration, and gaining recognition from community members. These interests

caused healthcare workers to make do with poor working conditions and manage the resources at their disposal to sustain the delivery of services.

While the collective social entrepreneurship that keeps PHC facilities running is noteworthy, it has some unintended consequences. First, it results in increased user-fees for maternal healthcare services as patients paid more for healthcare services since revenues raised were used to pay volunteer stipends and provide commodities and amenities, such as security, water, and electricity. These higher user-fees lead to increased out-of-pocket payments for PHC services. They could lead to inequity and impact progress toward universal health coverage as some community members may not be able to afford the cost of maternal health services in PHC facilities, and opt for more affordable informal service providers, such as traditional birth attendants.

Furthermore, working amid significant resource constraints has implications for the quality and safety of the maternal health services provided. With an inadequately trained and supervised workforce without optimal motivation and adequate resources, there is a likelihood that some of the services offered may not be safe or of optimal quality. As such, task shifting with these underlying conditions has the potential to cause harm to some patients or even lead to maternal deaths. This possibility was highlighted by some study participants, who expressed concerns that the approach to task shifting for maternal health services in their facilities could cause harm to some patients.

7.5 Task-Shifting as a Policy Dilemma: Prioritising Quality of Care or Expanding Access to Services

Having outlined the implications of my findings for task-shifting policy and practice, a central policy dilemma emerges from this study: the tension between expanding access to maternal health services through task-shifting and ensuring that such services are delivered safely and

with high quality. This dilemma prompted me to critically reflect on whether task-shifting for maternal healthcare should continue in the FCT primary healthcare facilities. To explore this question, I considered the interests that influenced the emergence of the task shifting policy, the disconnection between the task-shifting policy and on-the-ground practice and the gaps in the competence, training, and supervision of primary healthcare workers. These concerns are compounded by the weakness of the referral system, inadequate regulation of task-shifting practices, and resource constraints in primary healthcare facilities. Considering these shortcomings, it is difficult to guarantee the safety and quality of care, despite the efforts of healthcare workers to sustain service delivery through collective social entrepreneurship. This is because collective social entrepreneurship leaves several key requirements that influence the quality and safety of healthcare services unaddressed. As such, services delivered via task shifting through the ongoing collective social entrepreneurship are likely to be unsafe and of low quality since requirements like training, supervision, role awareness and referral systems were found to be sub-optimal. With substantial gaps in the training and supervision of frontline workers, the robustness of referral systems, and the regulation of clinical practice, I have pertinent concerns about whether ongoing task-shifting can ensure patient safety and reduce maternal morbidity and mortality. This section examines the policy dilemma of whether the Nigerian health system should continue to scale task-shifting as a stopgap measure to expand access, or if greater emphasis be placed on ensuring that the quality of care delivered via task-shifting meets acceptable standards, even if this limits coverage expansion.

The Lancet Global Health Commission on High Quality Health Systems in the SDG Era highlighted the dilemma of striking a balance between expanding coverage of services and optimising the quality and safety of healthcare services.(Kruk et al., 2018; Kruk and Pate, 2020) This dilemma is significant because, while it underscores the imperative for pragmatic

strategies (such as task shifting) to expand access to healthcare services, it simultaneously raises critical ethical concerns regarding the potential exposure of patients to substandard care that could result in harm or even mortality. Universal Health Coverage emphasises not only access to services, but also quality of these services. (WHO, 2010) However, in many low and middle-income countries the increase in access to services is prioritised by policymakers, somewhat leaving healthcare quality optimisation as a secondary consideration.(Kruk et al., 2018) This aligns with the findings of my study in which shows interpretive communities of optimists and advocates promoting task-shifting as a vehicle to increase coverage of essential healthcare services, without a clear prioritisation of the quality and safety of healthcare services. However, advocates of Quality of Care are conservative about expanding coverage of services if the quality of these services are not optimal.(Kruk and Pate, 2020) The focus on the safety and quality of care is critical because low quality and unsafe care can do more harm than good.(Kumah, 2025) This is underscored by the Lancet Commissions finding that of the nine million deaths that occur annually from treatable conditions due to low quality care, 60% occurred in people who accessed these low-quality services but still died regardless. (Kruk et al., 2018)

Two foundational pillars for high quality care are the Workforce and Tools. While the workforce as a determinant of quality of care pertains to the numbers and skills of healthcare workers, tools pertain the equipment, medicines, commodities, data and infrastructure that are available to healthcare workers for service delivery.(Kruk et al., 2018) Given that my study highlights significant gaps in workforce numbers, training and supervision as well as the inadequacy in commodities, medicines and infrastructure available for task-shifting in primary healthcare settings, the services delivered are not guaranteed to be safe and of high quality. The three-delays model for examining the causes of maternal mortality identifies that delays with

the decision to seek care, reaching the healthcare facility and receipt of adequate care at the facility are critical to the occurrence of maternal deaths.(Barnes-Josiah et al., 1998) The quality-of-care argument for task shifting is linked to the third delay (i.e. delay in receiving adequate care at the facility) as healthcare services delivered via task shifting are not likely to be 'adequate' and could lead to adverse outcomes if these services do not meet safety and quality standards.

Although some of the literature on task shifting for maternal and other essential healthcare services suggest that services can be delivered without compromising quality of care (Dawson et al., 2014; Deller et al., 2015; Jennings et al., 2011), my findings indicate otherwise, that the practice of task shifting in resource-constrained settings leads to the delivery of services without guaranteed safety and optimal quality. The occurrence or potential for low quality care associated with task shifting practices has also been reported in previous studies.(Ajisegiri et al., 2023; Joshi et al., 2018; Limbani et al., 2019; Nabudere et al., 2011) Without requisite training, adequate supervision, effective regulation and functional referral systems for task shifting practice in FCT primary healthcare settings, the quality and safety of healthcare services delivered is uncertain. As such, if the conditions were ideal, I would argue that ***the immediate cessation of task-shifting practice for maternal healthcare in FCT primary healthcare facilities*** would be ethically justified to mitigate the potential harm associated with unsafe and low-quality healthcare services. This is because there is a likelihood of preventable patient harm if services are delivered in resource-constrained settings where healthcare workers are overworked, underpaid, poorly motivated, lack requisite training and supervision and operate without effective referral systems, robust regulation and clarity of their roles. My argument is based on my findings and acknowledgement of the importance to quality of care, patient safety and the ethical principles that require the protection of patients from preventable

risk because preventable patient harm affects at least one in 20 patients in medical settings, leading to permanent disability or death in 12% of cases.(Panagioti et al., 2019) The current practice of task-shifting for maternal healthcare in FCT primary healthcare facilities under these resource-constrained circumstances, is akin to a game of Russian roulette, leaving patients to take their chances to see if they access healthcare services without adverse health outcomes arising for unsafe or low-quality care. It is particularly concerning that many patients are unaware of the potential risks associated with receiving maternal healthcare services in these primary healthcare facilities.

A counter argument to my perspective on stopping task shifting would be from a pragmatic standpoint as ***task shifting seems to be the only available option for delivering services amid the prevailing health systems challenges and resources constraints*** in FCT primary healthcare facilities. This pragmatic view would suggest that it may be better for more persons to have access to healthcare services that may be of 'questionable' quality, than for a significant proportion of the population to go without healthcare services. This contrast in the normative and pragmatic arguments reinforces the complexity of the policy dilemma as expanding coverage often entails compromises in quality, and prioritising quality may limit access to healthcare services. Several articles on task shifting acknowledge this compromise of expanding access to essential healthcare services at the expense of quality of care.(Ajisegiri et al., 2023; Deller et al., 2015; Sunny C Okoroafor and Christmals, 2023; Than et al., 2018)

Although this policy dilemma is highly pertinent, it has not received adequate attention from the key actors involved in task-shifting. Addressing the fundamental determinants of quality of care such as comprehensive training, effective supervision, robust regulatory mechanisms, and functional referral systems necessitates a systemic overhaul involving substantive reforms across the health system. However, these reforms are inherently complex and resource

intensive. Hence, policy actors appear to have prioritised the relatively expedient path of expanding service coverage through task-shifting without sufficient attention to the quality and safety of the services being delivered. The Lancet Global Health Commission on High Quality Health Systems highlighted a sense of urgency to expand essential service coverage in LMICs without an explicit focus on quality based on the debatable argument that equitable access for all is better that quality access for few.(Kruk et al., 2018) The findings of this study show that the practice of task shifting in Nigeria's FCT prioritises an expansion of service coverage at the expense of low quality of care.

While the pragmatic position of expanding service delivery is understood, it is imperative that all policy actors involved in task shifting pay more attention to the quality and safety of the services delivered, because increased access to poor quality services may not improve health outcomes. (Kruk et al., 2018) As the Nigerian Government continues to aspire for a significant reduction in maternal mortality, more intentional efforts are needed to ensure that quality healthcare services are delivered via task shifting. To inch closer to safer and higher quality care for task shifting, the government should adopt a clear vision for quality, address systemic challenges that impact on quality and strengthen the health workforce through competency-based clinical education, effective supervision and optimal motivation. (Kruk et al., 2018)

Having highlighted the dilemma of expanding access and optimising quality, I now provide tailored recommendations to improve the policy and practice of task-shifting in the FCT, and potentially across Nigeria.

7.6 Policy Recommendations

Having highlighted the dilemma of expanding access and optimising quality, I now provide tailored recommendations to improve the policy and practice of task-shifting in the FCT, and

potentially across Nigeria. These recommendations are contextually tailored as they are informed by my analysis and interpretation of the study data and draw from existing policy guidelines for task shifting and PHC in Nigeria.

7.6.1 Improving task-shifting policy evolution and connecting policy with practice

The findings of this study underscore the need for policymakers to connect with the on-the-ground realities of task shifting when reviewing policies. My study reflects a disconnect between task-shifting policy evolution and practice. While policymakers were expanding the scope of services that could be delivered via task-shifting, healthcare workers struggled to keep up with the demand for services amid inadequate resources. As such, it is necessary to objectively *evaluate task-shifting implementation, to understand the available resources and healthcare team dynamics*. It is also essential to address the prevailing power imbalances in policy formulation by *ensuring that frontline healthcare workers and regulatory agencies are meaningfully included in policy review processes* with due attention given to their perspectives and professional interests.

7.6.2 Strengthening training and supervision

The study highlights that the training and supervision of healthcare workers are sub-optimal. It is imperative that these are prioritised to ensure the availability of safe and quality maternal health services. The Government needs to allocate more funds to train the health workforce, prioritising the pre-service training of healthcare workers and facility managers should be provided with guidelines for selecting healthcare workers for training. In addition, 'step-down' training should be organised periodically, to fit into the work schedule of healthcare workers who are not nominated to attend in-person training workshops. It is also necessary for policymakers to engage professional associations and regulators to seek alignment on

pragmatic approaches to training and supervision, acknowledging their interests to reduce the rivalry that impacts their work.

7.6.3 Clarifying roles, responsibilities and boundaries

It is essential to clearly define the roles and responsibilities of different health worker cadres to reduce role ambiguity and encroachment of clinical boundaries. This will require engagement between regulators and healthcare workers through their professional associations, with all parties reaching a consensus on the roles and responsibilities of each cadre. Furthermore, adequate training and continuous supportive supervision would enable healthcare workers to remain aware of their roles and operate within their clinical boundaries. It is also necessary for regulatory agencies to be more proactive in sanctioning healthcare workers who deliberately overstep their professional boundaries, as this will deter others from doing so.

7.6.4 Addressing workforce shortages and improving volunteerism

It is crucial that the Government employs more clinical healthcare workers in PHC facilities, to meet the demand for healthcare services, and the expansion of services that can be delivered via task shifting. The government should take deliberate steps to address the precarious status of volunteer health workers in primary healthcare facilities by prioritising them for formal employment as a form of recognition and compensation for their sustained contributions. It is also vital for the Government and development partners to establish funding mechanisms to support the payment of volunteer stipends, and ensure that volunteers receive timely commensurate remuneration, even though they are working temporarily. Furthermore, volunteering in PHC facilities should be formalised, with a maximum duration of volunteering in PHC facilities set to give opportunities for the engagement of new volunteers, and prevent cases of protracted volunteerism.

7.6.5 Enhancing workforce motivation

Improving the motivation and retention of healthcare workers is critical to the implementation of task shifting. Policymakers should institute reward initiatives that recognise the contributions of healthcare workers. Beyond financial incentives, providing adequate training, career development, and professional growth opportunities can enhance job satisfaction and retention. Addressing working conditions, including improving infrastructure, and ensuring the availability of necessary commodities, can further boost the morale of healthcare workers.(Lagarde et al., 2019) As highlighted by the healthcare workers, the prospect of gaining formal employment after volunteering could be a strong motivation for volunteers.

7.6.6 Improving PHC infrastructure and providing commodities

The 2012 Minimum Standards for PHC in Nigeria and the 2023 Standards and Regulatory Framework for PHC Practice in Nigeria clearly outline the human resources, infrastructure, and equipment needs for different levels of PHC facilities in Nigeria. The Government and development partners need to work closely with facility managers to provide the infrastructure and commodities that healthcare workers need to deliver maternal health services as these will improve access to services, motivate healthcare workers, and reduce the user-fees paid by patients.

7.6.7 Improving healthcare team dynamics and reducing professional rivalry

Fostering inter-cadre collaboration is key for task shifting in PHC facilities. As such, policymakers should also consider creating platforms for regular dialogue and communication among healthcare workers: to address conflicts, promote a culture of collaboration, and assure healthcare workers that task-shifting will not undermine their professional identity. Furthermore, there should be clear guidelines on the leadership of PHC facilities to reduce the rivalry linked to facility leadership.

7.6.8 Focusing on quality and safety of services

Mechanisms need to be instituted to define, monitor, and improve the quality of maternal healthcare services in PHC facilities, with a provision of adequate resources for task-shifting practice.(Kruk et al., 2018) This will increase the uptake of maternal health services and reduce adverse outcomes such as incidents of maternal deaths in PHC facilities. It is also essential that efforts are made to strengthen the referral system between primary and secondary healthcare facilities and improve the capacity of regulatory agencies to regulate task shifting practice.

In **Table 7** below, I summarise the recommendations and indicate the policy actors related to each recommendation.

Table 7: Recommendations for improving task-shifting policy and practice

	FOCUS	KEY RECOMMENDATION	RELEVANT POLICY ACTORS
1.	Improving task-shifting policy evolution and connecting policy with practice	Policy should be reviewed based on the lessons learnt from practice and be updated with consideration of the context, influences and resource needs shaping task shifting in PHC facilities	Government officials, development partners and donors, professional associations, regulators, civil society organisation and healthcare workers.
2.	Strengthening Training and Supervision	Efforts should be made to improve training and supervision for task shifting with adequate resources provided.	Government officials, development partners and donors, professional associations, regulators, and healthcare workers.

3.	Clarifying Roles, Responsibilities and Boundaries	Adequate sensitisation of the health workforce should be done periodically to ensure clarity of roles, responsibilities and boundaries.	Government officials, professional associations, regulators, civil society organisation and healthcare workers.
4.	Addressing Workforce Shortages and Optimising Volunteerism	More healthcare workers should be employed with appropriate remuneration of paid staff and volunteers. Volunteers should be formally engaged for a limited period and adequately remunerated.	Government officials, development partners and donors.
5	Enhancing Workforce Motivation	Career advancement and training opportunities, timely promotion, adequate infrastructure, appropriate remuneration and other drivers of motivation should be put in place to enhance workforce motivation	Government officials, development partners and donors, and regulators.
6.	Improving PHC infrastructure and providing commodities	Efforts should be made to improve PHC infrastructure with provide adequate commodities provided to facilitate task shifting.	Government officials, development partners and donors.
7.	Improving Healthcare Team Dynamics and Reducing Professional Rivalry	Inter-cadre collaborations should be fostered with clarity in the guidelines for leadership of PHC facilities.	Government officials, professional associations, regulators, civil society organisation and healthcare workers.

8.	Focusing on Quality and Safety of Services	There should be increased regulatory oversight and stronger referral systems for task shifting with quality and safety of care being a key priority for services delivery	Government officials, development partners and donors, professional associations, regulators, civil society organisation and healthcare workers.

7.7 Original Research Contributions to Academic Literature

This study makes several important contributions to the field of health policy, human resources for health and interpretive research by providing insights into the policy landscape for task-shifting and its practice in primary healthcare settings in Nigeria's FCT. It has made a methodological contribution through a novel application of IPA to study task-shifting, moving beyond rational approaches to uncover how task-shifting policy is understood and contested by various actors. It is the first study that explores task shifting in Nigeria using an IPA framework and has shown that task-shifting policy and practice are shaped by the interests of relevant policy actors and the interpretations and meanings they ascribe to task shifting. By taking an interpretive approach and grounding the study in local meaning-making from the perspectives and experiences of frontline health workers and other key policy actors, this study contributes to a growing body of work that challenges the technocratic views to policy, and advocates for more context-specific and reflexive approaches.

There are gaps in the literature regarding an interpretive understanding of task shifting in Nigeria and its FCT, an understanding of the emergence and evolution of Nigeria's task-shifting policies, and an exploration of the influences that shape the practice of task shifting in the FCT. Through an IPA framework, this study addressed these gaps, highlighting how

Nigeria's task-shifting policy emerged, evolved, and has been interpreted to deliver maternal health services in PHC facilities. It also provides an understanding of how the interpretation and interests of policy actors in interpretive communities' influence task-shifting policy evolution and practice and outlines the dynamics and complexities involved in enacting task-shifting in resource-constrained PHC settings, identifying collective social entrepreneurship within PHC facilities in the FCT.

Furthermore, this study highlights a critical tension between the normative expectation for task shifting and the pragmatic realities that shape task shifting policy and practice. It moves beyond viewing task-shifting as a static solution but rather provides evidence that depicts task-shifting as a dynamic process that evolves in response to the lived realities of healthcare workers and the interests of policy actors. The findings shows that task-shifting, as currently implemented in the FCT, is not likely to meet the safety and quality benchmarks required to prevent adverse outcomes. As such, task-shifting practice may inadvertently perpetuate inequities and increase the risk of harm in primary healthcare settings, particularly for those with limited alternatives. Recognising task shifting continues to remain a key strategy for delivering services in PHC settings amid severe human resource shortages, the findings of this study shed light on the health system gaps and practice adaptations that have occurred in the FCT. Consequently, this study calls for more nuanced and reflective discussions on task shifting through an approach that tries to strike the delicate balance between the aspiration for quality of care and vision to increase access to healthcare services.

Overall, as specific contributions to scholarly research, my study has shown that:

a) The emergence and evolution Nigeria's task-shifting policies and its implementation in FCT PHC settings are influenced by the interests, interpretations,

and meaning-making of policy actors categorised into four interpretive communities (i.e. interpretive community of optimists, advocates, guardians, and practitioners).

b) The practice of task shifting for maternal healthcare in the FCT PHC settings is impacted by the inadequacy of funding, human resources, infrastructure, and commodities for PHC, as well as gaps in training, supervision, PHC referral systems, and workforce motivation.

c) Task shifting in PHC settings is affected by healthcare team dynamics and professional rivalry, particularly between nurses/midwives and CHWs.

d) The resource constraints in PHC facilities inadvertently caused healthcare workers to adapt through collective social entrepreneurship, developing a facility sustenance fund that kept facilities functioning and fostering collaborative practices among healthcare workers.

Overall, this study has advanced the understanding of task shifting in PHC settings in Nigeria and its FCT by highlighting the interplay between the interpretive communities, how their actions and inactions shape task shifting, the systemic challenges and resource constraints impacting task shifting practice and the efforts of the workforce to foster task shifting in PHC settings through collective social entrepreneurship.

7.8 Strengths and Limitations of the Study

While this study offers valuable insights into the policy and practice of task shifting in Nigeria and its FCT, it is important to acknowledge the limitations inherent in the study design and methodology, recognise the strengths of the study, and reflect on my experiences while conducting the study.

7.8.1 Limitations

One limitation of this study relates to my positionality as a medical doctor and policymaker with experience working with the Federal Ministry of Health. This may have influenced the dynamics of my interaction with study participants, particularly healthcare workers from other professional cadres such as nurses, midwives, and community health workers. The perception of my professional identity may have shaped the nature and depth of responses provided, potentially introducing subtle power asymmetries or social desirability bias during interviews and focus group discussions. Another methodological limitation of my study was the exclusion of ethnographic methods, which would have facilitated the direct observation of task-shifting practices in real-life settings. This approach could have further substantiated findings related to resource constraints, health workforce dynamics, and professional rivalry. The exclusion of patients from this study represents a limitation that prevented the capture of first-hand perspectives from service users. As a result, important insights into patients' views on the quality of care, functionality of referral systems, user charges associated with maternal healthcare services, and broader perceptions of task-shifting were not directly explored.

Another limitation of this study is that although the views of doctors contributed significantly to my analysis, I interviewed only three medical doctors who were directly involved in service delivery within the context of task shifting. This limited sample reflects the broader reality that few doctors are deployed to primary healthcare facilities. Nevertheless, the inclusion of additional doctors may have yielded further insights into the influences of task-shifting practices from the perspective of medical practitioners. Since some interviews were conducted virtually or in open-office spaces without guaranteed privacy, the interview setting might have influenced the participants' responses and willingness to share critical opinions.

While FGDs are valuable for capturing group dynamics and collective views, some participants may have been reluctant to express dissenting opinions or may have conformed to the views of more vocal participants, leading to the possible underrepresentation of minority perspectives. Furthermore, there is a chance that some FGD participants' recollections of past events and experiences may be influenced by their current perspectives, emotions, or the passage of time. They could have also yielded to social desirability bias (Bergen and Labonté, 2020), and given responses that they thought would appeal to the group, instead of their own independent opinions.

The organisation of FGDs according to cadre (with nurse/midwives separate from CHWs) may have influenced the discussions, and created an 'us versus them' dynamic, potentially amplifying the sense of professional rivalry expressed during the sessions. Additionally, the timing of data collection for the study shortly after the peak of the COVID-19 pandemic may have influenced the participants' availability and their perspectives on task shifting for maternal health services, since the COVID-19 pandemic impacted access to most essential healthcare services in Nigeria (Abubakar et al., 2022).

7.8.2 Strengths of the study

One key strength of this study is that it is first study to utilise an IPA framework to explore task-shifting policy and practice in Nigeria and its FCT. The interpretive approach allowed for a deeper understanding of the contextual realities and meanings that shape the policy and practice of task shifting in Nigeria. Furthermore, the use of a multiple qualitative methods approach, with reflexive thematic analysis of data from documentary analysis, interviews and FGDs, enhanced the analytic depth of the study. In addition, the participation of a diverse group of policy actors at national and FCT levels also enhanced the credibility and relevance of the findings. The study is also the first to report collective social entrepreneurship within the PHC

workforce and offer some explanations to the sustenance of PHC facilities amid resources constraints.

My positionality as a medical doctor with experience in both clinical practice and health policy is a key strength of this study. This dual perspective provided a nuanced understanding of the structural and operational dynamics of Nigeria's health system and enabled a deeper appreciation of the realities surrounding the delivery of maternal health services, thereby enriching both the interpretation and analysis of the study data. Another key strength of this study lies in its potential for broader theoretical and contextual relevance beyond the immediate study setting. Although the research focused on task-shifting within maternal healthcare services in the FCT, the use of an IPA framework, combined with in-depth, 'thick' description, allowed for the development of findings that are analytically robust and transferable. Given the structural and contextual similarities across the primary healthcare system, the patterns identified in this study are likely to be broadly replicable across other parts of Nigeria. Although local nuances may result in some variation, the core insights into policy-practice disconnects, implementation challenges, and frontline adaptations provide a valuable theoretical contribution with wider applicability in understanding task-shifting dynamics within similar health system contexts. Ultimately, the strength of the study is affirmed through its original contributions to academic scholarship on task shifting and human resources for health.

7.8.3 Reflections

My study provides a framework for viewing task shifting through an interpretive lens, highlighting the meanings, interpretations and interests that influence task-shifting policy and practice in Nigeria and its FCT. Other studies focused on task shifting in Nigeria have applied similar qualitative methods and obtained results that are comparable in some respects. However, the use of the IPA framework brought a unique angle that accounted for some of the

study's distinct findings. I also reflect on the experience of facilitating FGDs as my analysis and interpretations of the study data were shaped by the insights I gained from observing the arguments, agreements, and disagreements during each discussion.

As envisaged in my ethics application, I managed several ethical issues during fieldwork. One memorable situation occurred when a potential interviewee asked; '*What responses do you want me to give you? ...Just tell me the conclusion you would like to make so I can respond accordingly*'. This question raised ethical thoughts about the likelihood of the accounts from that person being objective and reliable, and I decided to interview another person from the same agency instead. Overall, I kept ethical considerations in mind at every phase of the study, adhering to the ethical guidelines recommended by the research ethics committees.

Throughout the study, I acknowledged my identity and positionality, having worked in Nigeria as a clinician and policymaker, remaining conscious of my reflexivity. On further reflection, I also acknowledged the advantage of my insider-outsider status (Bourke, 2014). My insider position allowed healthcare workers to trust me, feeling that I understood their plight, whilst policymakers perceived me as someone who saw things from their perspective. My outsider position made healthcare workers and policymakers view me as a disinterested party with no hidden agenda, just an aspiration to generate evidence on the policy and practice of task shifting. My insider position also shaped my interpretation and analysis, enabling me to develop probing lines of enquiry during interviews and discussions, and quickly comprehend the issues discussed and shaped my analysis.

My venture into academia as a doctoral student has been challenging, yet exciting and transformational. I have gradually learned to see things more interpretively, contrasting with my previous academic and professional thought processes. My immersion in my study data

and adoption of an interpretivist stance for my DPhil led me to understand the significance of salient yet important considerations, such as the meaning, values, experiences, and interests of interpretive communities. This alternative viewpoint allowed me to appreciate the complexities of task shifting policy and practice, and how the interpretations and actions of different policy actors shaped task-shifting practice, as showcased in this thesis.

7.9 Considerations for Further Research

Future research on the policy and practice of task shifting in Nigeria can build on the findings of this study to further explore task shifting using interpretive approaches. Future research should explore the perspectives of patients and community members to get their perspectives on task shifting and quality of care, the referral system and user charges for primary health care services to complement and deepen the findings presented in this study. Future research should incorporate a larger sample of medical doctors to generate wider insights into task-shifting practices from the perspective of those positioned at the intersection of clinical governance and frontline service delivery.

Similar research on the policy and practice of task-shifting for maternal health services should be conducted in other parts of Nigeria and Africa to provide comparative insights and generate further evidence to inform policy decisions on the health workforce. Where feasible, ethnographic methods should be used to explore the practice of task shifting to provide real-time insights into the resource-constraints in PHC facilities and the dynamics between healthcare workers. Future research can also explore specific aspects of task shifting, such as training, supervision, and power relations within the health workforce to get a deeper understanding of their influence on task shifting practice.

7.10 Summary and Conclusion

In this chapter, I have discussed my interpretation of the study findings and outlined the implications of these findings for the policy and practice of task shifting. I have shown how task shifting has worked in the FCT, and the policy actors whose interests are met by the emergence, evolution and implementation of the task-shifting policy. I have highlighted the original contributions of my study, made recommendation for the policy and practice of task shifting, provided considerations for further research, and reflected on experiences conducting this study.

I argued that under ideal conditions, the practice of task-shifting for maternal healthcare should be discontinued, given its limited capacity to ensure the consistent delivery of safe and high-quality services. However, since task-shifting remains a critical strategy for sustaining service delivery amid prevailing resource constraints and systemic challenges, the compromise is that task-shifting continues, but with deliberate emphasis on improving quality of care and intentional efforts to address the gaps identified in this study. Despite its limitations, I have demonstrated that this study offers an original contribution to the literature by illuminating that the policy and practice of task shifting for maternal health service in Nigerian primary healthcare settings are contingent, dynamic, and shaped by the lived experiences, knowledge, contextual realities, and diverse interests of policy actors.

CHAPTER 8: CONCLUSION

8.1. Introduction

In the preceding chapters, I showcased the progression of my study, introducing the fundamental concepts, reviewing the relevant literature, detailing the study's methodology and methods, and presenting and analysing the findings. Through this thesis, I have contributed to the literature, utilising an interpretive lens to provide further understanding on the policy and practice of task shifting in Nigeria and its FCT, highlighting the emergence and evolution of the policy, and outlining the influences that have shaped the practice of task shifting in the FCT. By employing an interpretive policy analysis framework in this study, I contested the rationalist perspective on policy, demonstrating that the task-shifting policy and its practice are socially constructed, and shaped by the interpretations, meanings, and interests of policy actors.

The study also reflects my own journey as a researcher, coming from a positivist background, but learning through my doctoral journey that the interpretive lens offers a unique perspective that considers the lived experiences, contextual realities, meanings, interpretations and values that shape the policy process. In a time when health systems globally are under pressure to do more with less, this research underscores the potential to deliver maternal healthcare services in resource-constrained primary healthcare settings, while emphasising the need to consider the influences that shape the policy and practice of task shifting.

It is imperative that I re-emphasise a key point that emerges from this study: task shifting, as practiced in Nigeria's FCT under significant resource constraints, could do more harm than good. While it provides increased access to maternal and other essential healthcare services, such access may lead to adverse outcomes for patients. This argument is grounded in ethical principles that place a premium on patient safety and the delivery of high-quality care.

Although the policy aspiration to expand access through task shifting is understandable, it should be matched by an equal commitment to ensuring the safety and quality of healthcare services. I recognise the complexity of the dilemma that policymakers face in balancing quality and access, yet I argue that this dilemma must not be used to normalise or institutionalise what was initially intended to be a temporary measure. Task-shifting, as originally conceived, was designed to serve as a stopgap solution to bridge immediate human resource gaps until health systems could be strengthened to produce, retain, and equitably deploy the health workforce necessary for effective service delivery. Consequently, I call upon all relevant policy actors in Nigeria's primary healthcare system to re-engage with the foundational intent of the policy. Task-shifting should not become a permanent feature of the health system simply because it is expedient; rather, it should be understood as a transitional strategy that has to be gradually phased out as systems mature.

Intentional and sustained efforts are needed to ensure that the primary healthcare system in the FCT and across Nigeria is adequately financed and supported to provide the human resources, commodities, and infrastructure required for optimal service delivery. Given the limited fiscal space for health and competing government priorities, calls for increased investment and system strengthening may appear aspirational. Nevertheless, they are essential in reminding all policy actors that a future without task-shifting in Nigeria's primary healthcare system is both possible and worth envisioning. Envisioning a world beyond task-shifting is a strategic imperative that can catalyse the policy and institutional reforms necessary to build a more resilient, equitable, and high-performing primary healthcare system. In the following section, I present an imagined scenario that illustrates what such a future might look like within Nigeria's primary healthcare system.

8.2 Imagining a Future Beyond Task-Shifting: A Vision for Nigeria's PHC System

Having raised important questions about the sustainability, safety, and quality of care associated with the practice of task-shifting and notwithstanding my critical stance calling for its cessation, I have also considered what a future might look like if task-shifting were to function not as a temporary fix, but as a catalyst for positive and long-term health system transformation. In alignment with the original conception of task-shifting as an interim solution to address health workforce gaps, I have developed the fictional vignette below to illustrate an imagined future in which Nigeria's primary healthcare system has matured beyond the need for task-shifting.

Box 8: Vignette envisioning a future primary healthcare system beyond task-shifting

It is a humid Monday morning in July 2040 at Dutse-Bmuko Health Centre, a mid-sized primary healthcare facility in a peri-urban district of Nigeria's FCT. The clinic bustles with patients, but the sense of chaos that once defined mornings has faded. A team of healthcare workers review a partograph, conclude that the patient in the maternity wing has obstructed labour and call the facility ambulance to immediately transfer her to the Garki General Hospital for a caesarean section. The team comprises four healthcare workers: a midwife, community health officer, a family physician, and a recently inducted nurse trained in advanced obstetrics. Mama Natasha, the facility manager smiles while watching the team from a distance and recalls a time when such harmony across healthcare workers cadres was an uncommon sight. On her tablet, she reviewed the monthly maternal health data showing 98% skilled birth attendance, zero maternal deaths recorded and 100% continuity of antenatal care over the past 18 months. A chart on the wall showed the facility staffing ratio which exceeded the national target for five years running. The revolving fund still existed, but it is no longer relied upon for essentials like gloves or sutures. Supply chains, once fragile, had been restructured through a national

logistics platform powered by a mix of public and donor investments. Task shifting, which had been the lifeline of the facility in the 2020s, now played a minimal role, confined to emergency backup protocols.

Mama Natasha recalled that the road to this point had been anything but smooth. As a junior CHEW back in the 2020s, she worked with other unsalaried volunteer healthcare workers to deliver babies under candlelight, improvising with outdated training, and working without supportive supervision, clarity of roles and a responsive referral system. Although the quality of care remained sub-optimal and the workload overwhelming amid resource constraints, task shifting continued. Nevertheless, policymakers were beginning to respond to calls for task-shifting to be leveraged as a means of building a more resilient primary healthcare system. Things began to change after the national health workforce reform initiative in 2026. The federal government, spurred by years of advocacy and mounting evidence, launched the Health Workforce Renewal Act. It was built on the failures and successes of task shifting. Drawing on research from across the country, the reform prioritised investment in rural training colleges, improved remuneration for healthcare workers, expanded internship placements, and the fast-tracking of volunteer health workers into formal employment, ensuring that their experience was respected rather than exploited.

By 2030, all primary healthcare facilities were required to operate with at least one certified midwife and one physician associate on rotation, supported by digitized supervision systems. The Basic Health Care Provision Fund had been strengthened and complimented government funding to adequately finance the primary healthcare system, providing all needed infrastructure and commodities for service delivery. The informal economy of maternal healthcare that was dependant on the facility sustenance fund gradually gave way to institutional stability as primary healthcare facility were adequately resourced. Mama Natasha

had since received two advanced diplomas in emergency obstetrics and midwifery leadership. She was no longer considered a volunteer and "stop-gap" solution, but a permanent, respected part of the healthcare team. These successes were built on the backbone of task-shifting which remained visible, though it had evolved. Task-shifting had become a principle of teamwork and was at the core of interactions between the healthcare workers. Each cadre knew their role, received adequate training, and worked within a culture of respect and accountability. The lines between cadres still existed, but they were bridges, not barricades. More importantly, the community trusted the primary healthcare system more, having renewed confidence in the healthcare workers and the referral system.

Mama Natasha stood up and looked at a plaque on the wall that commemorated the facility's first Safe Delivery Certification, achieved in 2032 after a national maternal audit and regulatory reform process. Below it, a quote was etched: *"We shifted tasks because we had no choice. We built systems so that our dream of maternal healthcare for all becomes a reality".* She smiled again, reflecting on how far the primary healthcare system had come, evolving from task-shifting with resources constraint to a resilient and sustainable system. The journey from survival to sustainability spanned nearly two decades, but it began with the collective courage of policy actors to envision a better future and to work diligently toward its realisation.

The imagined future of a world beyond task shifting depicted above does not ignore the political and economic constraints that define healthcare delivery in low-resource settings like Nigeria's FCT. It acknowledges the tensions, dilemma and trade-offs between quality and coverage and affirms the value of task shifting as an emergency strategy while maintaining optimism that the primary healthcare system can evolve beyond it. As this thesis has shown, the way task shifting is implemented matters. When driven solely by cost-effectiveness, coverage metrics or the interests of policy actors, it risks entrenching inequities. But when

designed with a long-term view, rooted in the lived realities of frontline healthcare workers and guided by principles of equity, quality of care, and professional development, it can be a foundation for transformation. The vignette is fictional, but the aspiration it reflects is not. It is a call to all policy actors in Nigeria's FCT to look beyond present-day challenges and work collaboratively towards a future with a resilient primary healthcare system that has evolved beyond task-shifting.

8.3 Epilogue

To conclude this chapter and finalise this thesis, I reflect on recent efforts to address human resource gaps and increase access to maternal health services in Nigeria's primary health care system. In May 2024, the Honourable Minister of Health and Social Welfare, Dr Muhammed Ali Pate, announced the renovation of 8,300 primary healthcare facilities across Nigeria to make them fully functional to deliver maternal and other essential healthcare services. He affirmed his commitment to the strengthening of referral systems and confirmed that 2,400 primary healthcare workers had been recruited, with the training of 120,000 frontline healthcare in progress. (Anyanwu, 2024). These ministerial commitment and proposed activities align with some of the recommendations in this thesis, indicating that my doctoral research on task-shifting for maternal healthcare services in primary healthcare settings is relevant and timely. However, beyond efforts to employ healthcare workers and provide needed infrastructure and commodities, it is crucial that the Government considers the interpretations and interests of the key policy actors involved in task shifting. It is also essential that there are roundtable discussions between the Government, development partners, regulators and the professional associations of healthcare workers to enable them to align on the realities of implementing task shifting, noting the key influences that shape task-shifting policy and practice. I look forward to stimulating such discussion, drawing from the findings

of this study, which I will disseminate through stakeholder engagement meetings, blog posts, peer-reviewed publications and conference presentations.

This thesis explored the critical role of task-shifting in Nigeria's primary healthcare settings, shedding light on the complex dynamics, challenges, and opportunities inherent in this approach. Given the prevailing shortage of healthcare workers, task shifting remains a strategy worth exploring to increase access to essential healthcare services in Nigeria's primary healthcare settings. Addressing the challenges identified in this study such as inadequate training and supervision, dysfunctional referral systems, and inter-cadre tensions does not guarantee that task shifting will be successful. However, acknowledging the complex dynamics between the health workforce, and understanding the interpretations, interests and incentives that influence the actions and inactions of policy actors would be crucial for enhancing the quality and accessibility of essential health services delivered via task shifting. Ultimately, these will contribute to broader initiatives and reforms aimed at strengthening Nigeria's primary healthcare system.

My experiences conducting my doctoral research and writing this thesis have been enlightening and humbling. I am optimistic that the insights from this study will inform the policy and practice of task shifting in Nigeria and other countries with similar contexts. Ultimately, this study should serve as a wake-up call for all policy actors in Nigeria's primary healthcare system to move beyond the narrow, rationalist view of task-shifting, to envision a resilient healthcare system that no longer depends on task-shifting, and to work collaboratively to ensure that the vision of timely access to quality maternal healthcare services becomes a reality.

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APPENDICES

APPENDIX I: DETAILED SEARCH STRATEGY

	Preliminary search: 17/06/2022	
	Global Health <1973 to 2022 Week 24>	
1	maternity services/ or prenatal care/	8065
2	exp family planning/ or reproductive health/	19889
3	(mnh or mch or (maternal adj3 (health* or care or service?))).ti,ab.	15044
4	((maternity or pregnancy or pregnant or prenatal or pre-natal or pre-part* or pre-part* or antenatal or ante-natal or perinatal or peri-natal or peripart* or peri-part* or intrapart* or intra-part* or obstetric or birth or postnatal or post-natal or postpart* or post-part*) adj3 (service? or care or healthcare)).ti,ab.	19078
5	((maternity or pregnancy or pregnant or prenatal or pre-natal or pre-part* or pre-part* or antenatal or ante-natal or perinatal or peri-natal or peripart* or peri-part* or intrapart* or intra-part* or obstetric or birth* or postnatal or post-natal or postpart* or post-part*) adj3 (clinic? or centre? or center? or ward? or unit? or visit?)).ti,ab.	11751
6	((family planning or reproductive or contracept* or abortion or preconception or pre-conception or prepregnan* or pre-pregnan*) adj3 (service? or counsel* or care or healthcare)).ti,ab.	6397
7	((family planning or reproductive or contracept* or abortion or preconception or pre-conception or prepregnan* or pre-pregnan*) adj3 (clinic? or centre? or center? or unit? or visit?)).ti,ab.	1618
8	1 or 2 or 3 or 4 or 5 or 6 or 7	56531
9	task shifting/	39
10	community health workers/ or medical auxiliaries/ or traditional birth attendants/	7928
11	(task* adj3 (shift* or shar* or delegat* or allocat* or reallocat*)).ti,ab.	1015
12	((extend* or expand*) adj3 (role? or responsib*)).ti,ab.	849
13	(skillmix or (skill* adj3 mix*)).ti,ab.	157
14	(((birth or midwife*) adj2 (attendant? or assistant?)) or doula?).ti,ab.	1763
15	(((community or village or primary health) adj3 worker?) or chw? or chew? or phcw?).ti,ab.	6659
16	((physician? or nurs*) adj2 assistant?).ti,ab.	784

17	((nonspecialist* or non-specialist or nonphysician or non-physician or non-nurs* or non-nurs* or nonclinical or non-clinical or nonmedical or non-medical) adj2 (assistant? or worker? or personnel or practitioner? or staff* or support)).ti,ab.	519
18	(substitut* adj3 (physician? or doctor? or obstetrician? or clinician? or clinical staff* or nurse* or midwife or midwives or worker? or practitioner? or personnel or staff*)).ti,ab.	56
19	9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18	16402
20	Nigeria/	34740
21	(nigeria or Lagos or Abuja or Port-Harcourt or Kano or Ibadan or Kaduna or Katsina or Enugu or Delta or Bauchi).ti,ab,in,gl.	60343
22	20 or 21	60343
23	8 and 19 and 22	251

Appendix I: Detailed Search Strategy in Ovid Global Health

APPENDIX II: FACILITIES SAMPLED IN EACH AREA COUNCIL

ABUJA MUNICIPAL	BWARI	KUJE
Garki 1 PHC	Dutse Alhaji PHC	Kuje PHC
Garki 2 PHC	Dutse Makaranta PHC	Kuchiyako PHC
Kabusa PHC	Dawaki PHC	Tukpechi PHC
Shiretti PHC		
Pyakasa PHC		

Appendix II: Facilities sampled in each local area council

APPENDIX III: INTERVIEW GUIDES

IMPROVING TASK-SHIFTING FOR THE DELIVERY OF MATERNAL HEALTHCARE SERVICES

POLICY STAKEHOLDERS INTERVIEW GUIDE

(Estimated duration – 60 minutes)

Version 2.0, 24th May 2022

1. Can you start by telling me about your current role: where you work and what you do? In what ways does your current role relate to task shifting?

2. What place does task-shifting have in the Nigerian health system? What about its place in the delivery of maternal health services within primary healthcare settings?

3. How and why have policies and guidelines for task-shifting been developed? How are they changing?

4. How has task-shifting policy shaped the delivery of maternal health services within primary healthcare settings?

5. What are the main benefits and challenges of putting task-shifting into practice?

6. Task-shifting aside, what else do you think has influenced collaboration amongst health workers involved in delivering maternal health services in primary care settings? How, if at all, has this connected with task-shifting policy and guidelines?

7. How can task-shifting for the delivery of maternal health services in primary healthcare settings be improved?

8. Do you have anything else you would like to talk about relating to task-shifting?

IMPROVING TASK-SHIFTING FOR THE DELIVERY OF MATERNAL HEALTHCARE SERVICES

HEALTH WORKERS INTERVIEW GUIDE

(Estimated duration – 60 minutes)

Version 2.0, 24th May 2022

9. Can you start by telling me about your current role: where you work and what you do? In what ways does your current role relate to task shifting and the delivery of maternal health services in primary care settings?

10. How have the personnel in your facility worked together to deliver healthcare services? What place does task-shifting have in the healthcare facility where you work? What about its place in the delivery of maternal health services?

11. How have policies and guidelines for task-shifting influenced the delivery of maternal health services in the facility where you work? How have these policies and guidelines changed?

12. What are the main benefits and challenges of putting task-shifting into practice based on the experience in the healthcare facility where you work?

13. Task-shifting aside, what else do you think has influenced collaboration amongst health workers involved in delivering maternal health services in the healthcare facility where you work? How, if at all, has this connected with task-shifting policy and guidelines?

14. How can task-shifting for the delivery of maternal health services in primary healthcare settings be improved?

15. Do you have anything else you would like to talk about relating to task-shifting?

APPENDIX IV: FOCUS GROUP DISCUSSION GUIDES

IMPROVING TASK-SHIFTING FOR THE DELIVERY OF MATERNAL HEALTHCARE SERVICES IN NIGERIA

FOCUS GROUP DISCUSSION GUIDE

(Estimated duration – 120 minutes)

`Version 2.0, 24th May 2022

16. Who provides maternal healthcare services in this facility? How do they work together?

17. What does the term ‘task-shifting’ mean to you?

18. What role (if any) has task-shifting played in the delivery of maternal healthcare services in your facility? What tasks, if any, have shifted; and why?

19. Again, focusing on maternal health services in your facility, in what ways do you think task shifting has shaped or changed:
    a. patient care
    b. the way you interact with other clinicians.

20. Task-shifting aside, what else do you think has influenced how you work together to deliver maternal health services? How, if at all, has this connected with task-shifting policy and guidelines?

21. Individually and as a group, what are the top 3 messages about policy on task-shifting you would like to feed back to policy makers responsible for formulating task-shifting policies?

22. What are the challenges of task-shifting? Can you give me some examples?

23. What else might be done to improve the way those providing maternal health services in your facility work together?

24. Do you have anything else you would like to talk about relating to task-shifting?

APPENDIX V: PARTICIPANT RECRUITMENT EMAIL AND LETTERS

PARTICIPANT RECRUITMENT EMAIL

Dear XXXX

I am a DPhil candidate based at the Nuffield Department of Primary Care Health Sciences at the University of Oxford. I am conducting a study aimed at understanding the policy and practice of task-shifting in Nigeria and generating evidence that can be used to improve the use of the task-shifting approach for the delivery of maternal healthcare services in the Federal Capital Territory (FCT) and across Nigeria. My study is funded by the Commonwealth Scholarship Commission in the United Kingdom.

I am contacting you because you have been identified as a stakeholder who has been involved in the policy and/or practice of task-shifting for delivering maternal healthcare services in Nigeria/Federal Capital Territory based on your role in the ………………. I believe that having been involved in the formulation, monitoring, supervision, or implementation of policies and guidelines that are relevant to task-shifting for maternal healthcare services, your participation in the study will provide valuable insights.

Your participation in the study will involve being interviewed for not more than 60 minutes. The interview is planned to be in-person but could be virtual if necessary and will be arranged at a time and venue that is convenient for you.

Further information about participating in the study can be found in the attached Participant Information Sheet.

I would be grateful if you could reply to francis.ayomoh@phc.ox.ac.uk if you consider taking part in the study.

If I do not hear from you, you will receive a reminder in two weeks to give you some further time to consider taking part. If you do not wish to receive a reminder or do not wish to take part, please do let me know and l will not contact you again

Thank you very much for your consideration.

Best regards,

Francis Ayomoh

INVITATION TO PARTICIPATE IN AN INTERVIEW FOR A STUDY FOCUSED ON IMPROVING TASK-SHIFTING FOR MATERNAL HEALTH SERVICES IN NIGERIA

I am a DPhil candidate based at the Nuffield Department of Primary Care Health Sciences at the University of Oxford. I am conducting a study aimed at understanding the policy and practice of task-shifting in Nigeria and generating evidence that can be used to improve the use of the task-shifting approach for the delivery of maternal healthcare services in the Federal Capital Territory (FCT) and across Nigeria. My study is funded by the Commonwealth Scholarship Commission in the UK.

XXXXXXX has been identified as a critical institution with strategic roles and strong influence on the policy and/or practice of task-shifting for delivering maternal healthcare services in Nigeria and the Federal Capital Territory. Given the participation and/or influence of your Institution on the policy and/or practice of task-shifting for the delivery of maternal health services, a representative of your Institution is hereby invited to participate in the study and provide valuable insights that can be used to improve the use of the task-shifting approach for the delivery of maternal health services in Nigeria.

The study focuses on a Human Resources for Health topic (task-shifting for maternal health services in primary healthcare settings), hence I would be grateful if, based on your best judgement, the most suitable Officer is nominated to participate in the study on behalf of your institution.

The participation of the XXXX in the study will involve an Officer being interviewed for not more than 60 minutes. The interview is planned to be in-person but could be virtual if necessary and will be arranged at a time and venue that is convenient for the nominated Officer. The anonymity of the interview participant is guaranteed in line with standard ethical practice and all data from the study will be handled confidentially.

Further information about participating in the study can be found in the attached Participant Information Sheet. Also attached is evidence of ethical approval from the University of Oxford, the National Health Research Ethics Committee and the FCT Health Research Ethics Committee.

I look forward to a response at your soonest convenience and can be reached via francis.ayomoh@phc.ox.ac.uk or 08065683004.

Thank you very much for your consideration.

Best regards,

Dr Francis Ayomoh

APPENDIX VI: PARTICIPANT INFORMATION SHEETS

IMPROVING TASK-SHIFTING FOR THE DELIVERY OF MATERNAL HEALTHCARE SERVICES IN NIGERIA

OxTREC Reference Number: 531-22

PARTICIPANT INFORMATION SHEET – INTERVIEWS

Version: 1.0, 8th June 2022

You are invited to take part in the above-mentioned research project because you are involved in the policy or practice of delivering maternal health services in Nigeria. This research is being conducted by the primary researcher as part of the requirement for completing a DPhil in Primary Health Care.

Before you decide if you would like to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

Why is this research being conducted?

Nigeria faces a pressing health workforce shortage with inadequate health workers and maldistribution of human resources for health at all levels but particularly in primary healthcare settings. This human resource gap has been linked to reported high maternal mortality rates with Nigeria accounting for about 20% of global maternal deaths. Task-shifting - a strategy adopted in Nigeria since 2014 - is recommended to address health workforce shortages and increase access to healthcare services. This study aims to understand the policy and practice of task-shifting for the delivery of maternal health services in Nigeria. The study is focused on understanding how healthcare workers interact to deliver maternal health services (such as ante-natal care, childbirth, and family planning) within primary healthcare settings, and the influence (or not) of task-shifting policies and guidelines on the delivery of maternal health services. Overall, Overall, we hope that this study will generate evidence that can be used to improve the use of the task-shifting approach for the delivery of maternal healthcare services in Nigeria.

Why have I been invited to take part?

You have been identified as:

- A stakeholder involved in the formulation, regulation, implementation, or monitoring of policies and guidelines that enable healthcare workers to collaborate towards delivering maternal health services using the task-shifting and task-sharing approach.
  OR
- A healthcare worker involved in delivering maternal healthcare services within primary healthcare settings in the Federal Capital Territory in Nigeria.

You have been invited to take part in this study because of your role in the delivery of maternal health services within primary healthcare settings through policy and/or practice. , We want to learn about your perspective and experiences regarding the delivery of maternal healthcare services within primary healthcare settings in Nigeria.

Do I have to take part?

No. It is your choice to take part and you can ask questions about the research before deciding whether to take part or not. If you do agree to take part, you may withdraw yourself from the study at any point without specifying a reason. Unless you specify otherwise, any data we have collected before you withdraw will be retained in the study.

What will happen to me if I take part in the research?

You will be invited to take part in an interview with the lead researcher (**Francis Ayomoh**) to be arranged at a time and place that suits you. If it is not possible for you to be interviewed in person, the interview can be conducted virtually (either via Microsoft teams or a phone call). The interview is expected to last about 45 minutes and will not exceed 60 minutes.

If you agree to take part, you will be asked to give informed consent. You will be given a consent form to sign about 48 hours before the interview or on the day of the interview depending on your availability. The interview will take up to one hour. During the interviews, you will be asked questions about your views about task-shifting policies and guidelines, the collaboration and interaction between healthcare workers involved in delivering maternal health services, and opportunities for improving the way(s) in which health workers collaborate/interact to deliver maternal health services. You do not need to prepare your answers in advance of the interview.

With your consent, we will make an audio recording of the interview. You can also ask to pause or stop the interview at any time or withdraw from the study completely even after the interview has commenced.

Your contributions may be used in published research based on the study findings, and we may use quotes from your contribution, but if so, they will be anonymized (to come from a general category, e.g., “a government official” or “a frontline healthcare worker”).

What are the possible disadvantages and risks of taking part?

There is a minor risk that you might be identifiable as the individual who has given us a particular statement when this is used in work that we publish – something which may or may not be of concern to you. To reduce this risk, we will be careful to attribute quotes to broad categories of individuals and not to use any statement which could only have been made by a particular individual. The actual record of what you say will be securely stored and accessible only to members of the project team.

The main disadvantage is that you will offer us some of your time, but we will arrange the interview at a time and place convenient to you.

Are there any benefits in taking part?

While there are no immediate benefits for you, the intention is that this research will lead to improvements in the policy and practice of task-shifting for maternal health services in Nigeria. Your participation in the research will enable you to contribute to the generation of evidence and allow you to play a key role in addressing the issues of health workforce shortages that are limiting access to maternal healthcare services within primary healthcare settings in Nigeria. There will be no payment for taking part in this study.

What information will be collected and why is the collection of this information relevant for achieving the research objectives?

The information that will be collected for the study will include **research data** and **personal data**. The information you provide during the study is the **research data**. Any research data from which you can be identified, such as your name, your email address, and a recording of an interview with you, is known as **personal data**.

The main research data that will be collected will be your views regarding the policy and practice of task-shifting for the delivery of maternal health services in primary health care settings in response to the interview questions. This information will be gotten from the audio-recording of the interviews.

Only the supervisors of the lead researcher and staff at the University of Oxford involved in analysing, handling, and managing research data will have access to personal and research data.

If a third-party provider is engaged to provide transcription services, they will have access to the audio recording of the interview. They will be expected to meet the criteria specified by the University of Oxford and be under the same obligations of confidentiality as the researchers. The transcription service provider will have access to the audio recording of the interview for the period they are transcribing the audio recording and will permanently delete the audio files from their servers once the transcription is completed. All transfers of data will be done securely through the secure Oxfile system (hosted by Oxford University IT Service) and files will be encrypted, and password protected before being transferred.

Personal data will be stored in the secure servers of the University of Oxford. These will be retained until the study has concluded. The audio recording of the interview is also personal data but will only be retained until the transcription of the audio files is completed. Immediately after all audio files from the discussion are satisfactorily transcribed, they will be permanently deleted from the University of Oxford servers, the devices of the research team and the servers of the transcription service provider.

Other research data (including consent forms) will be stored for at least 3 years after publication or public release of the work of the research. The researchers will have access to the research data. Responsible members of the University of Oxford may be given access to data for monitoring and/or audit of the research.

Research and personal data (name and contact details, audio recordings, transcripts, consent forms) will be stored in an encrypted computer at the University of Oxford. Audio recordings stored as password-protected files will be transcribed and destroyed after the transcripts have been checked for accuracy and anonymized by a member of the research team. The original audio recording will then be destroyed by deletion. Personal data (name and contact details) will be kept separately from the transcripts until the end of this project

Will the research be published? Could I be identified from any publications or other research outputs?

The research will be written up as part of the DPhil thesis of the primary researcher and efforts will be made to ensure that all study participants are anonymized. A copy of the DPhil thesis/ dissertation will be deposited both in print and online in the Oxford University Research Archive where it will be publicly available to facilitate its use in future research.

The findings from the study will also be published in academic publications, with summaries and updates being made available on the Nuffield Department of Primary Care Health Sciences website. Research findings will also be disseminated through conference presentations and policy briefs and may be disseminated widely using social media channels.

It may be possible for participants to be identifiable from the outputs as the individual who has given us a particular statement. Care will be taken to minimize the possibility of this as quotes will be attributed to broad categories of individuals and not to use any statement which could only have been made by a particular individual.

Data Protection

The University of Oxford is the data controller for your data, and as such will determine how your data is used in the study. The University will process the data for the research outlined above. Research is a task that is performed in the public interest. Further information about your rights concerning your data is available at https://compliance.admin.ox.ac.uk/individual-rights.

Who is funding the research?

The Research is being funded by the Commonwealth Scholarship Commission in the UK.

Who has reviewed this study?

This study has received ethics approval from a subcommittee of the Oxford Tropical Research Ethics Committee (OxTREC) at the University of Oxford, **(OxTREC Reference Number: 531-22).** The study has also received ethics approval from the National Health Research Ethics Committee (**NHREC reference: NHREC/01/01/2007-20/06/2022)** and the FCT Health Research Ethics Committee (**FHREC reference: FHREC/2022/01/96/28-06-2022)**.

Who do I contact if I have a concern about the research or I wish to complain?

If you have a concern about any aspect of this study, please contact ***Francis Ayomoh (francis.ayomoh@phc.ox.ac.uk, +2348065683004)*** *and/or the study Principal Investigator* ***Associate Prof. Sara Shaw (sara.shaw@phc.ox.uk)*** *and we* will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with.

If you remain unhappy or wish to make a formal complaint, please contact the **National Research Ethics Committee, Nigeria** via email (deskofficer@nhrec.net) or post (NHREC Administrative Officer Department of Health Planning and Research, Federal Ministry of Health 11th Floor Federal Secretariat Complex Phase III PMB 083, Abuja).

Further Information and Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact **Francis Ayomoh** via email **(francis.ayomoh@phc.ox.ac.uk)** or phone at **+234 8065683004**.

IMPROVING TASK-SHIFTING FOR THE DELIVERY OF MATERNAL HEALTHCARE SERVICES IN NIGERIA

OxTREC Reference Number: 531-22

PARTICIPANT INFORMATION SHEET – FOCUS GROUP DISCUSSION

Version: 1.0, 8th June 2022

You are invited to take part in the above-mentioned research project because you are involved in the policy or practice of delivering maternal health services in Nigeria. This research is being conducted by the primary researcher as part of the requirement for completing a DPhil in Primary Health Care.

Before you decide if you would like to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

Why is this research being conducted?

Nigeria faces a pressing health workforce shortage with inadequate health workers and maldistribution of human resources for health at all levels but particularly in primary healthcare settings. This human resource gap has been linked to reported high maternal mortality rates with Nigeria accounting for about 20% of global maternal deaths. Task-shifting - a strategy adopted in Nigeria since 2014 - is recommended to address health workforce shortages and increase access to healthcare services. This study aims to understand the policy and practice of task-shifting for the delivery of maternal health services in Nigeria. The study is focused on understanding how healthcare workers interact to deliver maternal health services (such as ante-natal care, childbirth, and family planning) within primary healthcare settings, and the influence (or not) of task-shifting policies and guidelines on the delivery of maternal health services. Overall, Overall, we hope that this study will generate evidence that can be used to improve the use of the task-shifting approach for the delivery of maternal healthcare services in Nigeria.

Why have I been invited to take part?

You have been identified as a healthcare worker involved in delivering maternal healthcare services within primary healthcare settings in the Federal Capital Territory of Nigeria.

You have been invited to take part in this study because of your role in the delivery of maternal health services within primary healthcare settings through policy and/or practice. We want to learn about your perspective and experiences regarding the delivery of maternal healthcare services within primary healthcare settings in Nigeria.

Do I have to take part?

No. It is your choice to take part and you can ask questions about the research before deciding whether to take part or not. If you do agree to take part, you may withdraw yourself from the study at any point, without specifying a reason. Unless you specify otherwise, any data we have collected before you withdraw will be retained in the study.

What will happen to me if I take part in the research?

You will be invited to take part in a focus group discussion which will be moderated by the lead researcher (**Francis Ayomoh**) and arranged at a time and place that suit you and all the other discussion participants. The focus group will be made up of 8 – 12 healthcare workers (nurses, midwives, or community health workers) who are likely to be from the same facility as you. The focus group discussion is expected to last about 90 minutes and will not exceed 120 minutes.

If you agree to take part, you will be asked to give informed consent. You will be given a consent form to sign about 48 hours before the discussion or on the day of the discussion depending on your availability. The discussion will take up to two hours. During the focus group discussion, you will be asked questions about your views about task-shifting policies and guidelines, the collaboration and interaction between healthcare workers involved in delivering maternal health services, and opportunities for improving the way(s) in which health workers collaborate and interact to deliver maternal health services. You do not need to prepare in advance for the discussion.

With your consent, we will make an audio recording of the discussion. You can also ask to leave the discussion at any time. However, any data collected before withdrawal may still be used as part of the study.

Your contributions may be used in published research based on the study findings, and we may use quotes from your contribution, but if so, they will be anonymized (to come from a general category, e.g., “a government official” or “a frontline healthcare worker”).

What are the possible disadvantages and risks of taking part?

There is a minor risk that you might be identifiable as the individual who has given us a particular statement when this is used in work that we publish – something which may or may

not be of concern to you. To reduce this risk, we will be careful to attribute quotes to broad categories of individuals and not to use any statement which could only have been made by a particular individual. The actual record of what you say will be securely stored and accessible only to members of the project team. There is a slight and unlikely risk that incidental findings (eg malpractice) may have to be reported to the appropriate authorities.

The main disadvantage is that you will offer us some of your time, but we will arrange the discussion at a time and place convenient to you and the other discussants.

Are there any benefits in taking part?

While there are no immediate benefits for you. The intention is that this research will lead to improvements in the policy and practice of task-shifting for maternal health services in Nigeria. Your participation in the research will enable you to contribute to the generation of evidence and allow you to play a key role in addressing the issues of health workforce shortages that are limiting access to maternal healthcare services within primary healthcare settings in Nigeria. There will be no payment for taking part in this study however light refreshments will be provided after the discussions and reasonable local transportation costs will be reimbursed.

What information will be collected and why is the collection of this information relevant for achieving the research objectives?

The information that will be collected for the study will include **research data** and **personal data**. The information you provide during the study is the **research data**. Any research data from which you can be identified, such as your name, your email address, and a recording of a discussion with you, is known as **personal data**.

The main research data that will be collected will be your views regarding the policy and practice of task-shifting for the delivery of maternal health services in primary health care settings in response to the discussion questions. This information will be gotten from the audio recording of the discussions.

Only the supervisors of the lead researcher and staff at the University of Oxford involved in analysing, handling, and managing research data will have access to personal and research data.

If a third-party provider is engaged to provide transcription services, they will have access to the audio recording of the discussion. They will be expected to meet the criteria specified by the University of Oxford and be under the same obligations of confidentiality as the researchers. The transcription service provider will have access to the audio recording of the discussion for the period they are transcribing the audio recording and will permanently delete the audio files from their servers once the transcription is completed. All transfers of data will be done securely through the secure Oxfile system (hosted by Oxford University IT Service) and files will be encrypted, and password protected before being transferred.

Personal data will be stored in the secure servers of the University of Oxford. These will be retained until the study has concluded. The audio recording of the discussion is also personal data but will only be retained until the transcription of the audio files is completed. Immediately after all audio files from the discussion are satisfactorily transcribed, they will be permanently deleted from the University of Oxford servers, the devices of the research team and the servers of the transcription service provider.

Other research data (including consent forms) will be stored for at least 3 years after publication or public release of the work of the research. The researchers will have access to the research data. Responsible members of the University of Oxford may be given access to data for monitoring and/or audit of the research.

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Will the research be published? Could I be identified from any publications or other research outputs?

The research will be written up as part of the DPhil thesis of the primary researcher and efforts will be made to ensure that all study participants are anonymized. A copy of the DPhil thesis/ dissertation will be deposited both in print and online in the Oxford University Research Archive where [it will be publicly available to facilitate its use in future research.

The findings from the study will also be published in academic publications, with summaries and updates being made available on the Nuffield Department of Primary Care Health Sciences website. Research findings will also be disseminated through conference presentations and policy briefs and may be disseminated widely using social media channels.

It may be possible for participants to be identifiable from the outputs as the individual who has given us a particular statement. Care will be taken to minimize the possibility of this as quotes will be attributed to broad categories of individuals and not to use any statement which could only have been made by a particular individual.

Data Protection

The University of Oxford is the data controller for your data, and as such will determine how that data is used in the study. The University will process the data for the research outlined above. Research is a task that is performed in the public interest. Further information about your rights concerning personal data is available at https://compliance.admin.ox.ac.uk/individual-rights.

Who is funding the research?

The Research is being funded by the Commonwealth Scholarship Commission in the UK.

Who has reviewed this study?

This study has received ethics approval from a subcommittee of the Oxford Tropical Research Ethics Committee (OxTREC) at the University of Oxford, **(OxTREC Reference Number: 531-22).** The study has also received ethics approval from the National Health Research Ethics Committee (**NHREC reference: NHREC/01/01/2007-20/06/2022)** and the FCT Health Research Ethics Committee (**FHREC reference: FHREC/2022/01/96/28-06-2022)**.

Who do I contact if I have a concern about the research or I wish to complain?

If you have a concern about any aspect of this study, please contact ***Francis Ayomoh (francis.ayomoh@phc.ox.ac.uk, +2348065683004)*** *and/or the study Principal Investigator* ***Associate Prof. Sara Shaw (sara.shaw@phc.ox.uk)*** *and we* will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with.

If you remain unhappy or wish to make a formal complaint, please contact the **National Research Ethics Committee, Nigeria** via email (deskofficer@nhrec.net) or post (NHREC Administrative Officer Department of Health Planning and Research, Federal Ministry of Health 11th Floor Federal Secretariat Complex Phase III PMB 083, Abuja).

Further Information and Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact ***Francis Ayomoh*** *via email* ***(francis.ayomoh@phc.ox.ac.uk) or phone at +234 8065683004***.

APPENDIX VII: INFORMED CONSENT FORM

NUFFIELD DEPARTMENT OF
PRIMARY CARE
HEALTH SCIENCES
Medical Sciences Division
Radcliffe Observatory Quarter, Woodstock Road, Oxford, OX2 6GG

Principal Investigator: Professor Sara Shaw | sara.shaw@phc.ox.ac.uk
Primary researcher: Francis Ayomoh (DPhil Candidate) | francis.ayomoh@phc.ox.ac.uk
Oxford University telephone number: 01865 617855

IMPROVING TASK-SHIFTING FOR THE DELIVERY OF MATERNAL HEALTHCARE SERVICES IN NIGERIA

OxTREC Reference Number: 531-22

Purpose of Study: This study aims to understand the policy and practice of task-shifting in Nigeria and generate evidence that can be used to improve the use of the task-shifting approach for the delivery of maternal healthcare services in Nigeria.

CONSENT TO TAKE PART IN A STUDY

Version 1, 8th June 2022

	Please initial each box if you agree with the statement
I confirm that I have read and understand the participant information sheet **Version 1** dated, **8th June 2022** for the above research. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any point without giving any reason.	
I understand who will have access to personal data provided, how the data will be stored, and what will happen to the data at the end of the project.	
I understand the extent to which I could be identifiable from any publications, or reports that will be produced from the study.	
I consent to be audio recorded.	
I understand how audio recordings will be used in research outputs.	
Use of quotations: Please indicate your preference (select *one* option):	
a) I do not wish to be quoted. **or**	
b) I agree to the use of quotations in research outputs if I am not identifiable.	

I give permission for you to contact me again to clarify information. ☐

I understand how to raise a concern or make a complaint. ☐

I agree to take part. ☐

______________________	dd / mm / yyyy	______________________
Name of participant	Date	Signature

______________________	dd / mm / yyyy	______________________
Name of person taking consent	Date	Signature

APPENDIX VIII: PARTICIPANT ENROLMENT POSTER

NUFFIELD DEPARTMENT OF
PRIMARY CARE
HEALTH SCIENCES
Medical Sciences Division

Radcliffe Observatory Quarter, Woodstock Road, Oxford, OX2 6GG

Principal Investigator: Professor Sara Shaw | sara.shaw@phc.ox.ac.uk
Primary researcher: Francis Ayomoh (DPhil Candidate) | francis.ayomoh@phc.ox.ac.uk
Oxford University telephone number: 01865 617855

IMPROVING TASK-SHIFTING FOR THE DELIVERY OF MATERNAL HEALTHCARE SERVICES

Ethics Approval Reference:
OxTREC:
531-22
NHREC:
NHREC/01/01/2007-20/06/2022
FCT HREC:
FHREC/2022/01/96/28-06-2022

VOLUNTEERS NEEDED TO PARTICIPATE IN A STUDY

We are conducting a study on the policy and practice of task-shifting for maternal healthcare services in the Federal Capital Territory (FCT), Nigeria.

We are looking for healthcare workers involved in the delivery of maternal health services (ante-natal care, childbirth, post-natal care, family planning, etc) in **primary healthcare facilities** within **Kuje, Bwari, and Abuja Municipal Area councils** to tell us their views by taking part in a focus group discussion that will last up to 2 hours and take place between August and December 2022.

We are particularly interested in hearing from you if you are a **nurse, midwife, or community health worker** providing services in a primary healthcare facility.

If you are interested and would like more information, please contact the lead researcher, **Francis Ayomoh,** via email at francis.ayomoh@phc.ox.ac.uk or call him on **08065683004**.

You can kindly share this with your friends and colleagues who may be able to participate in the study.

Thank you!

APPENDIX IX: ETHICAL APPROVAL LETTERS

Oxford Tropical Research Ethics Committee

University of Oxford
Research Services, Research Governance, Ethics & Assurance
Boundary Brook House, Churchill Drive, Oxford OX3 7GB
Tel. +44 (0)1865 (2)82106
E-mail: oxtrec@admin.ox.ac.uk

Associate Professor Sara Shaw
Nuffield Department of Primary Care Health Sciences
Radcliffe Observatory Quarter
Woodstock Road
Oxford OX2 6GG

20 June 2022

Dear Professor Shaw

Full Title of Study: Improving Task-Shifting for the Delivery of Maternal Healthcare Services: A Multi-Method Case Study of Policy and Practice in the Federal Capital Territory in Nigeria

OxTREC Reference: 531-22

Thank you for your email of 20 June 2022, and for your updated documentation.

I am pleased to confirm that approval has now been granted for this study. This is valid for the planned duration of the study as detailed in the application and is subject to receiving local ethical approval (if this approval has not yet been received).

The documents approved for this study are as follows:

Documents:	Version:	Date:
Study Protocol – Task-Shifting for Maternal Health Services	1.0	8 June 2022
Participant Information Sheet - Interview	1.0	8 June 2022
Participant Information Sheet – Focus Group Discussion	1.0	8 June 2022
Informed Consent Form	1.0	8 June 2022
Interview Guide – Healthcare Workers	1.0	8 June 2022
Interview Guides – Policy Makers	1.0	8 June 2022
Focus Group Discussion Guide	1.0	8 June 2022
Flyer Advert – Task-Shifting for Maternal Health Services	1.0	8 June 2022
Participant Recruitment Email – Task-Shifting for Maternal Health Services	1.0	8 June 2022
Follow Up - Participant Recruitment Email – Task-Shifting for Maternal Health Services	1.0	8 June 2022

Any subsequent changes to the application must be submitted to the Committee as an Amendment. This should include a letter to give the reasons for the proposed modifications and all revised documents with changes tracked.

Please ensure that you submit a completed Annual Report form on every anniversary of this approval and a final End of Study Report. The relevant forms can be found on the OxTREC website.

Finally, please note the following **important information**:

Data safety—all studies
It is the responsibility of the PI to ensure that all data collected during the course of the study is stored and transferred safely and securely. Further guidance and advice are available from the Research Data Team.

Only studies that will involve storing human tissue samples in Oxford
If you are planning to import the samples into England, you will need to make arrangements before the samples are transferred to store them under the governance of a Human Tissue Authority (HTA) licence. It is a legal requirement that any tissue or fluid made up of or containing human cells to be used for the purpose of research is stored on premises licensed by the HTA unless covered by an exemption. OxTREC approval is not a recognised exemption. Further information may be found on the University's human tissue governance web pages.

Yours sincerely

DocuSigned by:

BA168DF4624B463...

Dr Karen Melham
Sponsorship and Ethics Lead

for
Research Ethics Manager, OxTREC

National Health Research Ethics Committee of Nigeria (NHREC)

Promoting Highest Ethical and Scientific Standards for Health Research in Nigeria

Federal Ministry of Health

NHREC Protocol Number NHREC/01/01/2007-27/06/2022
NHREC Approval Number NHREC/01/01/2007-20/06/2022
Date: 20th June, 2022

Re: Improving Task-Shifting for the Delivery of Maternal Health Service: A Multi-Methods Case Study of Policy and Practice in the Federal Capital Territory

Health Research Ethics Committee (HREC) assigned number: NHREC/01/01/2007

Name of Student Investigator: Dr Francis Ifeanyi Ayomoh

Address of Student Investigator: Nuffield Department of Primary Care Health Science
Radcliffe Observatory Quarter
Woodstock Road, Oxford Ox26GG
University of Oxford
Email: francisayomoh@gmail.com
Tel: +2348065683004

Date of receipt of valid application: 27/06/2022

Date when the final determination of research was made: 20-06-2022

Notice of Expedited Committee Review and Approval

This is to inform you that the research described in the submitted protocol, consent form, advertisement and other participant information materials have been reviewed and *given expedited committee approval by the National Health Research Ethics Committee.*

This approval dates from 20/06/2022 to 19/06/2023. If there is a delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study.* In multiyear research, endeavour to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code.

The HREC reserves the right to conduct a compliance visit to your research site without previous notification.

Signed

Professor Zubairu Iliyasu MBBS (UniMaid), MPH (Glasg.), PhD (Shef.), FWACP, FMCPH, FFPH(UK)
Chairman, National Health Research Ethics Committee of Nigeria (NHREC)

FEDERAL CAPITAL TERRITORY

Health Research Ethics Committee

Research Unit, Room 10 Block A Annex, HHSS, FCTA Secretariat,
No. 1 Kapital Street 11, Garki, Abuja-Abuja.

Notice of Research Approval
Approval Number: FHREC/2022/01/96/28 - 06 -22

Full Study Title:	**Improving Task-Shifting for the Delivery of Maternal Healthcare Services: A Multi-Method Case Study of Policy and Practice in the Federal Capital Territory in Nigeria.**

Principal Investigator: **Francis Ifeanyi Ayomoh**

Address of Principal Investigator: No 4A Ademola Awosika Street, Kubwa Extension III, Kubwa, Abuja - FCT, Nigeria.

Date of receipt of valid application: 27/05/2022

The FCT Health Research Ethics Committee (FCT HREC) has approved the research described in the above stated protocol.

This approval is valid from **28/06/2022** to **27/06/2023**.

Note that no activity related to this study may be conducted outside of these dates. Only the FCT HREC approved informed consent forms may be used when written informed consent is required. They must carry FCT HREC assigned protocol approval number and duration of approval of the study. The FCT HREC reserves the right to conduct compliance visit to your research site without prior notification.

The National Code of Health Research Ethics requires the investigator to comply with all guidelines, rules and regulations regarding the conduct of health research, and with the tenets of the code.

Modifications: Subsequent changes are not permitted in this research without prior approval by the FCT HREC.

Problems: All adverse events or unexpected side effects arising from this project must be reported promptly to FCT HREC.

Renewal: This approval is valid until the expiration date. If this project is to proceed beyond the expiration date, an annual report should be submitted to FCT HREC early in order to request for a renewal of this approval.

Closure of Study: At the end of the project, a copy of the final report of the research should be forwarded to FCT HREC for record purposes, and to enable us close the project.

For further information contact FCT HREC office. I wish you best of luck with your research.

Desmond Emereonyeokwe
Secretary, FCT HREC
June 28, 2022