Integrating HIV and Maternal Health Services: Will Organizational Culture Clash Sow the Seeds of a New and Improved Implementation Practice?

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Abstract: Drawing on an analysis by Pritchett et al of the "techniques of persistent implementation failure" common across many development sectors, this commentary suggests that health systems attempting to integrate maternal health and HIV services may need to contend with a profound clash of organizational cultures. For decades, countries have been pressed to implement global "best practices" in maternal health without attention to the systemic capacity building needed to support complex interventions. The result is often form without function, a kind of "isomorphic mimicry" in which policy documents and program plans that meet global standards ultimately camouflage deep dysfunction in the actual delivery of lifesaving services. As a result, the organizational culture that surrounds maternal health services often stands in stark contrast to the can-do style that has characterized the rapid, well-resourced deployment of HIV services over the last few years. As integration proceeds, the resolution of this clash may hold the seeds of a much-needed transformation of implementation support practices in both fields.

Key Words: capacity building, implementation support, innovation, integration, maternal health, organizational culture

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Increasingly, the question for the global health community is not *whether* to integrate HIV and maternal health services, but *how*. The integration literature focuses primarily on the building blocks of the health system (human resources, equipment and supplies, infrastructure, and information) required for overlapping areas of service delivery, such as prevention of mother-to-child transmission and antenatal care. Addressing the mechanics of delivering linked services will certainly be essential. But successful and sustained integration must be premised on a more basic understanding of what makes these services work—*or not work*—as complex adaptive systems. When the checkered and halting history of implementation efforts in the maternal health field meets the can-do style of a well-resourced HIV implementation machine, a clash of organizational cultures looms. Its resolution may hold the seeds of a much-needed transformation of implementation support practices in both fields.

Many constituent parts of overlapping health services, such as laboratory services and commodity procurement, can be routinized, scaled, and improved with appropriate attention to the details of evidence-based guidelines. The heart of the delivery challenge for both maternal health and HIV, however, is those services that are both highly discretionary (ie, requiring providers to make skilled judgments that cannot be fully systematized or even, indeed, fully observed and monitored) and transaction-intensive (ie, requiring thousands or millions of individual provider–patient interactions).[1] A significant change or innovation in such highly discretionary, transaction-intensive services—such as those required for both maternal health and HIV—cannot be implemented simply by promulgating the right policy or even by initiating a program with a full complement of evidence-based protocols, standards of care, and indicators for monitoring and evaluation.

The implementation challenge for such services is more deeply human. To sustain the level of change in actual performance imagined by integration advocates requires an analysis that starts not only with the top–down logic of evidence-based medicine but also with the logic of individual health workers embedded in organizations and systems that profoundly shape the choices they make, the way they exercise the discretion so fundamental to their work—and the actions of patients in response.

It is in the individual–organization–system dynamics—that is, the "ecological space" for implementation[2]—that maternal health and HIV typically diverge. Although there are certainly inspiring success stories in maternal health,[3] in many countries with high maternal mortality rates, maternal health services bear the hallmarks of the more general development syndrome that Pritchett et al[2] have called "persistent implementation failure." Obstetric services provide a prime example. In settings where maternal mortality remains stubbornly high, these services, existing in some form since the systems began decades ago, are now often deeply dysfunctional: health care worker absenteeism of 20–40% is routine[4]; leakage of funds and stockouts of drugs reach epic proportions[5]; a huge "know–do" gap persists, despite wave upon wave of in-service training[6]; and rampant mistreatment of patients[7] is but the tip of the iceberg of dismal quality care.

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These are not problems fixed by an improved training course or better equipment or more reliable supplies. They are so-called wicked problems,[8] now deeply entrenched within the organizational culture that often surrounds maternal health and many other areas of care.

The impact of this "ecology" of implementation on efforts to promote evidence-based practices is sobering. The literature is replete with examples of globally endorsed best practices launched with great fanfare only to fall rapidly back into dysfunction. Active management of third stage of labor, an effective intervention for postpartum hemorrhage—the number one cause of maternal mortality globally—has failed to take hold at scale.[9] Magnesium sulfate, the drug of choice for hypertensive diseases of pregnancy—the number two cause of maternal mortality—is regularly missing or sits on shelves unused.[10,11] Partographs to help recognize and manage obstructed labor, another leading cause of maternal deaths, are routinely ignored[12]; and even the teaching of instrumental delivery has been abandoned in many countries.[13] Infection prevention practices fall by the wayside.[14] Focused antenatal care does not happen.[15] Even in cases when innovative accountability mechanisms explicitly designed to tackle performance problems at the front line have initially succeeded, some were ultimately sabotaged by the adaptive response of the system, returning to the status quo of poor services.[16]

Although the fundamental causes of such problems are no doubt multiple, diverse, and context-specific, the "*techniques* of persistent implementation failure" follow some clear patterns. Pritchett et al[2] explicate a pair of the most common and influential.

The first stems from the fundamental assumption that function will follow form and that appropriate forms can be identified and promoted through so-called best practices. Although regularly dressed up in layers of well-intentioned talk about eschewing blueprints and urging adaptation, this approach fails to grapple with the more profound weakness of the administrative systemic capacity on which so many best practices, in adapted form or not, ultimately depend.[17] Rather than invest in the difficult and contentious work of building such capacity organically from the ground up (as wealthier countries did over several centuries), development practitioners encourage countries to engage in a kind of "isomorphic mimicry"[2] in which organizational forms (best practices) adopted and adapted from elsewhere become a strategy to camouflage deeper dysfunction. Egged on by donors and experts, good policies are issued, annual workplans are designed, indicators are chosen, training packages are launched. From a global perspective, all looks well and the money continues to flow. But the actual functioning required for impact on health indicators remains elusive.

The view from the ground is dramatically different. As new evidence-based technologies continue to emerge from the global research enterprise and are translated into best practice guidelines, the ideal capacity-intensive systems assumed by policies and program plans grow increasingly distant from the harsh reality existing at the front lines. As the disconnect widens and intensifies, the pressures on system integrity become intolerable. Individual agents (front-line health workers and managers) face an incentive structure in which the pressure to pursue private interests, including rent-seeking, at the expense of poorly supported health-based system goals, intensifies as well. The dysfunction reaches a tipping point. The prevailing organizational culture shifts as poor performance and the rationalizations and thought patterns that go with it become normative—even as some true champions labor on, providing excellent services in the face of daunting challenges. This second technique of persistent implementation failure—"pre-mature loadbearing"[2]—captures the dynamic that has long prevailed in many settings where maternal mortality has been high and intractable.

Enter HIV services. Launched in emergency response mode, HIV services were something new. Tackling a frightening and bewildering disease, unconstrained by centuries of traditional practice, HIV services required the introduction of new treatments and protocols. Systemic administrative weaknesses were often dodged by establishing separate HIV subsystems. Backed by generous resources, technical assistance, supportive mentoring for health workers, and even the allure of new career possibilities,[18] the results are truly impressive: >5.2 million people in low- and middle-income countries had access to antiretroviral therapy (ART) by the end of 2009.[19] This is not to say that culture or cultural practices play no role in how HIV is understood, lived, and managed. But the *culture of the health services* for treating HIV was far more open to innovation—at least at the start.

Yet there is reason for pause. Anticipating scenarios in which the numbers of people living with HIV/AIDS needing ART far outstrip the available human resources and the administrative and managerial capacity of even a well-resourced system, Van Damme et al[20] predict that, unless there is profound transformation in the structure of HIV services, the status quo will soon descend into a dynamic of rent-seeking and unaccountable services characteristic of premature loadbearing, a dynamic reminiscent of where we have long been stranded in the efforts to improve and reinvigorate traditional maternal health services.

In the field of maternal health, trepidation about services requiring a level of systemic capacity that donors are generally loathe to support—such as emergency obstetric care—has led to a perpetual search for approaches that would avoid the health system altogether, such as the largely futile effort to find low-cost, simple methods to predict and prevent obstetric complications. Meanwhile, maternal deaths continued to mount. In contrast, no "simple" option for HIV treatment was available—or acceptable to the well-organized civil society movements pressuring donors and ministries of health to provide ART. With the decision to scale up the delivery of complex continuity care services, the foundation for health system strengthening has been laid.

The push for integration in the face of stagnating resources and increasing demand may now force the HIV community to confront the deeper challenges of implementation that have been so disastrously ignored in maternal health. The conceptual framework by Atun et al[21] for assessing integration provides a useful analytic starting point: by casting health systems as "complex adaptive systems" and interventions as "innovations" comprising not just novel technical elements but whole packages of "new ideas, practices, objects, or institutional arrangements," the framework will surface

many of the challenges latent in a system that has experienced long years of persistent implementation failure.

Perhaps a useful addition to the framework's guided exploration of critical health system functions would be a pointed question about what mechanisms are in place to support the ongoing *implementation* of innovation at scale. The likely answer will be that no such mechanism actually exists within the health system structure. But complex interventions do not implement themselves—a hard truth that sometimes becomes obvious only when population health indicators such as maternal mortality fail to respond to recommended policy changes and the best-laid program plans. Perhaps it is only when death in childbirth and death from HIV become truly unacceptable that the camouflage of isomorphic mimicry will finally become unacceptable as well.

If we have reached that moment, then fertile ground for cultivating a new approach may exist. The technical support infrastructure of HIV programs, such as the United States President's Emergency Plan for AIDS Relief (PEPFAR), provides a platform from which to develop a new implementation practice that takes seriously the need to build the capacity of the system to support innovation in both maternal health and HIV. The emerging field of implementation science[22,23] offers the possibility of lesson learning and best practices of a different order, one addressing not just form, but the harder challenge of function and the building of indigenous systemic capacity to support it.

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