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Combining task shifting and community-based care to improve maternal health: Practical approaches and patient perceptions

Jennifer J.F. Hosler*, Jasmine A. Abrams, Surbhi Godsay

University of Maryland, Baltimore County, Department of Psychology, 1000 Hilltop Cir, Baltimore, MD, 21250, USA

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ABSTRACT

Globally, community-based care and task shifting strategies are used to address maternal healthcare shortages in low-income countries. Limited research exists on models that combine these strategies. Using a qualitative approach, we explored Haitian women's perceptions of the Midwives for Haiti model, which unites task shifting and community-based care by training nurses as skilled birth attendants and offering healthcare via rotating, mobile clinics. Eight focus groups ($N = 52$) were conducted in rural Haiti in March 2017. Thematic analysis of data indicated that perceptions of care were universally positive. Participants cited accessible patient-centred care, affordable services, and health education as primary motivators to attend. Results illustrated the importance of women's perceptions on the future use of mobile clinic sites or other formal care. Future efforts to address maternal healthcare shortages should consider the Midwives for Haiti model, combining task shifting and community-based care to address common social, topographical, or financial barriers to maternal healthcare.

1. Introduction

Despite being one of the highest aid-receiving countries in the world, Haiti continues to experience high rates of maternal deaths. As the poorest country in the Western Hemisphere, Haiti experiences a shortage and an inequitable distribution of health resources, contributing to health outcomes for Haitian women that are among the worst in the world (World Health Organization, 2014). Haiti's 2013 maternal mortality ratio (MMR) was 380 deaths per 100,000 live births and the lifetime risk of dying from complications from childbirth was 1 in 83. Further, Haiti's MMR was much higher than the 2013 global MMR—210 maternal deaths—and was one of only two countries with high MMR outside of sub-Saharan Africa (World Health Organization, 2014).

High MMR in low-income countries has been explained by various systemic factors, including: limited accessibility to care, inadequate facilities, lack of trained practitioners at multiple skill levels (doctors, nurses, or skilled birth attendants), low percentage of prenatal and postnatal visits, high-risk deliveries in ill-equipped facilities, and delays in emergency care seeking (Barnes-Josiah et al., 1998; Kassebaum et al., 2014; Pacagnella et al., 2012). Numerous strategies are used globally to combat these issues. For example, task shifting—a capacity-building technique which equips individuals to fulfil healthcare roles typically served by those with advanced education—is recommended by the World Health Organization [WHO] as a cost-effective strategy for addressing healthcare worker shortages (Seidman and Atun, 2017; WHO, 2008). Community-based care is also cited as an effective approach (Darmstadt et al., 2009; Vaughan et al., 2015).

With an increase in programs and interventions aimed at improving maternal outcomes, more attention is needed to the quality of care provided and received (Austin et al., 2014). According to the Institute of Medicine (2001), quality care involves care that is safe, effective, patient-centred (defined as “care that is respectful of and responsive to individual patient preferences, needs, and values,” p.3), timely, efficient, and equitable. Numerous studies, especially those highlighting the work of community health workers, describe the health promotion benefits associated with combining task shifting and community-based care to address maternal health issues in low- and middle-income countries (Gilmore and McAuliffe, 2013). However, no information, to our knowledge, exists on patient perceptions to such an approach. Thus, the current study describes the simultaneous use of task shifting and community-based care to address maternal healthcare needs, with a focus on patient perceptions of this work. This information is timely and relevant for advancing knowledge about the utility of such a combined approach, since patient perceptions of care can influence motivations to seek care, sustainability of care, and improvements in healthcare practice (Black, 2013).

* Corresponding author.
E-mail addresses: jhosler1@umbc.edu (J.J.F. Hosler), jaabrams@umbc.edu (J.A. Abrams), sgodsa1@umbc.edu (S. Godsay).

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1.1. Maternal healthcare in Haiti

Political, financial, and environmental instability have led to Haiti's fragile and underdeveloped health system, comprised of an ad hoc 'system' of public, private, and non-profit providers (Durham et al., 2015). Coordination of care between organizations or individual providers tends to be lacking or non-existent. Some regions have varying degrees of healthcare access, due to a lack of infrastructure and accessibility in rural areas (Amibor, 2013; Kligerman et al., 2017). Notably, the 2010 earthquake disrupted the healthcare landscape and complicated systemic coordination across Haiti's public, private, and non-profit sectors of care (Amibor, 2013; Durham et al., 2015; Kligerman et al., 2017).

Although there are various cadres of maternal care in Haiti (see Floyd and Brunk, 2016 for a detailed description), the systems of care are under-resourced, fragmented, and inaccessible to many women around the country, resulting in significant barriers in accessing maternal care. Such obstacles include lack of infrastructure, prohibitive costs, cultural preferences, and social stigma (Cianelli et al., 2014; Peragallo Urrutia et al., 2012; Perkins et al., 2017; Williams et al., 2015). Haitian women also cite inadequate quality of care, long waits, and inconvenient hours as barriers to participate in formal maternal healthcare (Perkins et al., 2017; Cianelli et al., 2014).

Globally, strategies to overcome barriers to maternal care include providing family planning or contraception, subsidizing healthcare visits, developing birth centres, improving emergency transportation, and improving the healthcare work force (Elmusharaf et al., 2015). To assist women with overcoming barriers to care in Haiti, providers have employed task shifting and community-based care (Floyd and Brunk, 2016).

1.2. Task shifting

Task shifting is a capacity-building strategy that redistributes and reorganizes the service provision of healthcare (WHO, 2008). It does so by 1) developing and equipping a new category of healthcare professionals to fill roles typically served by providers with advanced education and qualifications; and/or 2) transferring tasks from specialized healthcare providers to other existing professionals with fewer years of training (Deller et al., 2015; WHO, 2008). For example, in task shifting, community health workers can receive training that targets specific diseases, risks, or health outcomes to equip them to perform duties traditionally performed by nurses (Seidman and Atun, 2017; WHO, 2008). In maternal health specifically, task shifting can train community health workers to handle postpartum haemorrhages, while non-physician clinicians can be equipped with skills for emergency obstetric care (Ejembi et al., 2013; Gessessew et al., 2011). Research has found that task shifting can expand maternal healthcare to those with little or no access in low income countries, achieving cost effectiveness and quality outcomes while reducing healthcare inequalities (Dawson et al., 2014; Deller et al., 2015).

1.3. Community-based care

Like task shifting, community-based care seeks to address critical shortages in the health workforce worldwide (Darmstadt et al., 2009; Vaughan et al., 2015). Community-based care (also known as community-oriented care) refers to healthcare delivered in community locations such as community centres, churches, schools, and/or homes. The term is also used to describe health services provided by community-based healthcare workers (i.e., individuals *local* to the context who have no formal professional degree; Vaughan et al., 2015). Community-based care workers may provide a range of services, such as preventative care, case management of illness, and referrals of patients to clinics and hospitals if needed (Schiffman et al., 2010). Given that community-based care is designed to increase local capacity for healthcare delivery, it enables healthcare to complement the social and cultural context specific to the community (Schiffman et al., 2010). Growing evidence suggests that community-based maternal healthcare has potential to improve maternal, neonatal, and perinatal outcomes (Azad et al., 2010; Tripathy et al., 2010). For example, a systematic review by Darmstadt et al. (2009) found that about a third of neonatal deaths can be reduced by community and outreach care.

1.4. Combining approaches

In low-income countries, most maternal and new-born deaths occur outside healthcare facilities and without skilled maternal care (Darmstadt et al., 2009; Schiffman et al., 2010). To address this issue, considerable international attention has been paid to the use of a 'facilities-based health approach,' which seeks to increase women's use of care in hospitals or clinics. However, critiques of this approach suggest that in under-resourced settings, facilities-based health systems may be prohibitive for women because formal care centres (e.g., hospitals) are either non-existent, inaccessible, and/or poorly functioning (Teela et al., 2009). Relatedly, while task shifting in existing facilities is useful, more population level health benefits may be realized by combining this approach with the delivery of community-based care.

Indeed, previous research demonstrates that multi-pronged, 'packaged,' approaches (e.g., those that ensure accessible maternal healthcare and well-trained providers) may be effective in reducing maternal morbidity and neonatal mortality in resource-limited countries (Lassi and Bhutta, 2015). However, less is known *specifically* about combining task shifting and community-based care, outside of community health worker models. An example of this combined approach can be seen in the work done by Midwives for Haiti (MFH), a non-profit committed to increasing access to maternal care for women in rural Haiti.

1.5. Midwives for Haiti model: combining community-based care and task shifting

Funded by foreign donors and foundation grants, MFH utilizes volunteer efforts (donations of time and supplies) to work within Haiti's developing infrastructure to increase Haitian women's access to maternal health services and skilled birth attendants (SBAs; Floyd and Brunk, 2016; MFH, 2016b). According to the World Health Organization (2004), a skilled birth attendant is

> an accredited health professional—such as a midwife, doctor, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the postnatal period and in the identification, management and referral of complications in women and newborns.

MFH accomplishes its goals by training Haitian women to be SBAs and operating a mobile pre/postnatal clinic. The focus of this paper is on the mobile clinic portion of MFH's work.

1.5.1. SBA training

Through a 12-month intensive educational and clinical training experience, Haitian nurses and auxiliary nurses are trained to be SBAs (also known as auxiliary nurse-midwives) by MFH Haitian and international maternal health experts (Floyd and Brunk, 2016). Graduates of the MFH training program make up 17% of skilled maternal healthcare providers in Haiti and are recognized by the country's Ministry of Public Health and Population (MFH, 2016a). Exhibiting task shifting, program graduates can assume tasks that more rigorously trained professionals (e.g., physicians or nurse practitioners) complete and are employed at birth centres, hospitals, and community organizations throughout Haiti, as well as with the MFH Prenatal Mobile Clinic. Further reading on MFH's task shifting work in training traditional birth attendants (i.e., *matrones*) and SBAs is described in detail in Floyd and Brunk (2016).