Delegación en Ginebra ante la ONU
Ministerio de Relaciones Exteriores

TODOS POR UN NUEVO PAÍS
PAZ EQUIDAD EDUCACIÓN

DCHONU No. 746/17

La Misión Permanente de Colombia ante las Naciones Unidas y otras Organizaciones Internacionales en Ginebra saluda atentamente a la Secretaria de Derechos Económicos, Sociales y Culturales, con el propósito de anunciar el envío de los anexos traducidos al idioma inglés de las respuestas a la lista de preguntas emitidas por el Comité para que se proceda con su análisis y correspondiente publicación.

La Misión Permanente de Colombia ante las Naciones Unidas en Ginebra aprovecha la oportunidad para reiterarle a la Secretaria de Derechos Económicos, Sociales y Culturales las seguridades de su más alta y distinguida consideración.

MISSION PERMANENTE DE COLOMBIE · AUPRÈS DE L'OFFICE DES NATIONS UNIES À GENÈVE ·

Ginebra, 10 de agosto de 2017

A la Honorable
Secretaria de Derechos Económicos, Sociales y Culturales
Ginebra

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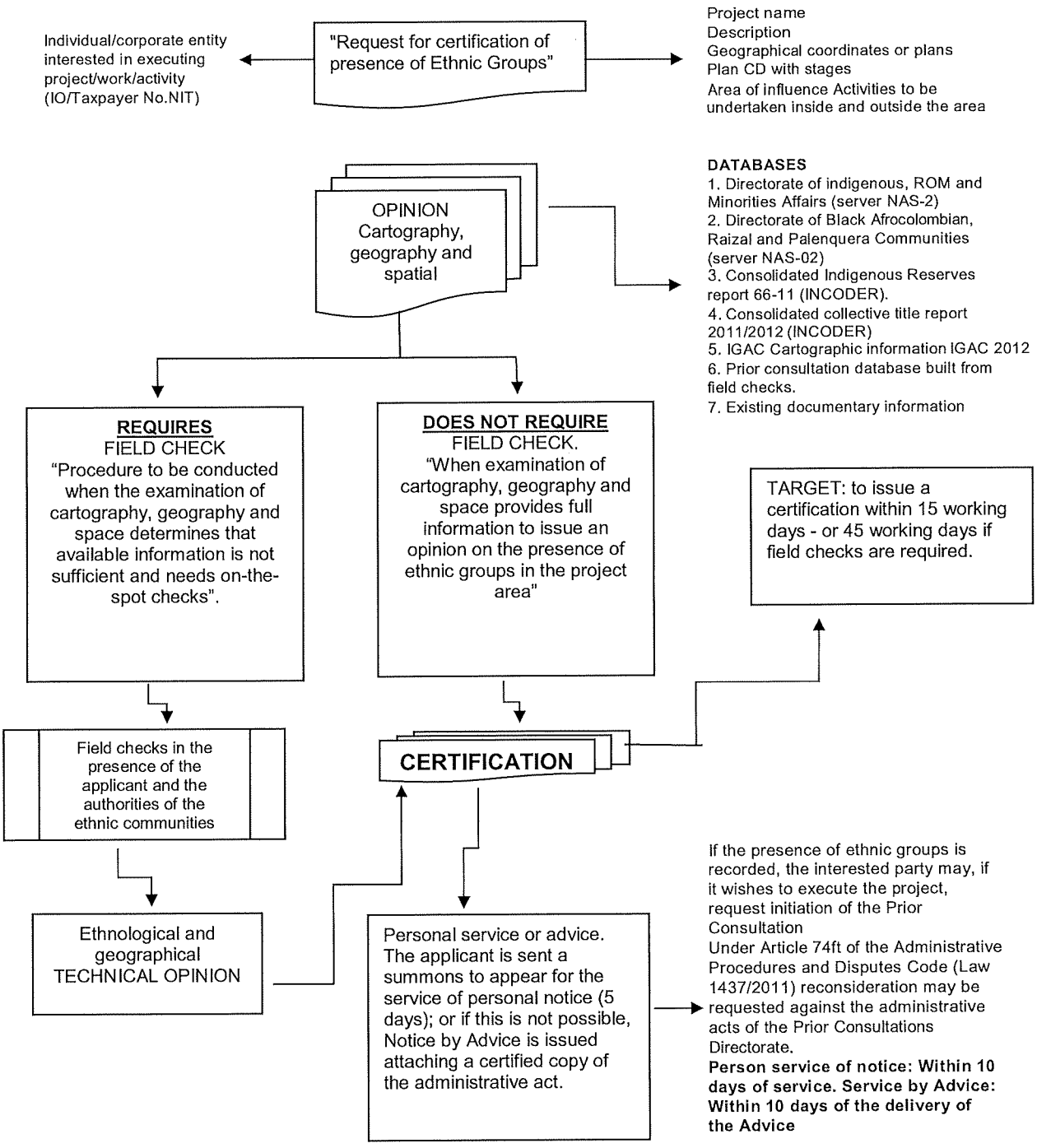
ANNEX 1. PROCEDURE FOR PRIOR CONSULTATION

I. CERTIFICATION STAGE



Annex 2

National public policy in the gender equity - Action Plan 2013-2016

The following are some of the results of the public policy in gender equity, each of its lines of action:

Line 1. Cultural transformation and peace-building

- 43 entities nationwide and 158 regional entities with technical assistance for the incorporation of the gender perspective
- 5746 members of the forces of law and order trained in gender equity, and in the procedures and operating instructions for prevention and response to sexual violence, particularly in relation to the armed conflict
- 14 research projects, in the construction of historic memory, incorporating elements with a focus on gender differential.

Line 2. Economic autonomy

- 37,500 community mothers are beneficiaries of formation programs in comprehensive attention to first infancy
- 50 businesses, organizations or entities engaged in the gender equity management system components
- 21,438 children of community mothers with access to child development centres
- for alliances and spaces for dialogue created to strengthen gender equity policy for women in the mining and energy sector
- 1,320 family subsidies for the free housing programme, delivered to mothers heads of household
- 40,100 women benefited from the digital business programme
- 1,410 women's enterprises took part in business rounds for women entrepreneurs and businesswomen.
- 160 associations or organizations of women beneficiaries of the rural women programme

Line 3. Spaces of power and decision-making

- 3 projects developed to strengthen political participation of women in popularly- elected bodies.
- 3 projects developed to strengthen women's networks and social organizations
- 2 projects developed to provide technical assistance to regional bodies to strengthen civic participation processes
- 8 workshops and spaces for dialogue held, addressed to women victims, and to indigenous community victims.

Line 4. Sexual and reproductive health and rights

- 3 strategies implemented to prevent adolescent pregnancy in mining and energy operating areas
- 95% vaccination coverage is for VPH in girls aged 9-15
- 38 event reports for epidemiological period III, VI. IX and XII and at the end of oversight of events of safe maternity-maternal mortality, extreme maternal morbidity, and perinatal and late neonatal mortality.
- 13 reports on events for the epidemiological period, III, VI, IX and XII and at the end of oversight of STDs.

Line 5. Gender focus in education

- 416,787 women engaged in the digital literacy process
- 94 education officers with inclusive education policy socialized

Line 6. Guarantees for a life free of violence

- 24 advisory and technical assistance packages provided for the incorporation of the gender focus into civic safety and coexistence plans
- 36 regional offices Ministry of Labour, with processes of sensitization and formation in employment equity, with a gender focus, and prevention of harassment at work.
- 49 strategies implemented for social mobilization for the prevention of gender violence
- 5400 radio spots in the Police broadcasting network, on issues of gender equity and a life free of violence for women,.
- 1,366 men and women officers trained in the strategy for formation of sexual reproduction health (SRH), and sexual and reproductive rights (SRR).
- 5 sets of guidelines for attention to victims of violence with a differential gender focus, applicable to the national framework of the national forensic medicine service (INMLCF)
- 1,026 family commissioners trained in technical guidelines on attention gender-based violence (GBV)
- 332,570 helpline phone calls, giving guidance on the women victims of violence
- 3,728 judicial operators and officers, trained in women's rights and Law 1257/2008
- 958 men and woman women officers of the Forensic Medicine Service, formed in attention to gender-based violence
- 100 comprehensive criminal care centres for victims (CAPIV) in operation
- 2,175 officers of the Houses of Justice, trained in technical guidelines and gender-based violence attention routes.

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ANNEX 3 HEALTH

1. Access and the Provision of Health Services

Access to health services in Colombia has evidently improved, as can be seen from the historical improvement of the related indicators, measured in the quality of life survey-ECV-of the Government statistical bureau – DANE . The survey is used nationwide to measure and characterize the conditions of life of people with variables related to housing, health, education, and other topics.

ECV, shows that there has been increased in healthcare for those who have health needs (institutional use of health services), and in a reduction of the reasons for not requesting medical attention, such as *they did not attend to me, poor service, lack of promptness of general medical and dental appointments,* and others.

On analyzing the type of engagement with Social Security System – SGSSS - the proportion of affiliates who experience the *need for health care in the last 30 days* between 2001 and2015, for the contributory regime was 11.21% in 2011 and 7.34% in 2015 for the subsidized regime, the figures were 8.83% and 8.68% respectively. 73.96% in 2011 and 70.33% in 2015, of affiliates to the contributory regime who had had a health need in the last 30 days, were attended to institutionally, whilst in the subsidized regime, this proportion was 64.16% and 67.32% (Table 1)

Table 1. Need for healthcare and institutional use of health services

	Health needs %			Institutional use %		
Year	Contrib	Subsid	Special	Contrib	Subsid	Special
2011	11,31	8,83	14,65	73,96	64,16	81,55
2012	10,27	10,52	12,57	84,04	74,52	86,02
2013	10,04	10,50	11,63	81,85	73,79	86,63
2014	7,60	9,88	10,65	80,62	68,20	77,14
2015	7,34	8,68	9,59	78,33	67,32	81,09

Source: DANE-ECV Calculations Health Ministry DPSAP

Among the reasons for not requesting healthcare, there was also a reduction in access barriers. For example, the reason *they did not attend to me* was less common among affiliates in the contributory regime in for 2011 and 2015, falling from 1.75% to 037%;

and in the subsidized regime, incidence fell from 2.34% to 0.87%. At the same time, the reason *poor service* fell during between 2011 and 2015 in both regimes, from 12.02% to 9.5% in the contributory regime and 12.49% to 8.6% in the subsidized regime. This indicates an improvement in the perception of health services (Table 2).

Table 2. Reasons they did not attend to me, or poor service

	Did not attend to me			Poor service		
Year	Contrib	Subsid	Special	Contrib	Subsid	Special
2011	1,75	2,34	0,00	12,02	12,49	8,30
2012	1,70	1,08	0,00	9,41	9,89	11,75
2013	1,88	1,61	0,00	9,06	13,13	12,53
2014	0,19	0,89	0,00	11,07	10,23	13,34
2015	0,37	0,87	4,72	9,75	8,60	22,41

Source: DANE – ECV Calculations: Health Ministry DPSAP

Reasons *they did not attend to me,* and the reason *lack of promptness of general medical or dental appointments,* there were improvements according to the contributory regime affiliates, from 4.37 days average in 2011 to 3.65 days in 2015; and in the subsidized regime, down from 2.99 days to 2.45 days in those years.

Table 3. Lack of promptness of appointments for general or dental treatment (days), and the health centre is a long way away:

	Lack of promptness in General/dental appointments			*Health centre is a long way away*		
Year	Contrib	Subsid	Special	Contrib	Subsid	Special
2011	4,37	2,99	4,12	2,58	8,32	0,45
2012	3,40	2,62	3,78	4,56	7,28	5,38
2013	4,95	3,74	3,47	3,70	8,61	0,72
2014	4,70	3,17	3,66	1,85	3,82	3,09
2015	3,65	2,45	5,38	1,12	5,32	0,60

Source: DANE – ECV Calculations: Health Ministry DPSAP

In relation to the availability of the offer of health services for 2011 and 2015, there was also a reduction in the reason *The medical Center is a long way away*", falling from 2.58% in the contributors regime to 1.12%; and from 8.3% to 2% to 5.32% in the subsidized regime (Table 3).

According to the ECV, in the *perception of quality in the provision of health services* (Table 5) the contributory regime patients said that it was "very good" in 15.19% in 2011, and 14.19% in 2015; for the subsidized regime, this increased from 6.83% to 8.19% in those two years. At the same time, the perception of "good" quality in the provision of health services was higher than 65% during the period analyzed. Nonetheless, there was a reduction in the perception of "good" quality in the provision of healthcare between 2011 and 2015, in the contributory regime, from 72.2% to

68.72%, and in the subsidized regime, from 79.51% to 79.1%, the this latter figure being an improved perception.

Table 5. Perception of *very good* and *good* quality

	Very good %			Good %		
Year	Contrib	Subsid	Special	Contrib	Subsid	Special
2011	15,19	6,83	14,81	72,20	79,51	73,14
2012	15,61	9,40	16,70	67,14	74,81	67,33
2013	14,06	12,53	11,93	67,28	74,83	71,16
2014	13,46	10,57	15,44	68,39	79,05	72,31
2015	14,19	8,19	7,08	68,72	79,10	74,92

Source: DANE – ECV Calculations: Health Ministry DPSAP

Those who perceive quality of attention as "poor" in the contributory regime increased from 10.32% in 2011 to 15.24% in 2015; and in the subsidized regime, the figures were 12.28% and 11.42%, respectively. The proportion of perception of quality as "very poor", in the contributory regime decreased from 2.29% to 1.85%, and in the subsidized regime, from 1.37% to 1.29% (Table 6)

Table 6. Perception of poor quality

	Poor %			Very poor %		
Year	Contrib	Subsid	Special	Contrib	Subsid	Special
2011	10,32	12,28	8,88	2,29	1,37	3,18
2012	14,41	14,30	14,36	2,84	1,48	1,61
2013	14,06	12,53	11,93	2,12	0,95	2,60
2014	16,19	9,05	12,05	1,95	1,33	0,20
2015	15,24	11,42	16,77	1,85	1,29	1,23

Source: DANE – ECV Calculations: Health Ministry DPSAP

2. Offer of health services

If we remember that Colombia is a country with diverse and heterogeneous population and regions, with some areas of high population density and others with a widely scattered population, these conditions have implications on access, not only when considering aspects of demand (due to social, cultural, economic and other characteristics of the population), but also in availability of health services nationwide. In geographical areas with denser populations and more dynamic markets, there is a greater offer of services, while in areas with very scattered populations (remote, and with problems of access), the offer is limited and provided mostly by public sector health service providers, responsible for healthcare in these populations (Table 7).

Table 7. Health Provider Companies – IPS per Departments and District Capital

	IPS 2015				IPS 2016				
Dept/District	Private	Mixed	Public	Total Dec 2015	Private	Mixed	Public	Total Dec 2016	Var % 2016/2015
Amazonas	10		1	11	13		1	14	27,27
Antioquia	801	3	129	933	809	3	129	941	0,86
Arauca	59		5	64	54	1	5	60	-6,25
Atlántico	704	2	28	734	759	3	27	789	7,49
Bogotá D.C	1.687	3	28	1718	1.648	2	9	1.659	-3,43
Bolívar	426		43	469	468		43	511	8.96
Boyacá	212		105	317	224		105	329	3.79
Caldas	177	1	32	210	177	1	31	209	-0,48
Caquetá	61		6	67	61		6	67	0,00
Casanare	120		6	126	123		6	129	2.38
Cauca	195		29	224	194		29	223	-0,45
Cesar	302		30	332	322	1	29	352	6,02
Chocó	141		6	147	154	1	4	159	8.16
Córdoba	347		33	380	360		32	392	3.16
Cundinamarca	248		52	300	263		52	315	5,00
Guainía	5		1	6	6			6	0,00
Guaviare	14		2	16	14		2	16	0.00
Huila	181		41	222	183		41	224	0,90
La Guajira	116		47	163	118.		46	164	0,61
Magdalena	324		37	361	339		36	375	3,88
Meta	247		15	262	233		15	248	-5,34
Nariño	196	2	81	279	229	2	81	312	11,83
Norte de Santander	261		17	278	261		17	278	0,00
Putumayo	69		11	80	61		11	72	-10.00
Quindío	135		14	149	147		14	161	8,05
Risaralda	189	1	16	206	199	1	16	216	4,85
San Andrés & Providencia	13	1		14	13	1		14	0,00
Santander	571	1	85	657	577	1	85	663	0,91
Sucre	273	2	29	304	274	1	29	304	0.00
Tolima	257		53	310	265	1	52	318	2.58
Valle del Cauca	906	2	56	964	911	1	55	967	0.31
Vaupés	1		1	2	1		1	2	0.00
Vichada	6		4	10	6		3	9	-10.00
TOTAL	9,254	18	1,043	10,315	9,466	20	1,012	19,498	1,77

Source: Special Register of Health Providers - REPS

According to information reported to the Special Register of health service providers (IPS), in Departments with scattered populations such as Amazonas, there is a growth in health service providing institutions (IPS), between 2015 and 2016 of 27.27%; while in Guainía, Guaviare and Vaupés, the number of IPS was constant during those years,

but in Vichada, it fell 10%.

The heterogeneity of territory was also observed in the number of beds installed, with distribution by Department and Metropolitan Districts, as shown in Table 8.

Table 8. Beds enabled and ratio of bed per 1.000 inhabitants 2015/2016

Department/District Capital	2015		2016	
	Total enabled beds - IPS	Bed ratio per 1.000 inhabitants	Total enabled beds - IPS	Bed ratio per 1.000 inhabitants
Amazonas	137	1,80	137	1,78
Antioquia	9.874	1,53	10.343	1,58
Arauca	292	1,11	366	1,38
Atlántico	5.918	2,40	6.892	2,77
Bogotá D.C	13.794	1,75	14.249	1,79
Bolívar	3.408	1,63	3.638	1,71
Boyacá	1.488	1,17	1.490	1,17
Caldas	1.954	1,98	1.954	1,97
Caquetá	664	1,39	671	1,39
Casanare	423	1,19	468	1,29
Cauca	1.267	0,92	1.288	0,93
Cesar	2.168	2,11	2.616	2,51
Chocó	816	1,63	872	1,73
Córdoba	2.339	1,37	2.599	1,50
Cundinamarca	2.447	0,91	2.643	0,97
Guainía	58	1,40	55	1,31
Guaviare	103	0,93	100	0,89
Huila	1.640	1,42	1.685	1,44
La Guajira	1.156	1,21	1.190	1,21
Magdalena	2.589	2,06	2.653	2,08
Meta	1.664	1,73	1.735	1,77

Nariño	2.281	1,31	2.402	1,36
Norte de Santander	2.040	1,50	2.094	1,53
Putumayo	378	1,10	391	1,12
Quindío	1.176	2,08	1.164	2,05
Risaralda	1.554	1,63	1.662	1,74
San Andrés y Providencia	181	2,37	181	2,35
Santander	3.915	1,90	4.282	2,07
Sucre	2.373	2,79	2.304	2,68
Tolima	1.937	1,38	1.971	1,40
Valle del Cauca	7.391	1,60	7.503	1,61
Vaupés	14	0,32	14	0,32
Vichada	84	1,17	75	1,02
Total	**77.523**	**1,61**	**81.687**	**1,68**

Source: Beds – IPS record
Population – DANE estimate at 2016

Due to differences in demand and other health services, there are disparities in access between urban areas and scattered populations, with limitations in the latter.

3. Strengthening the installed capacity of the public offer

Important sums of money have been made available to strengthen the ability of the health services to make to provide an offer to the public. For 2015, in Resolutions 2078/2015 and 7/2015 and 5422/2015, funds were assigned to this project for COP49,321 million and COP50,077 million, respectively. In 2016, Specific Contract No. 858, derived from the National Plan Contract for Northern Cauca to finance the project "construction physical plant for the relocation of medium-complexity hospital Francisco de Paula Santander-Santander de Quilichao, Department of Cauca", for COP35, 668 9 million, of which the Ministry of Health and Social Protection finances COP8,629 million. In the Contract Plan, (Law 1454/2011), Resolutions 3004/2015 and 5038/2015 COP1,030 million, and COPD5,523 million, respectively,