Strengthen Health Systems Response to Health Emergencies in Colombia

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Context

Colombia confirmed its first case of COVID-19 on March 6, 2020. By April, the government declared a state of emergency and adopted financial, policy, and social measures to respond to the pandemic. There was an imminent need to strengthen the country's surveillance systems, including case identification, investigation, active follow up of cases and contact tracing, and compilation and analysis of data for decision makers. At the territorial level, there were gaps in emergency and public health response capacity and some territories faced technical, operational (human resources, processes, and procedures), and financial obstacles when responding to the spread of COVID-19 and its burden on the medical system in a systematic and rapid manner.

USAID tasked the Local Health System Sustainability (LHSS) project, known as Comunidades Saludables in Colombia, to support the Colombian government response to the COVID-19 pandemic by assisting the Ministry of Health (MOH) and the local health secretariats of sub-national territorial entities to deploy, manage, and integrate surge human resources for health into existing structures using Rapid Response Teams (RRTs). In addition, LHSS Colombia supports the sustainability of surge human resources for health deployment for future emergencies. The program implemented a systematic cross-sectional approach focused on generating synergies within the MOH, territorial entities, and health institutions across the nation to strengthen public health surveillance and response through RRTs. To do this, LHSS Colombia built a roadmap for how to launch and build capacity in emergency response situations which included all of the stakeholders at a national and sub-national level. It also described the collaborative process and action plan that needs to be implemented in order to provide technical assistance, quality assurance, and human resources training to develop capabilities at an individual- and community-level. By engaging stakeholders at all levels, LHSS Colombia prioritized the national and local context of the Colombian health system and aligned its program accordingly.

Activity Description

LHSS Colombia, in June 2020, began supporting the country's response to the COVID-19 pandemic. Its new objective was to "strengthen health systems to respond to current and emergent health threats, including the COVID-19 pandemic" and initiate the urgently needed surge in human resources to increase capacity for rapid response in Colombia's territorial entities.

The RRTs were conceived at Colombia's national health system level for implementation at the sub-national level and focused on responding to the COVID-19 pandemic. The MOH's coordination units (Directorate for Promotion and Prevention Activities, and the Directorate for Demography and Epidemiology) were responsible for the design and specifications of the RRTs. LHSS Colombia, on the other hand, supported the contractual and financial agreements. Moreover, LHSS knew that contextual understanding at the local level and intentional collaboration were needed if the program was to successfully ensure ownership of the process at the level of implementation, that is, the health secretariats of the territorial entities. From the LHSS Colombia perspective, the third group of stakeholders were the RRTs.

To-date, three versions of the RRTs have been deployed (RRT 1.0, 2.0 and 3.0); one for each LHSS Colombia project year. RRTs 1.0 received basic capacity building training related to the control of COVID-19 illness and the project decided to document the step-by-step process for rapidly establishing human resources for health for future emergencies in a roadmap for Colombia's MOH that included methods, milestones, and actions plans for it to be reproduced in the future. As one of the first outcomes of the roadmap was that, after RRTs 1.0 were rolled out, RRTs 2.0 focused on supporting the process of identifying, monitoring, and isolating COVID-19 cases capitalizing on local synergies through the implementation of the Sustainable Selective Testing, Tracking, and Isolation Program (PRASS). It also enabled technical assistance for the elaboration of documents and related data analysis in the territorial entities. RRTs 2.0 enabled identification of COVID-19 cases and chains of transmission, promotion of sanitary and prevention measures, phone follow-up in cases where isolation and quarantine were needed, and surveillance and control during the pandemics four peaks of transmission. Version 3.0 of the RRTs focused on the instrumentalization of surveillance procedures, PRASS, and capacity building among human resources for health aimed at improving the effectiveness of swift decisions related to rapid response in 11 territorial entities prioritized by Colombia's MOH: Arauca, Atlántico, Antioquia, Bogotá, Cundinamarca, Bolívar, Buenaventura, La Guajira, Norte de Santander, Santander and Nariño.

In addition to the work LHSS Colombia did with the MOH and the local health authorities, implementation of the program involved providing capacity building and technical assistance to the different stakeholders of the Colombian health system such as human resources for health, insurance companies, and health care service providers in the areas of epidemiologic surveillance, protocol implementation, biosecurity, and identification of medical care routes. At the community level, the implementation of this program meant collaboration between community leaders, non-governmental organizations, and migrant and marginalized groups to promote the prevention and control of COVID-19. Many of the activities were carried out in a cross-sectional approach taking advantage of community-specific forums and schedules, like campaigns for migrants, teachers, or students, for example.

LHSS Colombia worked towards sustainability in all project phases. The project learned from the design and planning that the local health secretariats had to be involved in the process. Thanks to the local health secretariats, the program could find the profiles of professionals for the Rapid Response Teams since, in many territories, the initial profiles were unavailable. The authorities shaped the job descriptions and team composition, which incorporated their local knowledge of needs and human resource availability and increased their ownership of the RRT teams and processes. Also important was setting the right expectations of the local health secretariats regarding the role of the RRTs in oversight and responsibilities. The RRTs needed to be part of the health secretariat team if the territorial entities were expected to increase their financial obligations to the RRT team. During the implementation, the local health secretariats set the priorities for the RRTs. They discussed them in regular weekly and monthly committees with the project's officers and the Ministry of Health's officers. Also, among the primary responsibilities of the RRTs, we found the development of new processes to operationalize new COVID-19 guidelines. These processes have the steps and recommendations responsible for each activity. Finally, from the monitoring and project management tools, the program has methodologies like outcome mapping that provide qualitative results to understand milestone achievement and their determinants. These methodologies enable the program to know how local context facilitates or hampers the institutionalization of processes and how to adapt the strategy effectively.

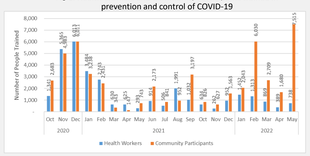
Activity Impact

Development of the RRTs intervention in Colombia's territorial entities enabled the **strengthening of local capacity** to rapidly respond to public health emergencies, which **improved quality of service provided** and **increased access to service for underserved populations**:

- 14 departments of the country with improved capacities for the implementation of the public health surveillance strategy with a community approach, from the instrumentation and adoption of 15 operational tools (formats, databases, technical guides) and 6 training modules for the community.
- Developing capacity for human resources for health to improve **equity and quality** in health services. The program supported the implementation of protocols and guides for medical case related to severe acute respiratory infections, including COVID-19, through RRTS 1.0 and 2.0, reaching approximately 31,546 health professionals between September 2020 and April 2022, in 1,056 inpatient and outpatient health care facilities.
- The health system was strengthened through additional epidemiologic surveillance and actively follow up of cases that included 63,076 Colombian residents and 1,902 non-residents. Contact tracing was done among 1,091,836 residents and 209,128 non-residents through PRASS. Clinical follow up through illness resolution was done among 920,038 residents and 2,256 non-residents.
- Strengthening of the community knowledgebase and practices to increase capacity for responding to the COVID-19 pandemic and emergent threats. LHSS Colombia met with community leaders, grassroots organizations, and migrant and minority ethnic groups to promote the process of COVID-19 prevention and control, increase safe biosecurity measures, and identify early signs and warning signals by training 34,905 community members.
- Cross-sectional implementation and coordination. At the community level, policy decision makers received documentation and data analysis results to choose adequate strategic and operational action plans in coordination with other territorial entity stakeholders like Committees for Community Surveillance.
- The program has been supporting 569 inpatient health facilities with technical assistance regarding technical documents and the implementation of new processes, including clinical practices for respiratory infections and guidelines for the correct implementation of PRASS, prevention control, WASH practices, and public health surveillance.
- Approach to ethnic groups: Colombia has 1.9 million indigenous people, who live in 102 towns across national territory, which required rapprochement with indigenous rulers and leaders, to agree and harmonize the approach strategies from an ethnocultural perspective. Knowledge meetings and ethno-educational communication pieces were held to promote key messages for the prevention of acute respiratory infection and COVID-19, education in healthy practices, hygiene and active community search, and support for the organization of vaccination days for different indigenous peoples of the territories prioritized by the program

Evidence

Fig 1. Health Workers and Community Participants trained in prevention and control of COVID-19



The program trained a total of 82,281 people in topics related to prevention and rapid response. The participants were health workers (31,546) and people from the community (50,375). The training is composed of surveillance and rapid response topics, including case investigation, contact tracing, and case finding. The training aimed for community revolve around Infection Prevention Control, WASH practices, and public health surveillance The program has been supporting 569 inpatient health facilities with technical assistance regarding technical documents and the implementation of new processes that includes clinical practices for respiratory infections and guidelines for the correct implementation of PRASS

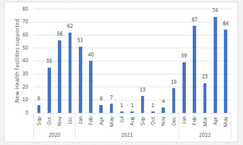


Fig 2. Number of new health facilities supported on COVID-19 guidelines

Figure 3

Figure 4

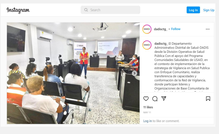


Fig 3 and 4. Social media from the Health Secretariats of Bucaramanga and Cartagena training communities on COVID-19 guidelines and community surveillance

Figure 5

Fig.5 USAID Administrator Samantha Power acknowledging RRT as an intervention supporting Colombian government response to COVID-19

Figure 6

Fig.6 USAID Mission presenting the strategy to prevent and vaccinate against COVID-19 with indigenous communities in Santa Marta, Colombia

Facilitators

- The existence of permanent spaces for coordination with national and local health secretariats (crisis room, epidemiological surveillance committee, analytical unit) of the health sector, made it possible to generate cocreated strategies to strengthen the response to the health emergency.
- The collaboration with the education and religious sectors, Colombian migration and community-based organizations facilitated both the approach to the community, as well as to vulnerable population groups (migrants, ethnic groups, among others) to promote key messages on preventing acute respiratory infections and COVID-19, education in healthy practices, hygiene, active community search and recognizing warning signs, and activating care routes.
- Having a regulatory framework and institutional development of the public health surveillance system, which integrates five surveillance strategies, these are: 1. Case surveillance, 2. Rumor surveillance, 3. Active Community Search (BAC), 4. Laboratory studies on the population, and 5. monitoring surveillance management, allowed the rapid institutionalization of the response actions that were created.
- The link and connection to existing strategies in the territories led by Colombian migration (migrant population affiliated activities), allowed us to expand the coverage of the migrant population we reached with ludicpedagogical activities to spread messages of self-care and COVID-19 prevention.
- The existence of scientific and educational material designed by universities and international organizations such as the WHO, facilitated the continuous training of the RRTs as the state of COVID-19 evolved, including using technical guidelines in the first 24 hours and replicating them immediately in the territories, including retraining the permanent local human talent.
- The willingness and commitment from the human talent of the territorial entities, health service providers, and insurance providers to adapt allowed the capacity development process to be carried out in a systematic and organized manner.
- The accompaniment and technical support provided by LHSS Colombia has been well received by the territories and has been key, for example, for the implementation of PRASS and strengthening capacities.
- Social mobilization and significant participation from communities made it possible to clearly define their role, the importance of continuing to carry out participatory exercises that allow their involvement from the beginning, and the recognition of agents and leaders to activate community networks and with this the possibility of deploying it in the territory.

Challenges

- Early in the RRT 1.0 implementation process, the sub-national territorial entities and LHSS Colombia realized that skills required for the specific team composition proposed by the national level were not always available at the local level. The territorial entities' staff immediately adapted and shaped the job descriptions and team composition. LHSS Colombia provided a manual for RRT performance evaluation, incorporating their local knowledge of needs and human resource availability and increased their ownership of RRT teams and processes.
- A second challenge was the national government mandated PRASS, legally requiring sub-national authorities to implement the program. Requiring more specific by sub-national authorities on the PRASS program components so they could be tracked, and implementation progress demonstrated. With this, LHSS Colombia co-created adaptations with stakeholders in regular coordination spaces. Adaptations included reorientating the RRTs towards the formalizing and creating processes within the institution to adapt the national mandate to local health secretariats' regular operations. This provided the territorial entities with an opportunity to provide input to the process that would become part of the PRASS systematization.
- At the beginning of this activity there were many unknowns about deploying human resources equipped to respond to the health emergency created by the pandemic at the territorial and local level. However, LHSS Colombia began this activity with a co-creation exercise with the MOH and designed and implemented a roadmap to be followed by national, departmental, district and municipal institutions to deploy RRTs to support the emergency response, making it possible to improve and speed up deployment of the strategy. Likewise, a human talent qualification plan had to be built, focused on three training pillars: a) safety and health at work, b) technical processes and procedures, and c) policies and institutional mechanisms, instruments and tools for work.
- There was an instance of low participation and receptivity from community actors when implementing the public health surveillance strategy with a community approach due to a lack of trust in the health sector institutional framework. LHSS Colombia implemented a motivational strategy for voluntary and participatory adherence to community surveillance, strengthened community surveillance networks, and designed educational materials for dissemination. Collaborating with different agencies and recognizing local dynamics was important, making it necessary to adapt strategies to approach the community and human talent in health in diverse areas, and coordinating actions with other USAID programs to expand coverage of community guards to other population groups, improving participation of diverse populations in line with the differential approach in the Community Public Health Surveillance Networks.

Lessons Learned

The deployment of RRT 1.0 and 2.0 has been one of the most significant learning experiences, if not the most, for LHSS Colombia. This experience and the specific technical and learning products taught us how to interact effectively with our key stakeholders, effectively organize our co-creation spaces, deploy HHR, acknowledge local context, adapt the deployment to each territory, make our processes more flexible.

An effective and sustainable deployment relies on establishing the appropriate expectations with ministries of health regarding the role of the RRTs in terms of supervision and responsibilities. RRTs needed to be considered part of the health secretariat team if territorial entities are expected to increase their financial obligations to the RRT team and incorporate the surge mobilization roadmap into their future response plans. As a result of the effective interaction with the health secretariats, in at least 5 departments, some RRT professionals were integrated directly without resources from LHSS Colombia. Likewise, the RRT scheme has been used to support local health secretariats in the implementation of the National Vaccination Plan against COVID-19 and in strengthening community epidemiological surveillance.

Other lessons include:

- Communities in the territories where the RTTs were located were also beneficiaries of the deployment process, as they were actively involved, facilitating the processes of identifying and tracking COVID-19 cases. This work was possible thanks to collaboration at the local level through co-creation with community actors before the public health emergency.
- Interdisciplinary teamwork generated the best results during the implementation of the public health surveillance strategy. Based on the experiences of the RRTs and the Territorial Entities, work teams are usually diverse with complementarity skills, which enhances the products that are developed within the framework of the interventions.
- Public health surveillance, health promotion and disease prevention actions carried out in the territories must be systematized to identify points that can be improved and document good practices for future public health emergency responses.
- It was important to map the structure of the comprehensive planning and management model, its inputs and outputs, as well as the work carried out from the strategic management office of the territorial entity. The leaders and technicians of the missionary processes were required to dialogue with the members of the Institutional Management and Performance Committee to understand the advantages of working under the PRASS program and the public health surveillance strategy with a community approach in the context of the quality management system. Based on the tools of the comprehensive planning and management model, leaders at the managerial and operational levels collaborated and shared mandatory compliance actions to make sure they were sustainable.