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A systematic review of qualitative evidence on barriers and facilitators to the implementation of task-shifting in midwifery services

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ABSTRACT

Objective: to synthesise qualitative research on task-shifting to and from midwives to identify barriers and facilitators to successful implementation.
Design: systematic review of qualitative evidence using a 4-stage narrative synthesis approach. We searched the CINAHL, Medline and the Social Science Citation Index databases. Study quality was assessed and evidence was synthesised using a theory-informed comparative case-study approach.
Setting: midwifery services in any setting in low-, middle-, and high-income countries.
Participants: midwives, nurses, doctors, patients, community members, policymakers, programme managers, community health workers, doulas, traditional birth attendants and other stakeholders.
Interventions: task shifting to and from midwives.
Findings: thirty-seven studies were included. Findings were organised under three broad themes: (1) challenges in defining and defending the midwifery model of care during task shifting, (2) training, supervision and support challenges in midwifery task shifting, and (3) teamwork and task shifting.
Key conclusions: this is the first review to report implementation factors associated with midwifery task shifting and optimisation. Though task shifting may serve as a powerful means to address the crisis in human resources for maternal and newborn health, it is also a complex intervention that generally requires careful planning, implementation and ongoing supervision and support to ensure optimal and safe impact. The unique character and history of the midwifery model of care often makes these challenges even greater.
Implications for practice: evidence from the review fed into the World Health Organisation's 'Recommendations for Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions through Task Shifting' guideline. It is appropriate to consider task shifting interventions to ensure wider access to safe midwifery care globally. Legal protections and liabilities and the regulatory framework for task shifting should be designed to accommodate new task shifted practices.

Introduction

A key obstacle to the achievement of the maternal and child health-related Millennium Development Goals (4–6) is the chronic shortage and maldistribution of health workers in many countries (WHO, 2010). One important approach to addressing this human resource problem is the redistribution of tasks between health workers, an idea sometimes referred to as 'task-shifting' or 'task optimisation'. Task shifting is one way of addressing the broader question of the most effective and efficient 'skill mix' in a health services context, especially in settings with chronic shortages of health workers. By reorganising tasks and responsibilities more efficiently and effectively within the health workforce, policymakers hope to make better use of existing human resources and expand and strengthen coverage of key health interventions (WHO et al., 2007).

Midwives are a cadre of health worker that has long been familiar with the concept of task shifting and its attending

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opportunities and challenges. The notion of the 'triple gap' of competencies, coverage and access to midwifery care recently identified in the *State of the World's Midwifery* report speaks succinctly to the global human resource crisis in maternal and newborn health (UNFPA, 2011). In order to provide critical cover for some of these gaps, midwives have long worked in complex and often shifting and ambiguous relationship with other health-care workers (Sandall, 2012). And the persisting crisis in human resources for health will continue to put pressure on midwifery services to move health-care tasks both to and from midwives in an effort to maximise already thinly stretched human resources.

Important questions persist, however, around task shifting, in both midwifery services and in other contexts. One set of questions involves the safety and effectiveness of task shifting. There is growing evidence, from primary research and from quantitative systematic reviews of effects that task shifting can be safe and effective (Dovlo, 2004; Lewin et al., 2010; Bhutta et al., 2011; Fulton et al., 2011; Pyone et al., 2012). This evidence is, however, often mixed or ambiguous, with heterogenous effects and a wide variety of methodological quality being the norm.

One reason for these weaknesses in the effectiveness evidence is that the reorganisation of tasks among health workers is closer to a complex health systems intervention than a narrow clinical intervention. These kinds of complex interventions are more difficult to assess empirically. It is also becoming clear that the safety or effectiveness of task shifting depends as much on the implementation and ongoing management of task shifting as it does on the nature of the technical tasks being shifted (Callaghan et al., 2010; Georgeu et al., 2012).

Addressing questions of implementation, however, requires a different form of evidence, one focused on process, context and mechanism. Process evaluations of task shifting interventions (Glenton et al., 2011), and evidence syntheses of qualitative evidence on task shifting, are required for understanding how and why task shifting interventions might succeed in some settings and not in others.

Given the uncertainty around the implementation, safety, and effectiveness of some forms of task shifting, especially in critical maternal and newborn health interventions, the WHO recently set out to assess the relevant evidence in order to develop guidance on task shifting in this context. This review is one of a series of reviews that was used in the development of the WHO's recent 'Recommendations for Optimizing Health Worker Roles to Improve Access to key Maternal and Newborn Health Interventions through Task Shifting' (OPTIMIZEMNH) (WHO, 2012) (http://www.optimizemnh.org). While the more traditional quantitative reviews used in the process assessed the evidence on safety, effectiveness and efficiency of task shifting initiatives in maternal and newborn health, qualitative reviews like this one assessed evidence regarding the barriers and facilitators to successful implementation of task shifting.

This was the first time that the WHO has included systematic reviews of qualitative evidence in its official guidelines. The aim of this review on midwifery and task shifting was to synthesise qualitative research on task shifting to and from midwives in order to identify barriers and facilitators to their successful implementation.

Methods

Review design

We undertook a qualitative systematic review. As with systematic reviews of effectiveness, reviews of qualitative data should be carried out in a systematic and transparent way and the last few years have seen significant development in systematic review methodology for summarising data from multiple qualitative studies (Noyes, 2009). We used a four-stage narrative synthesis design (Popay et al., 2006) using thematic analysis informed by the SURE conceptual framework (described further below) with comparative case analysis across low, middle and high income contexts.

Study inclusion criteria

Types of study methodology

Studies including any type of qualitative method of data collection and analysis. Mixed method studies were eligible provided it was possible to extract the findings derived from qualitative research.

Types of studies and settings

Studies from low-, middle-, and high-income countries (LMICs and HICs) were included. Studies conducted in hospitals, clinics, and communities were included as long as midwives were a central part of the reorganisation of tasks under review. Study participants could include midwives, nurses, doctors, patients, community members, policymakers, programme managers, community health workers, doulas, traditional birth attendants (TBAs) and other stakeholders.

Types of interventions

Studies reporting on interventions addressing specific task-shifting initiatives between midwives and either other health workers or other birth attendants or community-based health volunteers. Working from the International Confederation of Midwives' definition of a 'midwife' (2011), we understood a midwife to mean a skilled health-care worker with one or more years of legally recognised and regulated training, usually at the level of a registered nurse, who delivers antenatal care, delivery and postnatal care to women. As discussed below, some midwives may not frame their work as primarily 'biomedical' in focus but we were interested for the purposes of this review on task-shifting initiative in midwives who were recognised in some way as a formal part of the biomedical health system. We did not include 'traditional', 'community', 'lay', or 'village' midwives or other non-biomedically trained TBAs in this definition of midwife. We did include studies, however, where tasks were shifted between biomedically-trained midwives and these other forms of midwives and TBAs.

Deciding what constituted a concrete task-shifting intervention was sometimes difficult given that there are no commonly accepted criteria for identifying which 'new' tasks significantly expand or reduce the scope of work for midwives. We read abstracts and full texts of articles to determine (a) if there were specific tasks being shifted from one cadre to another (rather than the creation of new tasks not previously done by anyone) and (b) if the report authors or the study participants described the new tasks as representing a significant shift in their previous roles and responsibilities. We also limited this review to studies that were specifically relevant to the maternal and newborn health focus of the OptimizeMNH guidelines.

Exclusions

We excluded (a) studies assessing general attitudes of stakeholders to midwives or to task shifting in the absence of a specific task-shifting initiative, (b) studies proposing training programmes or detailing training needs and curriculum requirements in the absence of empirical research on task-shifting interventions themselves, and (c) studies assessing the internal reorganisation of