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SUMMARY: REPORT ON THE IMPLEMENTATION OF MATERNAL-PERINATAL HEALTH CARE PACKAGES

USAID Local Health System Sustainability Project (LHSS)

Task Order 1, USAID Integrated Health Systems IDIQ

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The USAID Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will strengthen local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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1. INTRODUCTION

The USAID Local Health System Sustainability Project (LHSS) aims to strengthen Colombia's health system to increase access to quality health services for the Venezuelan migrant population, Colombian returnees, and host communities. Accordingly, LHSS seeks to foster public-private partnerships and improve coordination between all levels of Colombian government and international cooperation agencies to expand health coverage for migrants and returnees and ultimately improve the health outcomes of these populations.

This document compiles stakeholders' experiences planning and implementing projects funded by international cooperation resources that address the provision of maternal-perinatal health care services, with the aim of:

1) Facilitating and supporting the contracting process and the delivery of health care services for pregnant women. The implementation of this process involves various stakeholders including health authorities, international cooperation actors, and health care providers.

2) Describing the barriers, facilitators, and lessons learned in strengthening the process of implementing maternal-perinatal health care packages in diverse contexts. These packages can serve as models for designing and delivering health care services for other prioritized population groups such as children, adolescents, elderly adults, and people with disabilities.

3) Equipping stakeholders (Ministry of Health and Social Protection (MSPS), health secretariats, health care providers, international cooperation actors, and private companies) with information and evidence on the management, financing, and delivery of comprehensive maternal-perinatal health care packages. Additionally, the document serves to share the experiences of entities involved in expanding health care coverage for pregnant women, including Venezuelan migrants, across the country, thus fostering constructive relationships among the stakeholders involved.

This is an English language summary of the full report, which is available in Spanish.

Objective

The objective is to identify and outline the barriers, facilitators, recommendations, and lessons learned from implementing comprehensive maternal-perinatal health care packages for pregnant women from Venezuela with irregular migratory status.

Problem statement

Improving maternal health is one of the highest priorities for the Colombian government. The MSPS coordinates with various stakeholders to ensure access to high quality maternal health services. Notably, the national maternal mortality ratio dropped from 71.64 per 100,000 live births in 2010 to 45.29 in 2018. However, this progress was severely impacted by the increase in migration and the COVID-19 pandemic, with the maternal mortality ratio reaching 65.10 per 100,000 live births in 2020 and 73.60 in 2021.[1]

[1] Instituto Nacional de Salud. Boletín Epidemiológico Semana 46, resultados preliminares 2022. Bogotá. INS 2022. [Accessed December 9, 2022]. Available at: https://www.ins.gov.co/buscador-eventos/BoletinEpidemiologico/2022_Bolet%C3%ADn_epidemiologico_semana_46.pdf

One contributing factor to this increase was the challenge faced by women with irregular migratory status in accessing health care. Venezuelan pregnant women accounted for 88 of 456 total maternal deaths in 2021. At the time of writing this report, this group accounted for 27 maternal deaths out of 181 cases thus far in 2022.[2] In response to this situation, the MSPS, along with the Institute for the Evaluation of Health Technology (IETS) and international cooperation agencies designed a maternal-perinatal health care package based on the services included in the Comprehensive Maternal-Perinatal Healthcare Pathway (RIAMP).

This comprehensive maternal-perinatal health care package has served as a guiding framework for contracting and delivering health care services to pregnant women, financed by international cooperation agencies and private companies. It is important to meticulously document the implementation of this initiative to inform similar efforts in the future.

2. METHODOLOGY

This report employs a combination of qualitative and quantitative methods to assess available data for implementing comprehensive maternal health care packages. Two questions guided this reporting process:

- What are the lessons learned from implementing maternal-perinatal health care services, particularly for pregnant Venezuelan migrants?
- What were the achievements of these initiatives in terms of coverage and outcomes compared to the objectives of providing maternal-perinatal health care services?

LHSS conducted a concurrent mixed descriptive study, encompassing both qualitative and quantitative components, to analyze the planning and implementation of maternal-perinatal health care packages in Cúcuta and Bogotá.

Data collection and analysis were carried out separately for each component, followed by the triangulation and integration of results. This approach produced an overview of the planning, execution, and impact of the projects developed with international cooperation resources.

The qualitative component employed a hermeneutical method, which is a descriptive and interpretative approach (Rillo, 2015)[3]. This method used semi-structured interviews for data collection, and analyzed experiences "*to understand the processes in a specific project involving various stakeholders aiming primarily at improving its execution and gathering lessons learned*" (Tapella & Rodriguez-Bilella, 2014).[4] According to Tapella, it is critical to consider the different perceptions, opinions, and interpretations of the stakeholders involved in the components of each project. Therefore, understanding this diversity of insights requires first mapping relevant stakeholders.

For the qualitative component, LHSS conducted 13 semi-structured interviews with participants who had given prior informed consent. Rigorous security protocols guided the collection and storage of

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[2] Ministerio de Salud y Protección Social. 2022b. Boletín N° 4 Acceso a salud de las mujeres migrantes y refugiadas en edad fértil. May 2022. [Accessed December 7, 2022] Available at: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/GCFI/boletin4-acceso-salud-mujeres-migrantes-refugiadas-edad-fertil.pdf?ID=26128

[3] Rillo, Arturo G. 2015. "Análisis hermenéutico de la pregunta por la salud". Rev Hum Med 15(3). Available at: http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S1727-81202015000300002&lng=es

[4] Tapella, E., y P. Rodriguez-Bilella. 2014. "Sistematización de experiencias: una metodología para evaluar intervenciones de desarrollo". Revista de Evaluación de programas y políticas públicas 3(80).

information. Qualitative analysis software was used to transcribe and code data. Four categories guided the data analysis: I. Description of the project; II. Initial status and context; III. Intervention process; IV. Final or current status. These categories were inputs required for collecting and organizing the insights and testimonies of those involved, resulting in the findings outlined below.

The quantitative component employed a descriptive and analytical approach to measure the outcomes and estimate the cost/results ratio. Public sources, including the National Observatory of Migration and Health and the "Circular Letter 029" issued by the MSPS, were used due to the challenges of conducting a descriptive cross-sectional study based on international cooperation project reports.

The information reviewed was drawn primarily from planning and monitoring reports, beneficiary records, and accounting reports such as budgets and results reports, among other relevant documentation. Initial data analysis involved descriptive statistics establishing demographic aspects of beneficiaries, descriptions of expenditures, and outcome measures for each project. This information provided indicators for outcomes, access, coverage, and contract performance. Refer to Annex III for a detailed description of the methodology.

3. FINDINGS

A detailed analysis and latest results of the implementation of maternal-perinatal health care packages in Cúcuta and Bogotá are presented in Annex 3 of this report. The findings described in this summary focus on facilitators for the implementation of maternal-perinatal health care packages, the barriers limiting their development, lessons learned, and recommendations for their replication in other territories. Finally, this report outlines recommendations for designing and implementing health care packages targeting other population groups.

Facilitators

Technical assistance processes: The MSPS and territorial entities have supported the process of implementing the RIAMP, collaborating with different stakeholders such as State Social Enterprises (ESE), Benefit Plan Administration Companies, and health care providers. MSPS also provided support by creating technical tools for auditing international cooperation programs and costing the package to improve its implementation.

International cooperation resources: There is a consensus that the resources and projects provided by international cooperation agencies help helped bridge gaps in meeting the maternal-perinatal health care needs of migrant women.

Comprehensive and integrated service delivery networks: In Bogotá, the Integrated Subnetwork of Health Services North ESE implemented a comprehensive model of care. This model encompasses the entire health care pathway from health promotion to the provision of highly complex care.

Monitoring mechanisms and health care services for pregnant women: Monitoring mechanisms provided additional information beyond the scope of existing information systems, thereby contributing to the overall success of these initiatives.

Barriers and Limitations

This section features the barriers that impede the effective implementation of maternal-perinatal health care packages, differentiating between barriers to support provided during implementation and barriers to the actual implementation.

Misalignment of expectations: Despite the multilevel governance mechanisms for coordinating the response to mixed migratory flows, the greatest challenge at both the national and municipal levels was aligning the expectations and demands of the territories with the services provided by international cooperation agencies and the United Nations system.

Complex regulatory landscape: International cooperation entities directly providing health care services face complex health system regulations, and often require the guidance of health authorities. As a result, these cooperation agencies prefer to continue operating under a humanitarian care model rather than contracting territorial entities to deliver a maternal-perinatal services package, as it is easier for them at an operational level.

Implementation of contractual models: The successful implementation of contractual models for health care packages require specialized expertise from service providers, particularly for primary care providers. Expertise is required to understand and harmonize legal frameworks, operational and logistical models, and evaluation and monitoring mechanisms. A lack of awareness about these intricate legal and operational models creates barriers for providers. These barriers are exasperated by insufficient technical assistance, which should ideally be provided by health authorities or cooperation agencies.

Regulatory barriers: Emergency services serve as the entry point for health care services for pregnant women with irregular migratory status. The authority of territorial entities is restricted to paying for emergency services and childbirth. Consequently, the regulatory framework hinders the possibility of the government funding non-specialized outpatient services, such as a maternal-perinatal service package for migrants with irregular status.

Barriers related to the status of the migrant population: The vulnerable social conditions of migrants, particularly those with irregular migratory status, relegates health to a lower priority as their focus is on day-to-day subsistence. This vulnerability is particularly pronounced among the maternal population since their mobility impedes consistent access to the services package.

Cultural barriers: Cultural expectations regarding health care access carried from their home country, where accessing health care was reportedly less hindered, can impede the Venezuelan migrant population's engagement with Colombian health services. Additionally, limited knowledge regarding the operational norms of the Colombian health system further disrupts the consistent provision of health care packages to pregnant women.

Lessons Learned

The experience gleaned from this initiative underscores several lessons learned. A pre-established health care package tailored to pregnant women can serve as a pivotal tool. It not only directs health services to the target population (pregnant women and newborns), but also aids in selecting the appropriate contracting modality, estimating health care costs, establishing operational agreements, defining monitoring mechanisms, establishing information flows, and identifying potential beneficiaries.

The success of managing and implementing comprehensive maternal-perinatal health care packages hinges on recognizing the distinct characteristics of territories and institutions. The relationships among stakeholders involved in providing care to pregnant women and the governing role of territorial entities

significantly impact coordination efforts. When designing health care packages for pregnant women with irregular immigration status, several critical factors must be considered, such as: the demand for health care services, challenges in accessing care due to current regulations regarding enrollment in the General Social Security System in Health, unfamiliarity with access mechanisms, authorization guidelines for health services, and the fragmentated provision of low and medium complexity services.

Recognizing the specific health circumstances of pregnant women, especially Venezuelan migrants, is vital for defining the contents of the maternal-perinatal health care packages, as is assessing the interventions' impact, identifying current stakeholders' responsibilities, and potential stakeholders for financing or providing health care services to these populations. This entails obtaining information from official sources such as the Migration and Health Observatory and data analysis from relevant entities such as the Subcluster for Maternal Health, Sexual and Reproductive Health (SRH), and Gender-Based Violence (GBV).

Recommendations

The MSPS should organize potential funders of health care services for pregnant women to prevent duplication of efforts and financing for delivering these services. This coordination should also aim at expanding coverage in areas where the migrant population lacks access to health care services and enrollment in health insurance.

Although the contents of the maternal-perinatal health care package should at a minimum include the essential care for pregnant women with irregular migratory status, adaptation to local and territorial institutional and geographical context based on evidence and demand is crucial.

It is critical to promote local level coordination between territorial institutions providing health care services to the migrant population. This coordination should streamline administrative and operational processes to overcome barriers to delivering care and achieve desired outcomes for pregnant women.

Health care providers need technical and regulatory tools that help them to provide comprehensive care to pregnant women, avoiding missed opportunities. The MSPS should generate flexible regulatory and operational standards for health care providers that facilitate the delivery of comprehensive care to pregnant women.

It is also necessary to design a nationwide information campaign, tailored to local contexts, to inform pregnant women of the mechanisms for accessing the health care required for obtaining positive pregnancy outcomes. These campaigns should promote demand for timely health care services, building trust of pregnant women in the services received and improving the readiness and quality of care for this population.

Establishing mandatory reporting mechanisms for institutions providing care to migrant pregnant women with problems in accessing health care services is critical. Thus, it is necessary to create flexible and easy-to-use reporting mechanisms that increase the availability of information on services provided to the migrant population.

Enhancing collaboration with the Migration and Health Observatory and the Subcluster of Maternal Health, SRH, and GBV to update reliable and validated information is vital. Reliable data should inform decision-makers in designing initiatives to manage comprehensive health care services addressing the Venezuelan migrant population, Colombian returnees, and host communities.

4. SUSTAINABILITY

The information gathered in this document supports the potential replication of these health care packages in contexts and territories with similar characteristics and realities. This replication can facilitate the implementation of health care services, identify feasible delivery mechanisms, improve relationships among stakeholders, and establish mechanisms for monitoring and assessing the impact of such interventions on the health of pregnant women.

Moreover, this report detailing experiences in managing and implementing maternal-perinatal health care processes draws from a body of knowledge that may be transferred and adopted for future health initiatives targeting other vulnerable or prioritized population groups.

Finally, documenting both positive and negative experiences facilitate sharing critical elements for the administration and delivery of services, the management of comprehensive health care packages, and their implementation in different contexts, realities, and populations.