

Implementing a Task Shifting Programme in Maternal and Neonatal Health in Liberia: Insights From Policymakers and Frontline Health Workers

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Abstract

Background

Sub-Saharan Africa bears the world's highest burden of maternal and neonatal mortality, compounded by critical shortages of skilled health workers. Task shifting has been promoted by the World Health Organisation as a strategy to address health workforce gaps. In Liberia, since 2012, the NGO Maternal and Child Health Advocacy International (MCAI) has been implementing a task shifting programme to train midwives and nurses as obstetric and neonatal clinicians to help address a shortage of medical doctors in maternal and neonatal health in rural facilities. This study, embedded within the Oxford Maternal and Neonatal Health project, explored the perceived benefits of the programme for maternal and neonatal health and the challenges of integrating the programme into Liberia's healthcare system.

Methods

This qualitative study involved primary data collection through seven key informant interviews (KIIs) conducted in 2024 with policymakers, health workers, and an MCAI representative, as well as the secondary analysis of 11 transcripts from KIIs conducted in 2020. Data were analysed thematically using the framework approach with NVIVO 14.0, and coding by two researchers was done to enhance reliability. Ethical approval was obtained from OxtREC (Ref. 529 – 20) and Liberia's ACRE-IRB (Protocol #20-06-217).

Results

Participants reported that the MCAI programme enhanced responsiveness to maternal and neonatal emergencies and optimised workforce efficiency by reducing doctors' workload. However, several systemic challenges were identified as barriers to integration and sustainability. These include inter-cadre resistance from physicians, the lack of incorporation into accredited training institutions, unresolved licensing and regulatory frameworks, and reliance on donor funding.

Conclusion

The MCAI programme and task shifting were, for the most part, viewed positively by policymakers and frontline providers; however, political, governance and financial issues are impacting the sustainability of the approach. Although recent developments indicate that some reforms in licensing and training have emerged, the findings highlight both the promise and fragility of implementing a task shifting programme in Liberia.

INTRODUCTION / BACKGROUND

Maternal and neonatal mortality remain pressing global health concerns. In 2020, approximately 287,000 women died during pregnancy or within 42 days of childbirth, while an estimated 2.3 million newborns died in 2022.⁽¹⁾ Most of these deaths occur in Sub-Saharan Africa (SSA), which accounts for two-thirds of global maternal deaths and has a neonatal mortality rate (NMR) of 27 per 1,000 live births, more than double the global average.⁽²⁾

These deaths are largely preventable through the deployment of evidence-based interventions, including timely access to skilled care during pregnancy, childbirth, and the neonatal period.⁽³⁾ However, many countries in SSA face chronic shortages of the skilled health professionals required to implement these interventions.⁽⁴⁾ Task shifting has been promoted as a strategy to mitigate workforce shortages.⁽⁵⁾ Defined by the World Health Organisation (WHO) as the rational redistribution of tasks from highly trained professionals to cadres with shorter training, task shifting in SSA has been applied to maternal and neonatal health (MNH).^(5, 6) In Nigeria, initiatives in MNH include community health workers (CHWs) taking on initial case management for pregnant women to ensure prompt referrals to secondary facilities for specialised care.⁽⁷⁾ Meanwhile, in Malawi and Tanzania, task shifting in MNH has been formalised, with non-physician clinicians undergoing three to five years of training to provide Emergency Obstetric Care (EmOC).⁽⁸⁾

Research in Malawi has found that postoperative outcomes, including maternal general condition, incidence of pyrexia, wound infection, need for reoperation, neonatal outcomes, and maternal mortality, are comparable between non-physician clinicians and physicians immediately and 24 hours post-operation.⁽⁹⁾ In Tanzania, a three-month competency-based programme for non-physician clinicians and nurse-midwives to perform obstetric surgeries resulted in an increase in the number of births at the facility and appropriate use of caesarean sections. This also led to a decrease in fresh stillbirth rates and obstetric referrals.⁽¹⁰⁾

These studies suggest that task shifting can be a viable and effective approach to enhancing MNH services, particularly in resource-constrained settings with healthcare worker shortages. However, successful integration into existing healthcare services is complex and challenging.^(11, 12) Professional bodies in some contexts have raised concerns about patient safety, workforce shortages and the appropriateness of tasks that are delegated.⁽¹¹⁾

STUDY SETTING AND THE MCAI PROGRAMME

Liberia is a West African nation with an estimated population of 5.2 million (2022) and is administratively divided into 15 counties.⁽¹³⁾ The country's health system is organised across 93 health districts and approximately 936 health facilities (50% are public), including 830 clinics, 60 health centres, and 36 hospitals operating across primary, secondary, and tertiary levels of care.⁽¹³⁾

Liberia continues to experience one of the highest burdens of maternal and neonatal mortality globally. (14) Recent estimates indicate a maternal mortality ratio of approximately 628 deaths per 100,000 live births, while neonatal mortality remains high at around 37 deaths per 1,000 live births, far above the United Nations thresholds of 70 per 100,000 live births for MMR and neonatal mortality to 12 per 1,000 live births by 2030 for NMR. (14, 15) Although progress has been made since 2013, when maternal mortality exceeded 1,000 deaths per 100,000 live births, reductions have been slow and uneven, particularly in rural areas where access to quality obstetric care remains limited.(16)

A key driver of these poor outcomes is the critical shortage and maldistribution of skilled health workers, especially in rural settings.(16). These workforce challenges are linked to the long-term effects of Liberia's civil war that ended in 2003 and the 2014–2016 Ebola outbreak, which resulted in a critically low work force density. (17, 18) Despite government-led health workforce recovery efforts, the WHO reported only 0.84 physicians and 0.61 nurses and midwives per 1,000 population in 2020. (19) This remains significantly lower than the recommended minimum threshold of 2.3 healthcare workers per 1,000 population needed to achieve essential health coverage. (19) These workforce constraints contribute to delays in emergency obstetric care and exacerbate inequities in maternal and newborn health outcomes across the country.(16)

While the country as a whole has faced this workforce crisis, international NGOs such as Maternal and Child Health Advocacy International (MCAI) have been implementing geographically focused initiatives aimed at reducing the high maternal, neonatal and child mortality rates in Liberia. In 2013, MCAI (a non-profit organisation established in 1995 and funded by international organisations such as the Irish Aid (20) signed a formal Memorandum of Understanding with the Liberian Ministry of Health and international organisations, including the World Health Organisation (WHO), United Nations Population Fund (UNFPA), and UNICEF, to establish a task shifting programme in an initial four hospitals in 3 of the 15 counties in Liberia. (21, 22) This initiative was designed to address the shortage of physicians in rural hospitals by training midwives and nurses to assume advanced clinical roles as Obstetric Clinicians (OCs), Neonatal Clinicians (NCs) and Paediatric Clinicians (PCs).(21) Training is competency-based and apprenticeship-oriented, with obstetric clinicians undertaking a three-year programme and neonatal clinicians completing two years of training. (21, 22) Graduate OCs and NCs are equipped to provide emergency obstetric and neonatal care, including surgical interventions, with salaries funded by the Government of Liberia, and additional salary top-ups formerly provided by MCAI before reported financial constraints. Once qualified, clinicians work either in their original county public hospitals or in public hospitals selected by the Ministry.(21)

Since its establishment, the MCAI Liberia task shifting programme has expanded from the three counties to a multi-county programme supporting emergency obstetric, neonatal and paediatric care across 10 counties, including Grand Gedeh, Margibi, Bong and Lofa counties.(21, 23). A total of 59 clinicians have been trained (30 OCs, 17 NCs and 12 PCs), the majority of whom are deployed in rural hospitals. As of 2025, 53 clinicians trained through the MCAI programme are actively working in 18 hospitals and 4 Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities.(21)

Although maternal mortality has declined during the programme's implementation, this trend cannot be directly attributed to the MCAI intervention alone, given concurrent health system strengthening initiatives. (24) Programme-level evidence suggests improvements in service delivery and clinical outcomes, with trained clinicians playing a critical role in managing obstetric emergencies, performing caesarean sections, and delivering specialised neonatal care in settings with limited physician availability. (23) Nevertheless, robust epidemiological evidence linking the intervention to national-level mortality reductions remains limited.

Existing literature has highlighted both the effectiveness of the MCAI programme on MNH and associated systemic challenges, but the task shifting approach has yet to reach the status of national policy.(21, 25) There remains limited information on the perceptions and experiences of task shifting among policymakers and frontline health workers, and little understanding of how their responses to these challenges have the potential to affect implementation and long-term sustainability of the approach. This study aimed to fill that gap.

The study was embedded in the OMNeo health research project, a collaboration between the University of Liberia (UoL), the National Public Health Institute (NPHIL), the MoH and the Centre for Tropical Medicine and Global Health, Nuffield Department of Medicine, University of Oxford. Since 2020, this collaboration has aimed to synthesise existing MNH evidence, policies and programmes to identify gaps that can inform future interventions to improve MNH and achieve the SDG. This study explored the perceptions of policymakers and frontline health workers regarding task shifting and the MCAI task shifting programme in MNH, specifically the OC and NC cadres, with particular focus on its perceived benefits and factors influencing its implementation and long-term sustainability.

METHODS

Study Design

This study employed a qualitative exploratory design combining secondary analysis of interview data collected in 2020 with newly conducted key informant interviews (KIIs) in 2024. The secondary dataset originated from a broader qualitative study conducted by the OMNeo Health project in 2020 that examined MNH service provision in Liberia. The study was conducted in Margibi, Grand Gedeh, and Bong counties, which were selected due to their high maternal and neonatal mortality rates for the years 2018 and 2019 and the capital city, Monrovia, where the Ministry of Health and major health partners' offices are situated. Participants in the original study were purposively selected for their roles in MNH service delivery, policy, and community engagement.

Data Sampling and Collection

Secondary data from 2020

The first phase involved a secondary analysis of qualitative data collected between May and August 2020 as part of the OMNeo Health Liberia project. The original data collection was conducted by two Liberian doctors and a public health practitioner with experience in qualitative health research and previous participation in health systems research projects. The team was supported through bi-weekly meetings with the Oxford-based research team, all of whom have extensive experience in qualitative research. Data collection comprised 49 KIIs and 9 FGDs with stakeholders involved in MNH policy, programme implementation, service delivery and recipients of care.

The 49 KIIs included policymakers (n = 6), Ministry of Health (MoH) partners (n = 5, including MCAI), and health workers (n = 24), as well as Traditional Trained Midwives (n = 7), community leaders (n = 3), Community Health Assistants (n = 4), and Community Health Assistants/Volunteers (CHAs/CHVs). The 9 FGDs involved community members. The 24 KIIs undertaken with health service providers occurred across three hospitals, three health centres, and three clinics in Margibi, Bong, and Grand Gedeh counties. Participants at the hospital level included County Health Officers, Medical Directors, midwives and nursing supervisors, and obstetric and neonatal clinicians, while at the health centre and clinic levels, interviews included Officers-in-Charge and midwives.

For the present study, all available KII and FGD transcripts were reviewed to identify content related to task shifting and the MCAI programme. Eleven KII transcripts containing relevant discussions were purposively selected for secondary analysis. No substantive references to the MCAI programme were identified in the FGDs, and these were therefore excluded from further analysis. Details of the 11 selected participants are presented in Table 1.

Additional KIIs

Seven additional KIIs with purposively selected stakeholders were conducted for this study to further explore emerging themes on the MCAI task shifting programme from the 11 transcripts selected from phase one. The seven participants were selected based on their involvement in MNH policy and practice, as well as their engagement with the MCAI programme. Details of the 7 participants are presented in Table 2. While the phase one interviews conducted in 2020 addressed broader MNH issues in Liberia, these additional interviews focused specifically on task shifting and the MCAI programme.

The seven additional KIIs were conducted in 2024 by two of the authors, TL, a visiting researcher and medical doctor undertaking an MSc, and AW, a local public health professional with expertise in the local context and language. Both researchers had experience in qualitative data collection. Five interviews were conducted in person, and two were conducted online. All interviews used a semi-structured interview guide to deepen exploration of the MCAI task shifting programme.

The in-person interviews with health workers were conducted at one county hospital that had previously been included in the OMNeo Health Liberia project in 2020. The remaining interviews were conducted at a hotel conference facility and at the National Public Health Institute of Liberia, based on participants' recommendations for convenience. All phase two interviews were conducted in English and lasted approximately 30 minutes.

Audio recordings were transcribed by an independent consultancy and reviewed by the research team for accuracy. Identifying information was removed during transcription, and participant codes were assigned to maintain confidentiality. Audio recordings were deleted after transcription, and transcripts were securely stored on a password-protected laptop. An explanation of the cadres and roles of study participants in phase 2 is provided in Table 3.

Data analysis

The analysis followed a systematic deductive and inductive process using a framework approach, commonly applied in the thematic analysis of semi-structured interviews. (26) Deductive themes were developed from the study objectives and literature, while inductive themes emerged during transcript review. All transcripts were read repeatedly to allow thorough familiarisation with the data and to note initial impressions. Insights from the first phase informed the development of the second-phase interview guide and shaped the analytical focus on the task shifting programme. Transcripts from both phases were coded in NVivo 14.0, allowing identification of key concepts, patterns, and emerging issues. Similarities and new insights across the two phases were compared, with new issues from the second phase analysed separately. To enhance reliability, co-coding was conducted by two OMNeo researchers, and the codes were compared and refined into a shared framework comprising 19 codes. These codes were then synthesised into five overarching themes. This collaborative and iterative approach ensured that the analysis remained grounded in participants' perspectives and was validated through multiple analytical lenses.

RESULTS

Table 1
Phase one KII participants included in Phase two of the study

Location	Participant	Total number
Monrovia	MCAI representative	1
County 1	Hospital Medical Doctor (MD)-1	3
	Hospital Neonatal Clinician (NC)-1	
	County Health Officer (CHO) -1	
County 2	Hospital Registered Midwife (RM) -1	3
	County Health Officer (CHO)-1	
	Health Centre Officer in Charge (OIC) -1	
County 3	Hospital Medical Doctor (MD) -1	4
	Hospital Obstetric Clinician (OC) -1	
	Hospital Neonatal Clinician (NC) -1	
	Clinic Certified Midwife (CM)-1	
TOTAL PARTICIPANTS		11

Table 2
Phase two KII Participants

Location	Participant	Participation in KII 2 or KII 1 and 2	Online/In-person interview	Total no.
Monrovia	Polymaker- Family health unit – 1	KII 1 and 2	On-line	3
	MCAI representative-1	KII 1 and 2	On-line	
	Polymaker- MoH Policy and Planning Department – 1	KII 2	In-person	
County 2	County Health Officer (CHO)-1	KII 1 and 2	In-person	4
	Hospital Obstetric Clinician (OC)-1	KII 2	In-person	
	Hospital Registered Midwife (RM) -1	KII 2	In-person	
	County Maternal and Child Health Supervisor (MCHS)-1	KII 2	In-person	
TOTAL NUMBER OF PARTICIPANTS				7

Table 3
Types of study participant and description of roles

Participant	Role
MCAI representative	Ongoing management of the MCAI task shifting programme.
Hospital Medical Doctor	A medical doctor who is responsible for overseeing the medical services within a hospital, including MNH care.
County Health Officer	A Medical Doctor who heads the County Health and Social Welfare Team (CHSWT) and is responsible for overseeing health and social welfare services in the county, including MNH.
Hospital Registered Midwife	A midwife who provides comprehensive maternal, newborn, and reproductive health services within a hospital setting.
Health Centre Officer in Charge	A clinician responsible for the overall leadership, coordination, and management of a health centre
Hospital Medical Doctor	A medical doctor who provides comprehensive diagnostic, curative, and preventive medical care to patients admitted to or attending the hospital.
Hospital Obstetric Clinician	A midwife trained by the MCAI programme to undertake obstetric care tasks normally done by medical doctors
Hospital Neonatal Clinician	A midwife trained by the MCAI programme to undertake neonatal care tasks normally done by medical doctors
Clinic Certified Midwife	A midwife who provides essential maternal, newborn, and reproductive health services at the clinic or health centre level
County Maternal and Child Health Supervisor	A nurse who provides technical oversight, coordination, and supervision of MNCH services across health facilities within the county. Responsibilities include supporting the implementation of national MCH policies and guidelines; conducting supportive supervision and mentorship of facility-based MCH staff; and monitoring service quality, coverage, and key MNCH indicators.
Policy maker Family Health Unit	Involved in RMNCAH policy in the MoH and was involved in the inception of the MCAI task shifting programme
Policy maker- MoH policy and planning	Involved in policy development at the MoH, including RMNCAH policies.

The findings are presented under two broad categories: perceived benefits of the MCAI task shifting programme and perceived challenges and barriers to its integration into Liberia's health system.

Positive Effects

Increased responsiveness and optimised efficiency

Most participants across all cadres perceived that the MCAI task shifting initiative had improved responsiveness to MNH emergencies. They described how before introducing OCs, patients had to wait extended periods for a doctor to arrive and provide necessary care. However, it was also clear that, even if not present, the doctor's permission was required before the OC could proceed.

"The changes it brought, like I said before when patients are brought, the doctors are not there. We have to wait for the doctors. It takes some time before the doctor will come. But now the Obstetric clinicians are on the ground. When midwives assess the patient and they notice that the patient has to go through surgery, they call the Obstetric clinician and they assess together. When they have assessed, the Obstetric clinician says yes, and then they inform the doctor. The doctor quickly gives them the go-ahead when they are not there. So, the work is done faster than before where you wait until sometimes two, three hours for the doctors." (KII-2 MCHS-County 2)

"The nurses that have been trained or the midwives that are trained, once we have our emergency and the doctor is far, the trained midwife will take that patient in and just present the patient information to the doctor and go ahead with surgery, most especially once they are confident in doing the work." (KII-2 RM-County 2)

Participants not trained by the MCAI initiative, including all doctors whose work had been shifted to the OCs and NCs, were also very positive about the effects on their workload of the programme. They reported that the implementation of the MCAI task shifting programme had optimised the efficiency of the healthcare workforce through relieving workload for doctors and providing additional health workers with advanced skills.

"So, I was the only doctor in the hospital and it was really overwhelming. At that time, we had sent two of our midwives to go for the task shifting training, so blessedly for me, when they came back, they actually helped me a lot. If I was in the theatre with a patient, and another patient fit within their criteria, they would go to the next theatre and take that task off my hands. They were of great assistance to me and they are still doing great." (KII-2-CHO-County 2)

"Yes, the presence of the OB and NC clinicians is very much helpful to us, like I told you the patients load is very heavy and these people are there, especially the ER and the postnatal ward they see these patients and they clear them and they call us, give us update" (KII-1-MD-County 3)

Perceived Challenges and Barriers

Inter-cadre tensions

Despite their reporting of positive effects on their workload, resistance from doctors emerged as a recurrent theme. Several of the respondents reported inter-cadre tensions as a significant challenge to the effectiveness of the MCAI task shifting programme, and that some doctors perceived the programme as encroaching on their professional domain. However, none of the doctors who participated in this study expressed concerns about the task shifting programme.

"there was opposition from some doctors to the concept of having nurses and midwives doing advanced hospital care, particularly obstetric care, involving caesarean section surgery and so on, despite the fact that they were trained to a very high level by international and national doctors, and they really wanted to stop the programme " (KII 2-MCAI).

A policymaker further elaborated that doctors have raised concerns about the OCs and NCs being underqualified to perform specialised tasks and taking over their responsibilities

"Before this started, there are some colleagues, most of our professional colleagues, the doctors, and some of them were not really happy about this programme, especially the neonatal clinicians' part, and today some are still not happy with the notion that we are taking their job and giving it to those who were not trained originally to do it so we have been having a lot of back and forth on this." (KII 2-Policy maker 1).

The MCHS confirmed the ongoing resistance to OC and NC cadres by medical doctors within their facility, stating that while some doctors embrace the new cadre of trained nurses, others do not.

"There are some doctors who really accept the programme that they work with them at ease. But there are other doctors who have not accepted, they will only want themselves to do it. Some doctors, like the medical director that was here, they work well together. The one that just went out. And there are other doctors here too who don't respect the OB and neonatal clinicians at all," (KII-2 MCHS-County 2).

Another OC bluntly stated that the resistance of task shifting from doctors could impact the hoped-for outcomes of reducing maternal and neonatal mortality.

"Liberian doctors don't want this task shifting program so I don't know where they're coming from to say they will reduce maternal mortality and almost all of the death that can occur people dying, I'll be frank with you,". (KII-2- OC-County 2)

Training and institutionalisation

From the KII 2 interviews, it emerged that a key challenge in implementing the MCAI task shifting initiative was that the training programme was conducted by an NGO through the hospitals involved in the programme and not the MOH or an academic institution.

Policymaker 1 referred to the training institution challenge as a lack of institutionalisation and reported that the training of OCs and NCs had been hospital-based since the programme's inception. Despite progress in training these cadres, the reliance on hospital-based training has only hindered the programme's recognition by a regulatory body, and, consequently, the provision of licenses to graduates.

"The last one that we are still struggling with is institutionalising the program, as it is now, we are still doing hospital-based training and we started with the hospital base and we are still doing the hospital base training and because of this we are finding it very difficult to give the license to these people who have graduated." (KII 2-Policy maker 1)

The representative from the MCAI programme, who provided new insights on this issue in KII 2 confirmed the policy maker's reports about the intention to integrate the programme into a training institution in 2020. However, he reported that the proposal to integrate the training into a public university was met with resistance, particularly from a senior official working with the Ministry of Health, who also suggested that it should be part of a private university, but the programme declined the suggestion.

"And with the Liberian board, their view was that we should try and get it institutionalised within the universities. In 2020, it was agreed that xxx would organise this particularly for X University. However, he didn't do anything, and he kept getting in the way of us doing it. In the end, he said, "What we want you to do is to work with a private university in A or in B County. We said, "We can't. It has to be with a National Liberian University. Otherwise, we won't be involved." (KII 2-MCAI)

Regulatory body and Licensing challenges

A further concern that arose during the KII interviews was regulatory body and licencing issues which were described as a significant barrier for the MCAI programme. The MCAI representative explained that initially, the issuance of licenses to the OCs and NCs fell under the Liberia Medical and Dental Council. After an evaluation report by the WHO, it was decided that the Liberian Board of Nursing and Midwifery would be more appropriate to handle the licensing process, as the professionals in question were nurses and midwives. He stated that complications arose when the MoH intervened and said they would provide the licences but failed to follow through on their promise, leading to significant delays and challenges in the issuance of licenses to OCs and NCs.

"Well, LMDC did originally provide the licenses. Well after the evaluation report by WHO, it was decided that it would be more appropriate for the Liberian board of Nursing and Midwifery, to provide the licenses because these people were nurses and midwives. We didn't have a problem as long as they provided the licenses. Then the Ministry of Health got in the way of that. So, I think that it ended up that the Liberian board couldn't work with the Ministry of Health. Then the Ministry of Health got in the way and said, "We will do it, but they didn't actually do it " (KII 2-MCAI)

An OC reported that, although earlier graduates of the task shifting training programme initially received licenses from The Liberian Board for Nursing and Midwifery, they encountered difficulties in renewing them. She shared that when she attempted to renew her license, she faced obstacles due to the LMDC

and nursing regulatory bodies' reluctance to accept the NC and OC cadre.

"We don't go to surgery because our license got expired, they gave us one year license our license got expired we went back to the nursing and midwifery board to renew our license The board told us, no, we can't renew your license because the doctor has seen you people doing surgery. It is LMDC that's supposed to give your license and LMDC is telling us not to give your license"(KII-2- OC County 2)

The MCHS and OC from KII 2 further reported that the inability to offer licenses to the OC leads to their hesitation and delays in providing patient care. They further shared that some OCs often refrain from performing surgeries independently without formal licensing, opting to wait for licensed doctors. This hesitation is partly due to fears about the lack of regulatory body support and backing if mistakes occur.

"Because they are not giving them license, Sometimes the OB clinicians will sit they will not go because they say they say so long they don't have license, they will not go to surgery. They will wait until the doctors come. So, it causes delay for the time to do surgery for patients." (KII-2 MCHS-County 2)

Financial constraints

Financial challenges were mentioned by participants as another significant bottleneck for task shifting, affecting both the training of OCs and NCs and their motivation. Both of the policymakers highlighted that the programme needs to be incorporated into the national budget, as it is still donor-dependent.

"And the next is the logistics and the finances for training. The training for the OB clinicians is intense, based on the course and the finances. So to address these issues one is to actually put the programme on the national budget to be able to allocate the funding for this programme because you know this is heavily donor driven, but donors will not incur recurrent cost and the issues of salary is recurrent cost so if this programme is placed on the budget and funded that funding most of it could go to the recurrent cost of this programme to give them their salary and all of that while we work with donors to do the logistics and take care of administrative and all of that issue"(KII 2-Policy maker 1)

"There has been, uh, the new salary structure has been drawn up with everybody participating. But sometimes again, the resource is not there. So, it's about having a deeper reflection across government agency, the Ministry of Finance and the treasury to see how we can address the OC and NC issue it is critical."(KII 2-Policy maker 2)

One of the OCs reported that many of the OCs and NCs were still receiving their midwife salary, which has not been topped up after they obtained the new qualification.

"Yeah, in fact, for some of them, they're still taking their midwife's money. Like batch after us they have not even stepped them up. Some of them are still taking their \$, their \$ Yeah." (KII-2- OC-County 2)

A CHO reported dissatisfaction among OCs and NCs when their increasing responsibilities are not matched with appropriate financial compensation.

"They are not motivated. Initially, they were motivated. They thought their salary was going to improve. Because you're adding tasks to me now. Alright? So, my salary has to add up you can't add more tasks to me and then my salary stayed the same. There should be some upgrading. Because these are specialised health workers." (KII 2-CHO-County 2)

The MCAI representative reported that they had made efforts to provide incentives to the OCs and NCs but have experienced challenges sustaining the financial support and expressed frustration with the lack of support and commitment from the MOH in taking up this responsibility.

"And we were giving this incentive until last month,

\$. But now we can't afford it because all our money's gone. And we made that clear to the Ministry and they didn't care. They didn't. And we were \$ towards it by the former minister of health which never appeared." (KII 2-MCAI)

DISCUSSION

Participants in this study perceived the MCAI task shifting programme positively, recognising its contribution to strengthening maternal and neonatal care in resource-constrained rural settings. By training midwives and nurses as obstetric and neonatal clinicians, participants perceived that the programme had improved responsiveness to obstetric and neonatal emergencies, reduced delays in surgical interventions such as caesarean sections, and alleviated the workload of doctors. These findings add to the growing body of evidence supporting task shifting as an effective health workforce strategy in sub-Saharan Africa and beyond, with studies from Mozambique, Ethiopia, and Malawi demonstrating that non-physician clinicians can safely and effectively provide essential surgical and obstetric services. (8)

Despite the positive reception by all participants, political governance and financial barriers have limited the initiative's formal integration into Liberia's government system and affected its sustainability. A key challenge highlighted was inter-cadre resistance, particularly from medical doctors. Some participants noted that opposition to the programme was present from its inception and remains evident at the hospital level, where doctors often hold decision-making authority. This resistance reflects entrenched power dynamics within the health system, where physicians perceive task shifting as encroaching on their professional domain. Evidence from task shifting programmes in other low-resource settings suggests that such tensions commonly arise when new or expanded cadres alter traditional divisions of labour, particularly when existing professionals feel that it diminishes their role in the health system or believe that quality of care may be compromised. (12) Such dynamics not only create tension within clinical teams but also influence policy-level decisions, thereby affecting implementation. (27)

The lack of formal health system integration was also evident in the regulation and training of the OCs and NCs. At the time of the study, these cadres were not fully incorporated into formal licensing and accredited training pathways. However, subsequent developments reported after completion of this study suggest some progress toward addressing these barriers. A 2025 publication on the MCAI programme reported that OCs undertaking abdominal surgery are now licensed and registered through the Liberia Medical and Dental Council, and that curriculum development processes are underway to institutionalise training within a public university setting.(21) These developments indicate growing formal recognition of the cadres, although they emerged more than a decade after the programme's establishment in 2013, highlighting the slow and complex process of integrating the OC and NC cadres into formal government systems.

Some participants attributed this gap directly to the prevailing power dynamics, stating that some officials in government influenced the progress of regulatory body oversight and training in public universities. As a result, OCs and NCs remained excluded from licensing frameworks for many years which at the time of the study limited their legitimacy and career progression within the health system. While these cadres are now being formally recognised through licensing and training reforms, the long-term implications of delayed institutionalisation for workforce stability and professional development remain to be fully assessed.

By contrast, Malawi provides an example of the early formal integration of task shifting cadres into the national health system, with clinical officers being trained through public universities, licensed by established regulatory bodies, and incorporated within government health services for many years..(28) This early institutionalisation of task shifting has facilitated enhanced career security, professional recognition, and continuity of services.(29)

Financial insecurity further undermines the sustainability of such initiatives. Training OCs and NCs is resource intensive, yet the programme is heavily donor dependent. Participants highlighted that donors are unable to cover salary upgrades, resulting in these cadres being underpaid for the additional work they do. While progress has been documented in licensing and curriculum development, sustainable financing and remuneration remain insufficiently documented in the literature. (21) This challenge reflects broader evidence from task shifting programmes in low- and middle-income countries, where expanded responsibilities are often not matched by corresponding remuneration. Across many settings, cadres report increased workloads and higher levels of responsibility without commensurate financial recognition. This has reportedly produced unintended consequences with some health workers developing informal mechanisms to supplement income, such as charging unofficial fees. (12)

Other contexts illustrate how this challenge could be addressed. In Kenya and Malawi, salary structures for clinical officers are formalised within government systems, with opportunities for further training linked to increased remuneration. While delays in this process do exist in these contexts, some staff receive compensation commensurate with their qualifications. Such policies not only ensure workforce stability but also improve motivation and retention. (29)

Limitations of the study

This study has several limitations that should be considered when interpreting the findings. First, the analysis was based partly on secondary data, which limited the ability to probe responses in greater depth or to clarify ambiguities in the original data sources. It also limited the inclusion of community level insights of the programme.

Second, the study was conducted within the context and time frame of a master's research project and dissertation, which imposed constraints on time and resources. As a result, opportunities for further data collection, triangulation, or longitudinal follow-up were limited.

Consequently, the findings may be limited in scope and may not fully capture the diversity of perspectives across all stakeholders involved in the task shifting programme. These limitations should be taken into account when considering the transferability of the results to other settings.

CONCLUSION

These findings highlight both the promise and fragility of task shifting programmes in Liberia. Lessons from countries where task shifting has been successfully institutionalised suggest that formally embedding the cadres into government systems through regulatory oversight, recognised training pathways, and structured career progression is essential for transforming short-term donor-dependent initiatives into sustainable health system solutions.

The delay in the Liberian government's formal integration of the MCAI task shifting programme calls for a deeper exploration into the underlying processes and complexities within the health system that affect the full integration and implementation of task shifting initiatives in MNH. This study's findings focus on health workers and policymakers directly or indirectly involved in the MCAI task shifting programme and thus do not reflect the perspective of all key stakeholders. It is crucial to identify and interview those who are less supportive of or potentially obstructing the strategy. This includes regulatory bodies and doctors who have resisted the MCAI programme and other task shifting initiatives. Additionally, research into patients' perspectives on the role of the MCAI task shifting programme and task shifting in MNH could provide valuable insights into the implementation and effectiveness of these initiatives. This broader perspective is crucial for developing inclusive strategies that address concerns, ensuring that task shifting initiatives are more effectively integrated, accepted, and sustained within the healthcare system.

Declarations

Clinical trial number: not applicable.

Ethics approval and consent to participate

This study was conducted in accordance with the ethical principles of the Declaration of Helsinki. The study was approved by the Oxford Tropical Research Ethics Committee (OxTREC Ref. 529 – 20) and Liberia’s ACRE-IRB (Protocol #20-06-217). Written and verbal informed consent was obtained from all participants before participation in the study. Consent included permission to record interviews, analyse data, and use anonymised quotations in publications.

Consent for publication

Consent for publication was obtained. Participants were informed that anonymised quotations from the interviews could be used in publications and reports arising from the study. No identifying information is included in this manuscript.

Data (and Software) Availability

The datasets acquired and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing Interests

No competing interests were disclosed

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Contribution to knowledge

This study contributes to the evidence on task shifting in maternal and neonatal health by providing insights from both policymakers and frontline health workers in Liberia. It extends the existing literature by shedding light on the perceived and experienced political, institutional, and professional barriers that influence the implementation and sustainability of task-shifting programmes in the Liberian context.

Author Contribution

TL participated in the design of phase two of the OMNeo health research project reported in this paper, data collection, data analysis and interpretation and drafted the manuscript. WG participated in the broader phase one OMNeo health research project and provided supervision of phase two of the study reported in this paper, and facilitated participant identification/recruitment. AW participated in the broader phase one OMNeo health research project and in data collection and analysis for phase two of the study reported in this paper. CJ participated in the design of phase two of the OMNeo health research project reported in this paper, provided supervision of the research and helped draft the manuscript. CA participated in the broader phase one OMNeo health research project and participated in the design of phase two of the study reported in this paper, provided supervision of the research and helped draft the manuscript. PA is the Principal Investigator of the broader OMNeo health research project. All authors reviewed the manuscript.

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Data Availability

The datasets acquired and/or analysed during the current study are available from the corresponding author on reasonable request.

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