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Implementation and aspiration gaps: whose view counts?


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The Lancet's Maternal Health Series[1–6] paints a sobering picture of the state of maternal health today. The Series focuses on the "mismatch between burden and coverage", which "exposes a crucial gap in quality of care"[6] and spotlights the millions of pregnant women and adolescents who never get access to services at all. But 30 years after the start of the safe motherhood initiative, this mismatch exposes something else as well: a dangerous disconnect between the way the global health community has framed problems, proposed strategies, and pushed solutions, and the lived experience of people and providers. Thus the quality and access gaps defined in the *Lancet* Series through epidemiological analysis and quantitative data could also be framed as implementation and aspiration gaps, drawing on a wider range of empirical data to speak a different truth to power.

Take the example of facility-based delivery care. The central aim of global skilled-birth-attendance strategies has been to ensure that routine births are managed in accordance with evidence-based practices and that obstetric complications are treated in facilities where emergency obstetric care (EmOC) is delivered. Whether women are driven to deliver in facilities by their own desires, by financial incentives, or even by government compulsion is often unclear—and rarely considered to matter. Seemingly, what counts is that facility-based delivery has increased, sometimes dramatically. What do women experience when they arrive at facilities ready to give birth?

Suellen Miller and colleagues[2] identify 51 high-quality global and national clinical practice guidelines issued since 2010 for routine maternity care in facilities. Focusing on middle-income countries to determine what actually transpires, they document pervasive, health-threatening deviations from those guidelines, characterised by too little, too late (insufficient appropriate care) and too much, too soon (excessive medicalisation).[2] Other recent reviews[7] round out the picture by exposing a startling range and level of disrespectful and abusive treatment, in countries both rich and poor.

Implementation gaps are not limited to the four walls of the health facility. Oona Campbell and colleagues[3] show that the indicators we in the global health community have so confidently promoted for coverage measurement at the population level often serve only to hide catastrophic failures. They say that "governments and policy makers can no longer pretend to provide life-saving care, using phrases such as skilled birth attendant and EmOC to mask poor quality".[3] Pretend is perhaps a good choice of verb. Campbell and colleagues[3] show that standardised, globally formulated strategies pressed upon countries in an attempt to make services widely available and accessible ultimately ignore the varied topographies, health-system configurations, and demographic characteristics of different countries—which makes achievement of globally determined norms at a globally determined pace manifestly unrealistic.

A view from the ground would show globally formulated strategies ignore many other things as well: different histories, governance styles, and social dynamics; minimal state capability to influence the dynamics at the periphery of the system;[8] and corrosive distrust of health systems by both the people who work for them and the people meant to benefit from them.[9] A view from the ground would show that people's interactions with maternal health services are never only about attaining health outcomes. These interactions are also about aspirations to have some control over their birth experience, to be treated with dignity and respect, and to use their choices around childbirth to signal who they are and who they want to be.[10,11]

But in the fervour to see results, the global health community has inadvertently turned the policy face of countries (especially aid-dependent countries) toward the global, instead of toward their own citizens. Data elicited in this Series display the telltale signs of isomorphic mimicry, the phenomenon in which countries adopt the outward-facing forms (eg, policies, indicators, curricula) that international donors demand, but do not change the fundamental content or dynamics of health services.[8] When the mimicry works, funds continue to flow, and the cycle begins again. Even as progress against indicators is made, the reality experienced on the ground—a reality that finds only muted expression in global health literature—diverges ever more starkly from the dominant global discourse.

The point is not that global strategies, evidence-based guidelines, or high-level monitoring and accountability initiatives are inherently wrong or unnecessary. But when they consume most of the oxygen in the room, drowning out voices and signals coming from the ground, they distort both understanding and action.

Three emerging areas of work are beginning to rectify this imbalance. First, in the programme domain, implementation support practices are increasingly designed not just to assure compliance but to create systems attuned and responsive to learning from the ground, where challenging social and organisational contexts can blunt even the purest commitment to behaviour change. Use of the active implementation frameworks[12] and problem-driven iterative adaptation[13] are two examples of how evidence-based implementation strategies can be adapted, applied, and sustained within programmes to strengthen health services. Second, in the research domain, field-building efforts such as those around health policy and systems research and South–South research coalitions are alert to ground-level dynamics and give heightened attention to these issues.[14] Third, in the advocacy domain, the expanding field of social accountability bolsters efforts to create a robust civil society. We in the global health community can call for people's voices all we want, but unless investments are made in the organisational structures to make these voices heard over the clatter of globally driven advocacy initiatives, that call will be little more than rhetorical flourish.

For those of us who work primarily in the global arena—no matter which countries we are from—some humility is in order. The true engine of change in maternal health will not be the formal clinical guidelines, polished training curricula, model laws, or patient rights charters we produce. The engine will be the determination of people at the front-lines of health systems—patients, providers, and managers—to find or take the power to transform their own lived reality. Our job in global health is first to listen to them, and then to co-create the conditions at every level of the system that can make that locally driven transformation possible.

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