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Research Article

Barriers, promoters, and strategies for improving task shifting and task sharing implementation in Nigeria: qualitative perspectives of policymakers

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Background

Nigeria developed a National Task Shifting and Sharing Policy due to protracted inequitable distribution of health workers, especially at the primary level of care, and the low stock and production rate of skilled health workforce. Following the development of Nigeria's task shifting and sharing policy and strategy, implementation was promulgated at various levels, with States adopting and implementing the national policy. However, the policy environment for task shifting and sharing varies widely. Consequently, evidence on barriers to and factors promoting successful implementation are inconclusive. Hence, strategies for improving implementation are needed. The evidence from this study can inform the scale-up and strengthening of implementation approaches as Nigeria strives to achieve the national goals, universal health coverage and sustainable development goals.

Methods

An explorative, descriptive research study approach was applied with 20 key informant interviews conducted to explore the perception of policymakers on barriers and promoters of task shifting and sharing in Nigeria. In addition, strategies for improving task shifting and sharing implementation were explored.

Results

The barriers to effective implementation of task shifting ad sharing from our study were the persistent shortage of health workers, inter-cadre rivalry, perceived sub-optimal capacity of the beneficiary cadres, and lack of adequate equipment for delivery of needed services. The factors promoting the implementation of task shifting and sharing were the availability of adapted policies, the political will of the health sector leadership, acceptance of task shifting and sharing implementation by health workers, and the implementation of actions to improve knowledge and skills of health workers to implement shifted or shared tasks by various actors. The strategies to improve future task shifting and sharing implementation include improving staffing levels, scaling up training and periodic retraining, mentoring and supportive supervision, and improving the, use and dissemination of evidence generated.

Conclusions

Several factors influence the implementation of task shifting and sharing. Hence the identification and implementation of relevant strategies are pertinent in achieving set objectives and national goals. In policy and practice, therefore, a proactive exploration of the contextual understanding, barriers to implementation, enablers and learning from the performance of similar interventions is pertinent in shaping strategies for translating evidence to practice through an implementation framework. This should be done in collaboration with stakeholders to foster acceptance and participation.

Africa is faced with several health workforce challenges that are impacting the functionality of the health system, the trends of the burden of disease and high migration rates of health workers.[1,2] This trend is also evident in Nigeria, where numerous health workforce challenges abound. These challenges have been attributed to several factors, including weak capacities for human resources for health planning, low production of health workers, and high attrition rate of existing health workers. Other factors include inequitable distribution of the health workforce, poor mechanisms for employment and retention of health workers and high workloads.[3-8]

Due to the protracted inequitable distribution of health workers, especially at the primary level of care,[3] and low production rate of the skilled health workforce, Nigeria developed the National Task shifting and sharing Policy in 2014[5] and updated it in 2018.[4] The policy aims to achieve universal health coverage by optimizing the use of existing health workforce to deliver essential health services. It endorses the rational distribution of tasks from health workers with a longer duration of training to those with a shorter duration towards ensuring improved access to essential health services at primary healthcare centres (PHCC). The priority tasks approved for task shifting and sharing in the policy were family and reproductive health services, maternal and child health services, HIV/AIDS, tuberculosis, and malaria. Identifying these tasks and formulating strategies for achieving task shifting and sharing, involved key stakeholders, including professional regulatory bodies and associations, civil society organizations and partners.[4] The professional regulatory bodies involved in the process were those that regulate the cadres of health workers normatively earmarked to provide health services at PHCC in the country.

Following the development of Nigeria's task shifting and sharing policy strategy implementation was promulgated at various levels, with 57% of the 36 States and the Federal Capital Territory adopting and implementing the national policy. Despite the implementation of the task shifting and sharing policy strategy in these states, the policy environment for task shifting and sharing varies widely with evidence on barriers to successful implementation, factors promoting successful implementation and strategies for improving implementation needed. This evidence will inform the scale-up and strengthening of implementation approaches as Nigeria strives to achieve its national goals, universal health coverage and sustainable development goals.[9] The difficulties encountered with implementing task shifting and sharing in Nigeria informed the design of this study to explore the perceptions of policymakers on barriers and promoters and strategies for improving implementation.

METHODS

STUDY DESIGN AND SETTING

An explorative, descriptive research study approach was applied with 20 key informant interviews conducted in Bauchi and Cross River States in Nigeria. The aim was to explore the perceptions of policymakers on barriers and promoters of task shifting and sharing in Nigeria and strategies for improving task shifting and sharing implementation.

Bauchi and Cross River States were purposively selected for this study because they adapted the National task shifting and sharing policy and plan into sub-national policies and plans in 2015 and have been implementing it. The target population in these states was policymakers in the ministries of health and primary health care agencies. This group was selected because they are responsible for policy formulation and implementation of task shifting and sharing. Hence, they can also provide rich information on their contextual perspectives on the barriers and promoters of task shifting and sharing in Nigeria and strategies for improving the implementation of task shifting and sharing based on their experiences in policy formulation and implementation.

SAMPLING PROCESS

We applied purposive and snowball sampling techniques[10] in selecting a sample of policymakers in Bauchi and Cross River States. Applying these sampling techniques enabled the investigators to recruit respondents that provided rich information and perspectives on barriers and enablers of task shifting and sharing They also provided recommendations for improving its implementation based on their experiences in policy formulation, planning and implementation. The sampling process was guided by a set of inclusion and exclusion criteria. The inclusion criteria were policymakers (irrespective of health worker category) who are fluent in English Language and responsible for formulating and implementing policy in Bauchi and Cross River States, and with two or more years of experience in implementing the policy. Respondents were excluded if they were policymakers who were not responsible for policy formulation or implementation, had less than two years of experience in the implementation of the policy and refused to participate.

DATA COLLECTION

A semi-structured interview guide (Online Supplementary Document) was developed after a review of the literature by the investigators (SC Okoroafor - SCO and CD Christmals - CDC), trained qualitative investigators with experience in the design, conduct, analysis, and reporting of qualitative studies. One investigator (SCO) conducted the semi-structured interviews to ensure consistency in questioning and immersion in the data collection process. The guide explored the understanding of task shifting and sharing, the rationale for task shifting and sharing, barriers to effective implementation of task shifting and sharing, factors promoting the implementation of task shifting and sharing, and strategies for enhancing task shifting and sharing practice. Probing for detailed descriptions and perspectives was undertaken to gain rich descriptions and allow for flexibility to elaborate on views and perceptions towards providing reach qualitative data.[11] The data collection process spanned from October to December 2022 and interview ses-

sions lasted between 30 to 60 minutes. All interviews were conducted in English, with information collected using two recognized qualitative data collection methods - field notes and audio records.[9] The interviewing process was terminated when data saturation was attained.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study was approved by North-West University Health Research Ethics Committee (NWU-00099-22-A1, 31 August 2022) and the National Health Research Ethics Committee (NHREC) of the Nigeria Federal Ministry of Health (NHREC/01/01/2007-30/06/2022). Permission was obtained from the leadership of the State Primary Health Care Development Agencies in Bauchi and Cross River States. All participants were intimated on the objective and methodology of the study using a participant information sheet, and they also signed informed consent forms.

To obtain consent, on receipt of ethical clearances and permission letters, an appointed independent person engaged potential respondents that met the inclusion criteria. The independent person shared the invitation letter with the information sheet, ethics clearances, informed consent form and permission from the States with the potential respondents via email. After reviewing the documents, the respondents contacted the independent person communicating a suitable time to initiate the informed consent process. The independent person and an investigator scheduled a meeting based on the suggested timeslot during which they signed the consent forms and returned a scanned copy that was also signed by the independent person and investigator.

DATA ANALYSIS

The audio recording and notes were transcribed verbatim, anonymized and analysed using the thematic analysis approach[12,13] with the Nvivo 12 Pro software by the investigators. SCO transcribed the audio recordings by listening to the audio records and developing written transcripts word-for-word. SCO and CDC ensured that the transcribed information was the same as the audio recording by listening to the audio and reviewing the transcripts. Afterwards, independently, they inductively coded the transcripts to identify themes and perspectives on the identified themes. Also, verbatim excerpts to illustrate the perspectives were extracted. The themes and perspectives identified were jointly discussed, until a consensus was reached. The themes and perspectives were presented to the participants from Bauchi State (BAU) and Cross River State (CRS), who validated the presented information.

TRUSTWORTHINESS

This study applied various measures to ensure trustworthiness. The study process is thoroughly described with insights provided on the processes followed while conducting the study; including the study participants and design, and the processes followed in analysing collected data; with the findings reinforced by citing excerpts. Other methods employed to achieve trustworthiness include prolonged engagement in data collection by one investigator (SCO), use of probes to clarify the interpretations drawn from information obtained, and audio taping and verbatim transcription of recordings. Respondents were also requested to verify if interpretations of information obtained from them during interviews correctly represent their perspectives on the subject.

RESULTS

UNDERSTANDING OF TASK SHIFTING AND SHARING, AND THEIR RATIONALE

Before exploring the barriers and promoters of task shifting and sharing, and strategies for enhancing task shifting and sharing practice, all the participants responded to questions on their understanding of the meaning of task shifting and sharing and its rationale. The respondents reported task shifting and sharing to mean the transfer or allocation of duties, assignments, or activities from highly skilled cadres to lower cadres when there are insufficient or no health workers to provide the services.

> "*Task shifting is a process of delegating work or task from a highly qualified health personnel to a less qualified health workers*." CRS Policy maker 10
> *"... the transfer of certain knowledge or know-how from one specialist to someone who was not formally trained on that particular activity..."* BAU Policy maker 5

In responding to questions on the rationale for task shifting and sharing, the policymakers presented the rationale to shift or share tasks due to the shortage of health workers to deliver quality service at the primary level of care. Further insight was provided that the shortage of health workers was particularly for nurses and midwives, and it negatively impacts maternal and child health services. Thus, task shifting and sharing were also reportedly critical for reducing maternal and child mortality.

> *"...in the rural area it (task shifting and task sharing) helps and reduces death like maternal and infant mortality."* CRS Policy maker 10
> "*Task shifting and task sharing ...helps us to reduce the morbidity and mortality of women and newborns.*" BAU Policy maker 8

Some respondents reported that the implementation of task shifting and sharing was geared towards ensuring that available health workers can provide health services in instances of both non-availability of certain cadres and absences from work. They further indicated that this practice ensures the availability of a range of health services, improves the health-seeking behaviour of the catchment population, and increases service utilization towards achieving universal health coverage.

> "*I think what the task shifting and task sharing intends to achieve is to increase utilization of services by making hands available at all times to attend to clients*". BAU Policy maker 6

> "*To ensure the availability of health care workers to attend to patients anytime they come into the facility*". CRS Policy maker 7

The respondents also reported that prior to the development and implementation of the state task shifting and sharing policies, its informal practice was widespread in primary-level facilities due to the absence of highly skilled health worker cadres (doctors, nurses, midwives, laboratory specialists, and pharmacists) and high workload.

BARRIERS TO EFFECTIVE IMPLEMENTATION OF TASK SHIFTING AND SHARING

THE PERSISTENT SHORTAGE OF HEALTH WORKERS

Respondents reported that the persistent shortage of health workers in the states evaluated, especially at the service delivery points, hampers the implementation of task shifting and sharing. They highlighted that some health facilities do not have adequate staffing levels to implement shifts and provide health services aligned with the tasks shifted or shared. According to them, this results in the high workloads for those available.

> *"...the shortage of staff also causes the lack of implementation of task shifting... Because if a health worker is alone in a facility, who would they shift or share tasks with? And we have seen a situation generally in the country and specifically my experience where wards are closed due to shortage of staff in the facility*." CRS Policy maker 9.
>
> *"...the issue of inadequacy of these frontline health workers. The facilities do not have enough, and so those available are overworked." BAU Policy maker 1*
>
> *"The workload is high; it is too much for the few that were trained to implement the tasks shifted or shared..."* BAU Policy maker 9

Another perspective offered in relation to health worker shortages was with the non-availability of experienced health workers to provide mentoring support to beneficiary cadres of task shifting and sharing.

> "*Inadequate personnel to go there to provide on - the - job support to ensure that whatever was the training they had, they actually reinforced it to do the right thing.*" CRS Policy maker 3

INTER- CADRE RIVALRY

All policy makers reported the influence of rivalry amongst the various cadres of health workers as a major barrier. According to the respondents, this rivalry is based on the view of the higher cadres that the lower cadres benefitting from the task shifting and sharing practice were being trained to take over their jobs and make them irrelevant in service delivery.

> *"Even at this point, I am aware that they do not want to hear of the task shifting because they believe it has taken some of their role, duties and responsibilities and given them to the CHEWS. And if that policy is allowed to continue, then it means that they will be rendered redundant, so they are opposed to the task shifting policy."* CRS Policy maker 1
>
> *"Some professionals feel threatened and are still adamant that they would not shift or share their tasks, because their work and their profession will be taken over by another cadre."* CRS Policy maker 9
>
> *"There is rivalry because those people who have the knowledge think that government is training another cadre who is taking up their job. Despite the fact that they know they are not taking over the job but helping to some extent."* BAU Policy maker 9

The respondents indicated that this rivalry is impeding the rapid implementation of task shifting and sharing in the States, with health worker categories protecting their professional practice scopes and not being willing to shift or share tasks that other cadres could implement.

> *"...there's conflict between cadres, and this issue delays task shifting and task sharing implementation."* CRS Policy maker 5

PERCEPTION OF CAPACITY OF PROVIDERS

All respondents reported that the capacity of the beneficiary cadres of task shifting and sharing is sub-optimal to deliver health services to quality. This was reported to result in resistance to supporting its implementation and a key barrier in policy and strategy formulation, as well as during implementation.

> *"...people are against task shifting because of this issue of taking the job for nurses. Some wonder whether the CHEWS, for example, will really be able to handle tasks the way, say, a doctor or a nurse would..."* CRS Policy maker 1
>
> *"Some health workers have raised concerns on the capacity of the trained cadres to provide services to quality, and this is affecting their willingness to allow task shifting to be applied."* BAU Policy maker 2

LACK OF ADEQUATE EQUIPMENT

Most respondents reported the non-availability of the medical equipment needed to deliver shared or shifted tasks at service delivery points. They reported it as a barrier affecting the appropriate implementation of task shifting and sharing.

> *"...if the equipment that the health workers are supposed to use in delivering services according to the tasks that are shifted to them are available, it will be helpful. We go around and hear them complain that they do not have certain equipment in the health facilities, and this hinders their ability to deliver as expected.*" CRS Policy maker 1

FACTORS PROMOTING THE IMPLEMENTATION OF TASK SHIFTING AND SHARING

AVAILABILITY OF POLICY

Policymakers acknowledged that the availability of state task shifting and sharing policy adapted from the national policy was the primary enabler of task shifting and sharing

implementation. They stated that without the state policy, which was based on contextual needs, it would not have been possible to implement task shifting and sharing.

> *"...the task shifting policy which ... we are implementing in the state which is one of the things that has enabled the task shifting to take place."* CRS Policy maker 1
> *"...the policy of task shifting and task sharing is the number one enabler because you cannot implement without a policy and the strategy."* CRS Policy maker 9
> *"One of the most important factors that promoted implementation of task shifting and task sharing is the availability of State's policy. You cannot implement task shifting and task sharing without a policy to back the activities."* BAU Policy maker 10

According to the respondents, implementing the State policy and strategy positively impacted access to skilled health workers and health service utilization.

> *"For me, I think we have increased the pool of service providers with this policy. We have a large pool, a larger pool of providers out there in the system. And because there's a larger pool of providers, utilization has improved. The clients are more satisfied, because they come out and they are not disappointed. They see somebody close to them to attend to them."* CRS Policy maker 3
> *"With the implementation of this policy, we have a large pool of service providers in the system and utilization of health services has improved. The clients are more satisfied because when they visit a facility close to them, they see health workers who attend to them."* BAU Policy maker 6

POLITICAL WILL

Besides the availability of state policies and strategies on task shifting and sharing, the political will of the health sector leadership was also stated as a key enabler. The respondents reported that the existing governance mechanisms in the States promote task shifting and sharing and provide resources to implement and monitor implementation.

> "*There is an enabling environment provided by the primary health care agency in the headquarters... that favours the implementation of the task shifting policy. Even in terms of monitoring of the implementation. The agency has been promoting and supporting implementation of task shifting and task sharing.*" CRS Policy maker 1
> *"...the political will by the government of the day, because without the political will, it would have been difficult to implement the policy in the State ..."* CRS Policy maker 8

ACCEPTANCE OF TASK SHIFTING AND SHARING IMPLEMENTATION

The participants reported the role of the acceptance of task shifting and sharing by the primary and beneficiary cadres as an enabler for task shifting and sharing implementation in the States.

> *"The health workers accepted the importance of sharing and shifting tasks and this really helped in ensuring that government was able to implement these across the State."* BAU Policy maker 8

The respondents stated that the cadres with the primary responsibility of tasks being shared or shifted expressed their willingness to the concept and demonstrated it by supporting planned activities, including policy development, capacity building and on–the–job mentoring.

> "*The willingness of the health workers to accept the task shifting policy also helped because they are the ones to implement, and they supported carrying out planned activities.*" CRS Policy maker 9

Also, the beneficiary cadres also expressed willingness to learn to meet the needs of the population and achieve the goals of the task shifting and sharing policy.

> *"The cadres trained to implement shared or shifted tasks were also willing to take up additional work because they are happy to meet the needs of their clients where they work."* CRS Policy maker 2

IMPROVEMENT IN KNOWLEDGE AND SKILLS

Respondents indicated that improvement in the knowledge and skills of the beneficiary cadres of task shifting and tasks sharing was a factor that enabled its implementation. They provided insights on actions taken to improve the knowledge and skills of health workers including convening and co-creating activities, obtaining support to implement planned activities from partners, and conducting training, providing supportive supervision and on – the – job mentoring for trained health workers.

> *"We had various planning meetings. And then, we had to search for funding from partners to see how they could help us to train because the question from the planning meeting was how do we go about it? So, we sourced for support from partners, and some came in and supported several activities."* CRS Policy maker 3
> *"...training and intensive supervision by experienced health workers has enabled implementation of task shifting and sharing."* BAU Policy maker 6
> *"To build their skill we do on - the - job training. When we go for monitoring and supportive supervision visits, we correct them where they need to be corrected."* BAU Policy maker 7

STRATEGIES FOR IMPROVING TASK SHIFTING AND SHARING PRACTICE

IMPROVE STAFFING LEVELS

All respondents indicated the importance of improving the staffing levels at health facilities through employment as a vital strategy for improving task shifting and task-sharing implementation. This was reported to be important to ensure continuity of quality service provision due to absences or exits from public service of health workers whose knowledge and skills have been improved.

> *"The facilities need more health workers so that in case somebody is not around, another person who is also trained who can provide services is available."* Bauchi Policy maker 8
> *"We need more staff, more hands to work, you see every month people are retiring, even those whose capacity has been built, and this reduces the number of available hands."* Bauchi Policy maker 10

One participant emphasized the importance of the employment of additional health workers being focused on the cadres whose primary tasks are being shifted or shared to increase their availability.

> *"...since the original motivation for task shifting and task sharing is to bridge the gap caused by health worker shortage, the government should employ health workers. Especially nurses because the CHEWs are already in larger numbers and constitute the majority of the health workforce."* CRS Policy maker 1

SCALE UP TRAINING OF HEALTH WORKERS TO IMPROVE KNOWLEDGE

The respondents reported the importance of conducting training and retraining using national training manuals to improve knowledge of the beneficiary cadres to deliver quality health services. They also reported that this is pertinent in increasing the proportion of trained health workers and the population's access to competent health workers.

> *"There should be training and re-training to ensure that frontline health workers have the needed knowledge and skills."* CRS Policy maker 9
> *"More health workers should be trained, like when they did the training, it was two staffs that were here. After some months, one of them was posted to another facility. If you can train more persons, it will be better".* CRS Policy maker 4
> *"For me, I think a retraining will help. It's not just good to go to sleep and say they have been trained, they are dealing with clients, and some of these areas are very technical. So, retraining of them will actually go a long way to reinforcing their knowledge."* CRS Policy maker 3

IMPROVE SKILLS THROUGH MENTORING AND SUPERVISION

In addition to training, most respondents specified the importance of mentoring and coaching to enhance the skills of the cadres benefiting from task shifting and sharing roles.

> *"What we call "on-the job training" after the classroom training of the frontline health worker is very important in building their capacity better. When you impact the knowledge ..., some of them do not know how to use the equipment in the facility. But through coaching and mentoring they learn and become experts."* BAU Policy maker 1

The respondents also indicated that supportive supervision is vital in assessing whether the trained health workers gained knowledge and skills and in enhancing the skills of health workers to implement shared and shifted tasks.

> *"...after their trainings, you carry out post-training supervision to see how competent and proficient they are in the knowledge and skills that was transferred to them."* BAU Policy maker 4

One respondent shared the practice in place of using checklists during supportive supervisory visits and highlighted that this practice was an important strategy for scaling up task shifting and sharing implementation.

> *"And after the training ... we're not stopping there, we need to supervise, so checklists were developed to assist the states and partners to carry out supportive supervision."* CRS Policy maker 3
> Another respondent also shared insight on ensuring that supportive supervision is conducted by experienced members of the cadre whose primary tasks are being shifted or shared.
> *"Adequate supervision by the higher cadres is needed to ensure that tasks shared or shifted to lower level cadres are conducted properly at service delivery points."* BAU Policy maker 6

IMPROVE EVIDENCE GENERATION AND DISSEMINATION

Beyond implementing task shifting and sharing to meet contextual needs, the importance of investing in data collection to generate evidence for dissemination was emphasized. Most participants suggested that task shifting and sharing practice has improved access to health services but indicated that mechanisms for data generation, monitoring, evaluation, and dissemination are still sub-optimal. Thus, they stated that to improve future implementation in task shifting and sharing, efforts should be directed at improving evidence generation, use and dissemination.

> "*There is a lot that has been achieved with task shifting and task sharing interventions, but it is not well captured, there is no valid and reliable data system. This is an area that needs to be improved*". BAU Policy maker 4
> *"Another plan that was not well done was using data to show that this task-shifting policy has made a difference in the system. The M&E needs to be improved. The M&E staff should be trained, tools should be developed, and data collection and collation processes should be in place."* CRS Policy maker 3

DISCUSSION

This study applied a qualitative approach to explore the perceptions of policymakers on barriers and promoters of task shifting and sharing in Nigeria and strategies for improving future task shifting and sharing implementation. To gain a contextual understanding of task shifting and sharing and the rationale for its implementation, we asked the 20 respondents to provide insights. The respondents were policy makers from Bauchi and Cross River States in Nigeria.

Our finding reports the understanding of task shifting and sharing to be the transfer of duties, assignments, or activities from highly skilled cadres to lower cadres due to the shortage of health workers and efforts to improve access to

skilled health workers by health service users. Participants' reported level of understanding is consistent with the national policy[4,5] and definition by WHO.[14] The reported rationale of its implementation is to address the shortage of health workers to deliver health services is also consistent with the findings of other studies in Nigeria[15-17] and in some countries in Africa.[18] A key perspective from this study is the secondary effect of improved access to health services enhancing health-seeking behaviour.

The reported barriers to effective implementation of task shifting and sharing from our study were the persistent shortage of health workers, inter-cadre rivalry, the perceived sub-optimal capacity of the beneficiary cadres of task shifting and sharing, and lack of adequate equipment for delivery of needed services. The shortage of health workers, especially at the primary level of care in Nigeria, has been reported,[16,17,19-22] and is also suggested to result in high workloads[21,22] and influence attraction and retention of health workers.[19,20,23] Health workers protecting their professional space was also a reported barrier, which has also been reported in Uganda.[24] Beyond this being to preserve professional scopes of practice and remain relevant, it may also be due to the perceived limited capacity of the beneficiary cadres of shifted or shared tasks to implement them. Addressing this requires concerted advocacy on the importance and benefits of task shifting and sharing, with assurances of continued professional relevance for the primary cadres, and actions to enhance the capacities of beneficiary cadres. These should be augmented with actions to ensure that equipment is available and working conditions are conducive for delivering quality health services and achieving the task shifting and sharing policy goals.

We also found that the factors promoting the implementation of task shifting and sharing were the availability of a national policy adapted to the contextual needs of states and the political will of the health sector leaders to implement the policy and monitor the implementation process. The other enablers were the acceptance of task shifting and sharing implementation by the primary and beneficiary cadres and the implementation of actions to improve the knowledge and skills of health workers to implement shifted or shared tasks by various actors. Policies and strategies informed by contextual evidence on the health workforce situation are critical in achieving national goals, universal health coverage and sustainable development goals.[25] However, policies, strategies and interventions can only achieve set goals with strong political will[20,26] and stakeholder ownership and participation,[27] with pertinent capacity enhancements done when needed. The role of knowledge and skills enhancement in facilitating task shifting and sharing implementation was also reported in Uganda,[28] and it is an important action in ensuring the policy goals are achieved. This is because, in most instances, the expectation on the beneficiary cadres is to engage in tasks above and beyond their training and scope of practice.

Several strategies are described in the literature to improve the implementation of task shifting and sharing. They include the availability of equipment required to perform the procedure,[29] training,[29] mentoring,[30,31] supportive supervision,[32,33] and provision of job aids.[34,35] In support, our findings show the importance of investments to improve staffing levels, scaling up training and periodic retraining to improve knowledge, mentoring, coaching and supportive supervision, and improving data collection, evidence generation, use and dissemination. Whilst most of our findings highlight actions already in the literature, the importance of data and evidence generation and use has not been highlighted previously, and this is often neglected in policy and practice. Our study indicated its importance in tracking policy implementation and achievements, how task shifting and sharing are impacting the health system, and the dynamics in access to health services. These are pertinent in tracking performance and evidence-based planning.

IMPLICATIONS FOR PRACTICE

Considering the protracted shortage, inequitable distribution, and low production of health workers, and the increasing demand for health service delivery, task shifting and sharing are widely practised and recommended in many settings.[24,36,37] In policy and practice, a pre-emptive exploration of the contextual understanding of task shifting and sharing, its rationale, barriers to successful implementation and potential enablers is vital. Learning from similar interventions on strategies to improve performance is also critical. These are essential steps when shaping strategies for translating evidence to task shifting and sharing practice through implementation frameworks.[38] This should be done in partnership with relevant stakeholders, with actions to ensure shared understanding and value should be implemented as needed to ensure acceptance and participation. Also, it is imperative that consensus on the implementation modalities, focusing on joint planning, implementation, review, evidence generation and use.

LIMITATIONS

Although, our study design is trustworthy and the processes are transferrable, and the findings are credible. However, our study has some limitations. Using a qualitative approach and focusing on two States in Nigeria limits the generalizability of our findings. Nonetheless, our study provides credible insights based on the experience of Bauchi and Cross River States in implementing task shifting and sharing in Nigeria.

CONCLUSIONS

This study explored the perceptions of policymakers on barriers and promoters of task shifting and sharing in Nigeria and strategies for improving task shifting and sharing implementation. Based on the study findings, we conclude that several factors influence the implementation of task shifting and sharing, and their identification and the implementation of relevant strategies are pertinent in achieving set objectives and national goals. In policy and practice,

therefore, a proactive exploration of the contextual understanding, barriers to implementation, enablers and learning from the performance of similar interventions is pertinent. This should be done in collaboration with stakeholders to foster acceptance and participation.

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ETHICS STATEMENT

This study was approved by North-West University Health Research Ethics Committee (NWU-00099-22-A1, 31 August 2022) and the National Health Research Ethics Committee (NHREC) of the Nigeria Federal Ministry of Health (NHREC/01/01/2007-30/06/2022). Permission was obtained from the leadership of the State Primary Health Care Development Agencies in Bauchi and Cross River States. All participants were intimated on the objective and methodology of the study using a participant information sheet and they also signed informed consent forms.

DATA AVAILABILITY

Data and materials are available on request.

FUNDING

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AUTHORSHIP CONTRIBUTIONS

Conception and design of the study: SCO, CDC; Data collection: SCO; Data analysis: SCO, CDC; Drafting the article: SCO; Critical revision of the article: CDC. All authors have read and agreed to the published version of the manuscript.

DISCLOSURE OF INTEREST

The authors completed the ICMJE Disclosure of Interest Form (available upon request from the corresponding author) and disclose no relevant interests.

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SUPPLEMENTARY MATERIALS

Supplementary material

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