Editorial

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The State and the obligation to guarantee maternal and perinatal health

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This issue of the Colombian Obstetrics and Gynecology Journal (RCOG) features an original research and expert consensus regarding key public health considerations, in particular as pertains to maternal health, such as prenatal care and obstetric emergency care. Against the backdrop of a potential reform of the General Social Security System in Health (GSSH), these two studies assess, after 30 years, the performance of this public health policy as relates to these two particularly vulnerable population groups which are part of the clinical practice of our specialty.

To start with, the study by Londoño Cadena et al. describes how, in the Department of Cauca in southern Colombia, 60 % of the population of pregnant women older than 35 years of age did not meet the minimum proposed standard of 6 prenatal visits, and only in 88 % of cases was gestational syphilis screening requested. These women are mostly indigenous and affiliated to state-subsidized insurance organizations. These findings are compatible with those of the Ministry of Health and Social Protection in 2020 which report that 44 % of the women attended prenatal care on week 10 or before that time (1). The same source reports that only 80 % of the pregnant women were screened for gestational syphilis and HIV.

Regarding coverage of prenatal care, defined as the number of women who attend a prenatal visit at least once over the total number of deliveries, the Ministry of Health and Social Protection reports that coverage was 66 % in the Department of Vaupés, 78.8 % in Chocó, 89.4 % in Guainía, 91.8 % in Guajira, 93% in Nariño and Amazonas, and 94% in Vichada and Putumayo (2). In the 2012-2021 national public health plan, the target for 2021 was that 95 % of women would have at least 4 or more prenatal visits in 94 % of the regional territories (3), with the current situation being still far from those goals. It is worth remembering that these departments are inhabited mainly by indigenous and Afro-Colombian communities, and that significant maternal health inequalities have been described in these groups, especially in the state-subsidized insurance regime (4), a situation that has not changed in the past 10 years (5).

As for syphilis, which is the main cause of sepsis and early neonatal death, national indicators are lower than the goals established in the *Strategy for the Elimination of Maternal Transmission of Syphilis and HIV* for 2021, which have been defined as 80 % for early prenatal care and 95 % for gestational syphilis screening (6). However, this is not the only worrisome fact because, apparently, the situation is getting worse every year. The National Health Institute reported an increase in prevalence from 8.8 in 2018 to 13.5 x 1,000 live births (LB) in 2020 (7); moreover, a prevalence of 7.7 x 1,000 LB plus fetal demises was reported for Bogota in 2021, and of 9.2 x 1,000 LB

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plus fetal demises for the first semester of 2022 (8). In all likelihood, the situation in the Pacific departments and the old national territories is much worse. For congenital syphilis, the scenario has also worsened, with an incidence of 1.5 x 1,000 live births in 2018, and 2.7 x 1,000 LB (7) in 2020, 5 times higher than the elimination goal (0.5 x 1,000 LB).

Brazil declared a syphilis epidemic in 2017 when the prevalence of gestational syphilis reached 17 x 1,000 LB (9). These data suggest that we are facing a syphilis epidemic in the Colombian population. However, given de absence of screening in women of childbearing age as well as in men, particularly men who have sex with men (MSM) who are considered the primary source of this infection worldwide, with a prevalence of 10.6 % in Latin America and the Caribbean (10), and considering that reporting is not mandatory, it is difficult to confirm this silent epidemic that will continue to affect children if no multiphase population programs are implemented like it was done in Brazil (11).

On the other hand, the expert consensus for the Management of Placenta Accreta Spectrum identified the challenge of providing adequate obstetric emergency care in the absence of coordination among the institutions of the Colombian social security system (insurance companies, hospitals and clinics, national and regional health agencies, and oversight and control bodies). This is compounded by the lack of centers specializing in the care of obstetric emergencies, which have been identified as a valid strategy in other settings (12).

The Ministry of Health Public Health Surveillance System (13) reported that, between 2017 and 2020, the Extreme Maternal Mortality (EMM) ratio went from 35.3 x 1,000 LB to 39.5 x 1,000 LB, and that EMM is more frequent in the State-subsidized regime (47 %) than in the contributive regime (38 %). Interestingly though, the EMM ratio is higher in the contributive regime at 44 x 1,000 LB, as compared to the subsidized regime at 37 x 1,000 LB. In terms of Maternal Mortality (MM), the Ministry of Health (14) reported that the MM ratio remained at a level close to 51 x 100,000 LB in 2016, 2017 and 2019, but rose in 2020 to 66.7 x 100,000 LB, to a level similar to that of 2011. This was attributed in part to the COVID-19 pandemic. MM analysis by insurance type showed that 62.7 % corresponded to the subsidized regime and 25 % to the contributive regime. As for the MM ratio, it dropped from 60.3 x 100,000 LB in 2016 to 49.8 x 1,000 LB in 2018 and rose to 79.8 x 100,000 LB in 2020 in the subsidized regime, higher than the numbers for the contributive regime at 33.2 in 2016, 25.0 in 2019 and 47.7 x 100,000 LB. The reason why the EMM ratio is higher in the contributive regime is not clear, but the MM ratio is higher in the subsidized regime. Existence of greater access to intensive care units for women with EMM in the contributive regime is a matter to be explored.

It is clear that creating standards does not suffice as it does not translate into the expected maternal and perinatal health outcomes in disadvantaged and rural populations. Consequently, the GSSSH created by Law 100 of 1993, which assigned individual protection and care activities to the subsidized regime management organizations has not met its objectives and has not reduced inequalities or accomplished its goals. Doing more of the same will not change the situation. Profound changes are required in the health system if the rights of these disadvantaged populations are to be realized and if the Colombian State is to guarantee their right to health.

The current government must bear in mind the need for the Ministry to directly coordinate, oversee and manage many individual and collective health programs, particularly those targeted to the pediatric population, and the sexual, reproductive and maternal health of the population covered by the subsidized regime in particular. A similar situation occurred in the past with the management of the expanded immunization plan which had to be returned to the Ministry of Health in order to recover the accomplishments of the 1980's in terms of vaccination coverage and child protection. This would be needed, for example, to secure access to safe contraception

methods, reduce the rate of teenage pregnancy which perpetuates poverty cycles, and improve coverage and access to timely prenatal care. Also, to ensure care of sexually transmitted infections, apart from HIV, in terms of epidemiological surveillance and population screening for syphilis, multi-resistant gonorrhea and human papilloma virus infection (15), HTLV and C. trachomatis infections which affect, in particular, afro, indigenous and young populations.

On the other hand, it is important for the Ministry of Health to strengthen public hospitals, including the Maternal and Child Institute (I*nstituto Materno Infantil*), a flagship hospital in Colombia, as a referral, research, innovation and training center for obstetric emergencies, maternal fetal medicine and neonatal care in Bogota; to build similar institutions in other regions of the country; and to create a maternal and perinatal care network to provide effective and safe care at a reasonable cost, with no administrative hurdles and with the necessary financial liquidity to provide timely high-quality services in the public network and, why not, in partnership with the private network.

It is important for physicians and other healthcare workers to actively participate in all discussions and proposals aimed at improving the Colombian health system, and not remain as passive by-standers - as was the case in 1993 - in order to ensure full implementation of the Statutory Health Law and the creation of decent working conditions.

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