OPINION EDITORIAL

Access to Maternal Care: Persisting Challenges in Colombia

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Despite improvements in maternal health in Colombia over the last 20 years, indicators such as maternal mortality ratio (MMR) lag behind other Latin American countries at similar levels of economic development [1] . Unique political, economic and social circumstances in Colombia may be contributing to the poor improvements in maternal health indicators relative to other countries in the region.

After over 50 years of armed conflict, a peace accord between the Revolutionary Armed Forces of Colombia (FARC) and the Colombian government was signed in 2016 [2]. Decades of armed conflict left millions, the majority of whom are women and children, affected by forced displacement and violence [3]. The complexities of accessing healthcare services in a post-conflict setting are compounded by social and economic inequalities. Although Colombia is an upper-middle-income country, it has one of the most unequal income distributions in the world, with about 35% of the country's population living in conditions of poverty or extreme poverty, compared to 20% in Peru [4–6].

In addition to conflict within Colombia, the political turmoil and socioeconomic crisis in the Bolivarian Republic of Venezuela has resulted in the departure of millions from the country. As of October 2020, over 1.7 million Venezuelan migrants were reported to be living in Colombia, although the actual number is likely higher [7]. The Venezuelan migrant crisis has raised important humanitarian concerns, including equitable access to required healthcare services for both regular migrants, who have legal migration status and documentation, and irregular migrants, who entered Colombia through unauthorized points and therefore lack documentation [8].

To achieve the Sustainable Development Goal (SDG) 3.1, to reduce the global MMR to less than 70 per 100,000 live births by 2030, the persisting political, economic and social barriers to accessing maternal healthcare must be acknowledged and addressed. This article will discuss how historical and ongoing violence, socioeconomic inequalities, and increased migration has impacted maternal health in Colombia.

MATERNAL CARE IN POST-CONFLICT AND CONFLICT SETTINGS

Though a peace accord has been reached, decades of historical violence continue to impact access to maternal healthcare. Municipalities with large numbers of women victims of violence, such as Vaupés, Chocó, Guainía, Nariño, Putumayo, Vichada and Huil, continue to have large gaps in access to antenatal care and skilled birth attendance [3].

The long-lasting effects of armed conflict in rural regions have prevented universal delivery of sexual education, family planning programs and antenatal care [9]. Seizures of medical supplies, scarcity of medications, limited health personnel, lack of hospital security, and mobility restrictions have caused disruptions in healthcare provision [9]. Consequently, municipalities historically more affected by armed conflict have higher MMRs [9].

Inequalities in access to care as a result of historical violence have been further compounded by a resurgence of armed conflict. In 2020, the United Nations documented nearly four hundred killings in Colombia, which included former combatants,

human rights defenders and community leaders [10]. The ongoing threat of violence poses a risk to access of maternal healthcare services, particularly for women in rural regions.

Barriers to accessing healthcare specific to the post-conflict setting must be addressed to prevent a widening of maternal health disparities. Interventions could include additional training for community health professionals in rural regions, resource allocation to improve care for victims and ex-combatants, and interdisciplinary coordination between government agencies to ensure adequate healthcare infrastructure and supply chain management [9].

THE INTERSECTION OF POVERTY AND MATERNAL HEALTH

The Colombian healthcare system underwent structural reforms in 1993, although a comprehensive policy for maternal health was not enacted until 2003, and universal healthcare coverage was not achieved until 2011 [11]. The stagnant maternal health indicators, despite high levels of health coverage, point to potential issues in the access to quality maternal care.

Health insurance in Colombia is provided through two major schemes: the contributory regime, for formal workers or those with the capacity to pay, and the subsidized regime, for informal workers, those who are unemployed or living in poverty [12]. However, beneficiaries of the subsidized regime access fewer services and demonstrate worse health outcomes, including higher maternal morbidity and neonatal mortality, than those in the contributory regime [11,13,14]. Furthermore, about 30% of the population considered to need health services do not access the available services, largely due to perceived low-quality and the inability to pay for private services [15].

Wealth disparities explain a large degree of the inequities in access to maternal care in Colombia, including skilled birth attendance and antenatal and postnatal care [11]. Additional economic barriers to accessing care include the need to work, costs of transportation and childcare [16]. Consequently, women of higher-income households are more likely to complete the recommended four antenatal care visits, compared to those of lower-income households [17].

The economic gradient in access to healthcare services and health outcomes are of particular concern in the pursuit to improve maternal health indicators. To promote equitable access to care, the Colombian government could incentivize the provision of higher-quality services in poorer and underserved communities, and implement training for trusted community-based providers to deliver care and promote the use of maternal health services [18].

ADDITIONAL SERVICE NEEDS OF MIGRANTS

As of October 2020, over 1.7 million Venezuelan migrants were living in Colombia, but less than half have residency or regular stay permits required to access comprehensive health insurance through the subsidized scheme [7].

Concerns about access to care for migrants were partly addressed in a recent ruling by the Colombian Constitutional Court, enabling individuals with irregular status to receive free emergency care under the subsidized insurance regime. This could include services related to pregnancy, childbirth and postpartum care [8]. Though emergency services are covered, the out-of-pocket costs of primary care, laboratory tests, drugs and nutritional supplements often inhibit health-promoting or preventative behaviors among migrant women [8]. Consequently, nearly 40% of Venezuelan migrants surveyed in a study reported that they had not received prenatal care during their pregnancy [19].

Both uninsured and insured migrants struggle with the denial of services, particularly in public hospital networks, despite theoretical coverage [20]. The fear of discrimination often prevents individuals from accessing care, as the decision of what constitutes an ‘emergency’ is often left to the discretion of non-medical personnel, such as security guards [21]. Even

when seeking covered services, such as prenatal care, migrants often face xenophobia within hospital settings [20].

Cumulatively, these barriers result in a higher risk of maternal morbidity and mortality for migrant women [8]. Increased primary care coverage for migrants is necessary to help detect and address preventable health complications [8]. Furthermore, multidisciplinary efforts from local governments, community leaders and private providers are required to reduce xenophobia and discrimination in healthcare settings [8].

CONCLUSION

The effects of conflict, poverty, and migration continue to threaten maternal health in Colombia. To achieve universal access to maternal healthcare, and meet the MMR target of SDG 3.1, a pro-equity approach is required to increase access to care for the most vulnerable communities of women in Colombia.

Barriers to accessing healthcare have been exaggerated by the recent COVID-19 pandemic, and likely extend to other areas of care beyond maternal health. It is essential that the intersecting vulnerabilities of marginalized women be considered first in the design of equitable and accessible healthcare programs [8,22,23].

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