ACHIEVING HEALTH OUTCOMES IN COLOMBIA
CIVIL REGISTRATION AND VITAL STATISTICS SYSTEM, UNIQUE PERSONAL IDENTIFICATION NUMBER, AND UNIFIED BENEFICIARY REGISTRY SYSTEM FOR BIRTHS AND DEATHS

DISCUSSION PAPER
August 2019

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Samuel Mills

WORLD BANK GROUP
Health, Nutrition & Population
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Health, Nutrition and Population (HNP) Discussion Paper

Achieving Health Outcomes in Colombia: 
Civil Registration and Vital Statistics System, Unique Personal Identification Number, and Unified Beneficiary Registry System for Births and Deaths

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Abstract: This case study on Colombia describes how the civil registration and national identification system and the health information system have facilitated progress toward universal health coverage. The study includes a description of Colombia’s General Social Health Insurance System (Sistema General de Seguridad Social en Salud [SGSSS]), assignment of a unique personal identification number (UPIN) at birth, and the interoperability of the civil registration and health information systems. It explains how the civil registration system and the UPIN have helped improve health outcomes and explains the role of death registration. The study finishes with conclusions, lessons learned, and recommendations. A brief overview of Colombia is presented in Annex 1. This study focuses on identification of and access to health services, which are considered rights in Colombia. This report emphasizes the importance of establishing an individual’s legal identity in childhood to facilitate early access to social and other services and for greater accuracy in population statistics.

Keywords: Colombia, civil registration, national identification system, health information system, universal health coverage.

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADRES</td>
<td>Resource Administrator of the General Social Health Insurance System (Administradora de los Recursos del Sistema General de Seguridad Social en Salud)</td>
</tr>
<tr>
<td>BDUA</td>
<td>Unified Health Beneficiary Database (Base de Datos Única de Afiliados)</td>
</tr>
<tr>
<td>CONPES</td>
<td>National Council on Economic and Social Policy (Consejo Nacional de Política Económica y Social)</td>
</tr>
<tr>
<td>DANE</td>
<td>National Department of Statistics (Departamento Administrativo Nacional de Estadística)</td>
</tr>
<tr>
<td>EAPB</td>
<td>Benefit plan administration entities (Entidad Administradora de Planes de Beneficios)</td>
</tr>
<tr>
<td>ECLAC</td>
<td>United Nations Economic Commission for Latin America and the Caribbean</td>
</tr>
<tr>
<td>FARC</td>
<td>Revolutionary Armed Forces of Colombia</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>ID card</td>
<td>Identification card</td>
</tr>
<tr>
<td>IPS</td>
<td>Health care facility (Instituciones Prestadoras de Servicios de Salud)</td>
</tr>
<tr>
<td>MIAS</td>
<td>Integrated Model of Healthcare (Modelo de Atención Integral en Salud)</td>
</tr>
<tr>
<td>MINSALUD</td>
<td>Ministry of Health and Social Protection (Ministerio de Salud y Protección Social)</td>
</tr>
<tr>
<td>MIPRES</td>
<td>Mi Prescripción (Access to Services and Technologies Not Covered by the Benefit Plan)</td>
</tr>
<tr>
<td>ND</td>
<td>Birth and death (nacimientos y defunciones)</td>
</tr>
<tr>
<td>NDP</td>
<td>National Development Plan</td>
</tr>
<tr>
<td>PILA</td>
<td>Integrated Payroll for Settlement of Social Security Contributions (Planilla Integrada de Liquidación de Aportes a la Seguridad Social)</td>
</tr>
<tr>
<td>PISIS</td>
<td>Platform for Sistema de Información Integral de la Protección Social Integration</td>
</tr>
<tr>
<td>RIPS</td>
<td>Registro Individual de Prestaciones en Salud</td>
</tr>
<tr>
<td>RNEC</td>
<td>National Civil Registry (Registraduría Nacional del Estado Civil)</td>
</tr>
<tr>
<td>RUAF</td>
<td>Single Registry of Affiliates (Registro Único de Afiliados)</td>
</tr>
<tr>
<td>SAT</td>
<td>Health Enrollment Transaction System (Sistema de Afiliación Transaccional)</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
</tr>
<tr>
<td>SGSSS</td>
<td>General Social Health Insurance System (Sistema General de Seguridad Social en Salud)</td>
</tr>
<tr>
<td>SISBEN</td>
<td>Identification System for Potential Beneficiaries of Social Programs (Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales)</td>
</tr>
<tr>
<td>SISPRO</td>
<td>Social Protection Integrated Information System (Sistema de Información Integral de la Protección Social)</td>
</tr>
<tr>
<td>UPC</td>
<td>Capitation Payment Unit (Unidad de Pago por Capitación)</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UPIN</td>
<td>Unique personal identification number</td>
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</table>
ACKNOWLEDGMENTS

This report on the Colombia, one of a series of case studies commissioned by the Health, Nutrition, and Population Global Practice, provides a comprehensive view of how the assignment of a unique personal identification number (UPIN) at birth, and the interoperability of the civil registration and health information systems contributed to Universal Health Coverage (UHC).

The author would like to thank Roberto Iunes and Ronald Gómez of the World Bank for their comments and contributions to this paper; Patricia Delgado, Luz Emilce Rincón, and Oscar Rivera of the Office of Information Technology and Communications of the Ministry of Health and Social Protection of Colombia for their time, good will, and information on the functioning of and statistics on the Ministry’s information systems. Thanks also go to Jaid Rojas of the Department of Promotion and Prevention for providing statistics on and explanations of the functioning of the vaccine information system; Alexandra Porras for providing information on epidemiological transition in Colombia and other data; Lenis Urquijo for providing the document on health systems in South America; and Carlos Acosta for providing the child mortality map and the maternal mortality figure. Dr. Samuel Mills (World Bank) provided technical advice and overall guidance. The Korea-World Bank Partnership Facility, and the Gavi Alliance are gratefully acknowledged for financial support. The author is grateful to the World Bank for publishing this report as an HNP Discussion Paper.
The World Bank Group (WBG) Data Council endorsed the 2016–2030 Civil Registration and Vital Statistics (CRVS) Action Plan in December 2015. This plan has a goal of achieving universal civil registration (CR) of births, deaths, and other vital events—including reporting the cause of death and providing access to legal proof of registration—for all individuals by 2030. The WBG has been working closely with development partners to provide the requisite support to countries through three interlinked initiatives: The Strategic Action Program for Addressing Development Data Gaps; Identification for Development; and the Global Financing Facility.

The goal of the WBG’s Health, Nutrition, and Population Global Practice is to contribute to the two WBG goals of ending extreme poverty within a generation and boosting shared prosperity by helping countries improve HNP outcomes and reduce impoverishment due to illness. Enabling countries to achieve universal health coverage (UHC) is the main way to attain this goal, by ensuring that all people have access to the quality, essential HNP services they need without enduring financial hardship. Documentation and dissemination of the CRVS-related country case studies, such as the use of a unique identification number (UIN) for UHC are key to this process.
“Children’s right to identification includes the right to a name, nationality, and family; it is the legal way to prove that a person exists as a full citizen with rights and duties. The absence of the right to identification puts children at risk of exclusion from essential health and education services” (MINSALUD and Profamilia 2017).

PART I – IDENTIFICATION AS A RIGHT IN COLOMBIA

Establishing an individual’s legal identity at birth is important; the right to identification is protected in the Colombian Constitution of 1991, was developed in subsequent legislation, and is backed by various social policies. This section introduces the constitutional framework and laws and government policies related to this right.

1.1 CONSTITUTIONAL AND LEGAL FRAMEWORK OF THE RIGHT TO IDENTIFICATION

The right to identification is protected in Article 14 of the Colombian Constitution of 1991, which states that “every person has the right to recognition as a person before the law.” The basis for this article is the Universal Declaration of Human Rights, which states in Article 6 that, “Everyone has the right to recognition everywhere as a person before the law.” Article 120 of the Constitution states that the National Civil Registry (Registraduría Nacional del Estado Civil (RNEC)) is responsible for citizen identity. Article 266 assigns the functions to RNEC of managing and organizing civil registration and identification of persons. The right to identification set out in Article 14 of the Constitution became effective (in accordance with Article 85) without the need for any regulation or drafting of any legislation. Nonetheless, legislation drafted for other rights, many of which are related to children’s rights, led to enactment of various laws that highlight the importance of identification, especially during childhood. Two of these laws are discussed below.

The Code of Children and Adolescents (Law 1098 of 2006) protects the right to identification of children and adolescents, who for this purpose must be registered at the civil registry immediately after birth (Article 25). On the obligations of the state, Article 41 stipulates that the state should “ensure registration and the processing of birth registration through an efficient and free procedure. For this purpose, RNEC and the Ministry of Health and Social Protection (MINSALUD [Ministerio de Salud y Protección Social]) jointly manage the administrative process that ensures that children leave the health facility in which they were born with their birth registration and certificate of live birth.”

Law 1804 of the year 2016 established the State Policy on Holistic Early Childhood Development from Day 1. The policy seeks to materialize the rule of law and strengthen the institutional framework for the recognition, protection, and guarantee of the rights of pregnant women and children from birth to six years of age (from a translation of the law). It defined a comprehensive service roadmap, taking into account children’s rights and characteristics and available services. One of the services targeted at children for the first time

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1 Within the framework of a public administration reform enacted in 2002, several ministries were merged, as was the case of the Ministry of Health and the Ministry of Labor and Social Security, resulting in the Ministry of Social Protection (law 790 of 2002). Later in 2011 (law 1444) this ministry was split into two: Ministry of Labor and Ministry of Health and Social Protection. In this document, MINSALUD will be used to refer to these entities (Ministry of Health, Ministry of Social Protection, Ministry of Health and Social Protection).
month of life is “the processing of civil registration of every child during their first month of life, and in the event of failure to do so, making it enforceable thereafter” (De cero a siempre, circa 2014).

This seeks to strengthen the institutional framework for the recognition, protection and guarantee of the rights of pregnant women and children from zero to six years of age, as well as the materialization of the Social State of Law.

1.2 SOCIAL POLICY FRAMEWORK OF THE RIGHT TO IDENTIFICATION

The policies associated with the right to identification are directly related to social policies for children. The objective of the National Council on Economic and Social Policy (Consejo Nacional de Política Económica y Social (CONPES)) 109, Política Pública Nacional de Colombia por la Primera Infancia (NDP 2007), is to promote the development of children from gestation to six months of age in accordance with their needs and characteristics.

The current study determined that there are a significant number of minors without identification, especially those living on the Caribbean and Pacific coasts. This affects anywhere between 10 percent and 14 percent of children under five years of age, whose right to identification is compromised and who do not receive social services and benefits because they have not been registered.

One of the strategies of the policy is to improve identification processes in early childhood, because all children have the right to recognition and identification so that they can access services. The policy recommends that RNEC “implement strategies at the national and local level so that all children are registered at birth and that agreements with other institutions such as the MINSALUD be strengthened to ensure the registration of newborns in hospitals” (NDP 2007). The goal is for all children under six years of age to be civilly registered. The indicator for this goal is the number of registered children younger than six years of age as a percentage of the total number of children in the age cohort.

One of the objectives of the Equitable Colombia without Extreme Poverty strategy, which is part of the National Development Plan 2014–2018 (NDP), is to reduce inequity in provision of health care services. To achieve this objective, demographic and geographic disparities need to be better understood and characterized. The technical instruments for achieving this objective are the national Identification System for Potential Beneficiaries of Social Programs (Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales (SISBEN)), a tool used for targeting social programs (including health programs), and the Unified Beneficiary Registry System (Registro Único de Afiliados (RUAF)), which will be discussed in detail in Section 6, because it is one of the components of the SISBEN information system. Specifically, the births and deaths (nacimientos y defunciones (ND))

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1 The CONPES is the highest planning authority advising the government on economic and social development. It coordinates and guides the entities of the national government responsible for the country’s social and economic direction by studying and approving documents presented in sessions that the President of the Republic and the executive and technical secretariat preside over and the National Planning Department performs (United Nations Economic Commission for Latin America and the Caribbean [ECLAC] 2019).
module provides information on newborns, based on which the identification process and subsequent enrollment in one of the health insurance schemes are conducted.

Another objective of the NDP (2014-2018) is “improving the health conditions of the Colombian population and promoting the effective enjoyment of the right to health in conditions of quality, efficiency, equity, and sustainability” (NPD 2015). The first goal within this objective is “increasing effective access to services and improving the quality of care” by consolidating universal coverage and unifying insurance operations, among other strategies. To close coverage gaps, the plan stipulates that “mechanisms will be put in place to enroll newborns in the system, promoting their due identification through coordinated work between the health sector and the RNEC” (NPD 2015).

The objective of the Colombian National Health Plan for the First 1,000 Days of Life 2012–2021 (MINSALUD and PAHO 2015) is to “ensure women’s health during pregnancy, and fetal, neonatal, and child health during the first 1,000 days of life, in conditions of quality, effectiveness, and continuity and to expedite efforts to reach the target for reducing maternal and neonatal mortality that Colombia set for 2015 within the framework of the Ten Year Public Health Plan and the Public Policy on Early Childhood” (MINSALUD and PAHO 2015).

The Colombian National Health Plan for the First 1,000 Days of Life 2012–2021 establishes four areas of intervention; the second area of intervention is improving maternal and child health care services and increasing access to comprehensive health care in the first 1,000 days of a child’s life, in accordance with public policies on comprehensive early childhood care. The objective of the intervention is “ensuring universal health access and health care, in conditions of quality and continuity, by women and their partners from before conception, during gestation, delivery, postpartum, to breastfeeding, and of children under two years of age, to ensure rights-based and differentiated physical and mental health management” (MINSALUD and PAHO 2015).

One of the interventions proposed in this area is civil registration at birth, which is a gateway to various rights, such as to health, vaccination, food, early education, education, citizenship, and work.

The goal of this intervention was to ensure, by 2015, universal, accessible, free birth registration. One of the activities organized in this regard was guidance for families of newborns in completing civil registration at birth, especially for indigenous groups and the dispersed rural population.
PART II – UNIQUE PERSONAL IDENTIFICATION NUMBER

The citizen identification process in Colombia consists of four steps, three of which take place before the age of 18 years:

1. Birth registration
2. Issuance of identification card (ID card) at age seven
3. Renewal of ID card at age 14
4. Issuance of citizen ID card at age 18

This section explains what a UPIN is and how it is used in the identification process in Colombia based on age. Given the importance of birth registration, it concludes by discussing the geographic distribution of completion and the reasons for not completing birth registration for children under five years of age and the strategies implemented to issue identity documents to people in hard-to-reach areas and to vulnerable groups.

2.1 ABOUT THE UPIN

UPINs have been used in Colombia since 2004. The UPIN consists of 10 digits (starting at 1 000 000 000), is assigned at the time of birth registration, and remains with a person throughout their life. It is used for the ID card and subsequently the citizen ID card which is issued to individuals at 18 years of age. People who had citizen ID cards with eight-digit UPINs, before 2004, kept the same number (RNEC 2012).

The first three digits of the UPIN correspond to the office where the birth was registered. The next seven digits are numbered consecutively.

Personal identification numbers had been in use since 1971. They had 11 digits, with the first six digits corresponding to the date of birth, and the next five digits numbered consecutively and indicating gender. The same number was used for birth registration and the ID card. Upon turning 18, a person received his or her citizen ID card and was assigned a new number; a different number was used for each type of identity document (RNEC, 2013).

With the UPIN, a person is identified with only one number throughout his or her life on all three identity documents. This initiative of RNEC was intended to avoid inconsistencies in personal information on identity documents. Once the person dies, RNEC cancels the identity document based on the death registration, verifying and cross-checking the information from the ID card and birth registration file.

Law 962 of 2005 established that the UPIN “shall be valid as a universal identification number used in all institutions of the Comprehensive Social Security System (Article 22).”

2.2 BIRTH REGISTRATION

Birth registration allows a person to “be recognized as an individual person before the law, with a name and a UPIN. Birth registration allows for the recognition of one’s rights and duties as a citizen of Colombia and access to goods and services provided by the State” (RNEC 2019d). Lack of identification creates serious challenges for minors in receiving
Birth registration should be completed during the first month of a child’s life. The process is based on the certificate of live birth that the health care facility (institución prestadora de servicios de salud (IPS)) issues after a child is born. The content of the certificate of live birth is explained in Section 6. The RNEC established that, in the absence of a certificate of live birth, the birth can be registered based on a sworn statement by two witnesses present at the birth or with direct and reliable news of the birth. For births taking place outside of health facilities, employees of the civil registry shall fill out the certificate of live birth for statistical purposes and complete the birth registration procedure (DANE 2012). Figure 1 illustrates this process.

Figure 1: Process for Issuing Certificate of Live Birth and Completing Birth Registration with a Unique Personal Identification Number (UPIN)

The birth registration document consists of two parts. The first part contains the child’s given and family names, date of birth, sex, blood type, Rh factor, standard background
document (certificate of live birth with corresponding number) or witness statement, information on the registry office (RNEC, notary office, consulate, corregimiento [political and administrative division in departments with very low population density], police department), and folio number. There is also a space for the UPIN.

The second part contains the child’s parents’ names and ID numbers, witness information, and the names and ID numbers of birth witnesses in the absence of the certificate of live birth. The newborn’s footprints are placed on the back of the document. Copies of the birth registration documents are sent to the National Registration Service of RNEC.

Births can be registered in RNEC offices, notary offices, Colombian consulates abroad, and authorized hospitals and clinics. The last option became available in 2002, considering that most births take place in health facilities, where RNEC provides civil registration.

2.3 ID CARD

An ID card is issued to children starting at seven years of age. It has a blue background and shares some characteristics with the citizen ID card—photograph, fingerprints, the p’s signature, and a code that contains the minor’s biometrics to decrease the risk of counterfeiting. The biometric identification system was put in place in 2008, incorporating fingerprints into the national identification system to allow for automatic identity verification for minors. The ID card must be renewed when the holder turns 14 years to update the information included.

To receive a blue biometric ID card at age seven, a child must go to any RNEC office with a copy of his or her birth registration and his or her identity card and know or present a certificate of blood type and Rh factor. The same requirements apply when the minor renews the ID card upon turning 14. The ID card is issued free of charge.

2.4 CITIZEN ID CARD

The citizen ID card is the identity document of Colombians, by birth or adoption, starting from 18 year of age. To receive a citizen ID card a person 18 years of age or older must go to any RNEC office, present a copy of a birth registration or the original biometric ID card and a copy of the naturalization certificate for adoptees, confirm blood type and Rh factor, and provide three copies of a color photograph. After receiving and verifying the documents, the Civil Registry official issues a password, which serves as proof that the document is being processed. The password is associated with the applicant’s given and family names, UPIN, place and date of birth, and place and date of issuance of the document.

Citizen ID cards also contain the holder’s biographic details and physical and technological features such as laminated holograms, barcodes with security algorithms, and biometric information (including fingerprint to prevent counterfeiting) (RNEC 2019a).

2.5 GEOGRAPHIC DISTRIBUTION OF AND REASONS FOR LACK OF BIRTH REGISTRATION OF CHILDREN UNDER FIVE IN COLOMBIA
This section describes the regional and geographic (urban/rural) distribution of and reasons for nonregistration of children under five years of age. This information is sourced from the National Demographic and Health Surveys (Encuesta Nacional de Demografía y Salud) of 2005–2010 and 2010–2015. The section on reasons for nonregistration did not include factors other than those that survey respondents reported; nevertheless, this section attempts to briefly explain possible reasons to help elucidate the responses provided by survey respondents.

For the past three decades, the National Demographic and Health Survey has been conducted in Colombia every five years, with the 2015 edition being the seventh one. The main objective of the survey is to provide information on demographic characteristics, sexual and reproductive health, and maternal and child health to enable policy development and research in these areas. Over the years, the survey has incorporated new variables, such as men’s sexual and reproductive health, gender-related violence, and disability (MINSALUD and Profamilia 2017).

The 2010 and 2015 surveys included information on children under age five who had not been civilly registered. The surveyors asked mothers whether they had completed birth registration for their children. If so, the mothers were asked where they had completed the registration; if not, they were asked why they had not registered their children (MINSALUD and Profamilia 2017).

In 2010 and 2015, the highest percentage of underregistration for children under five years of age occurred in rural areas (5.4 percent in 2010, 2.5 percent in 2015) (table 1). Nonregistration decreased in urban and rural areas and nationally.

### Table 1: Unregistered Children Under Five According to Area and Nationally, 2010 and 2015

<table>
<thead>
<tr>
<th>Unregistered children</th>
<th>2010</th>
<th></th>
<th>2015</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Area</td>
<td>Total</td>
<td>Area</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>%</td>
<td>2.8</td>
<td>5.4</td>
<td>3.5</td>
<td>0.9</td>
</tr>
<tr>
<td>N</td>
<td>11,406</td>
<td>4,438</td>
<td>15,844</td>
<td>10,170</td>
</tr>
</tbody>
</table>

Sources: Profamilia 2011 (Table 3.17.1, p. 65); MINSALUD and Profamilia 2017 (Table 2.8, p. 84)

In 2010, the regions with the most unregistered children were, in descending order, the Caribbean, the Pacific, and the Orinoquia and Amazon regions (table 2). The Pacific\(^3\) and the Orinoquia and Amazon are sparsely populated regions with low quality of life indices. According to the National Demographic and Health Survey 2010, La Guajira and Córdoba departments of the Caribbean region, Chocó department of the Pacific region, and Vichada department of the Orinoquia and the Amazon region had the highest nonregistration rates in the country.

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\(^3\) Three of the four departments on the Pacific coast—Cauca, Chocó, and Nariño—have low population density (Carabali V. Michel Andrey 2016).
Table 2: Unregistered Children Under Five According to Region and Nationally, 2010

<table>
<thead>
<tr>
<th>Unregistered children</th>
<th>Region</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caribbean</td>
<td>Easter</td>
</tr>
<tr>
<td>%</td>
<td>5.7</td>
<td>2.2</td>
</tr>
<tr>
<td>N</td>
<td>3,723</td>
<td>3,013</td>
</tr>
</tbody>
</table>

Source: Profamilia 2011 (Table 3.17.1, p. 65)

As mentioned previously, National Demographic and Health Survey data from 2015 (table 3) show lower nonregistration rates, with the largest decrease from 2010 in Bogotá, followed by the Orinoquia and Amazon and the Central regions. Despite the decrease, the Caribbean (2.1 percent) and Pacific regions (1.6 percent) continue to have the highest nonregistration rates, which are above the national average (1.4 percent).

Table 3: Unregistered Children Under Five According to Area and Nationally, 2015

<table>
<thead>
<tr>
<th>Unregistered children</th>
<th>Region</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caribbean</td>
<td>Easter</td>
</tr>
<tr>
<td>%</td>
<td>2.1</td>
<td>1.4</td>
</tr>
<tr>
<td>N</td>
<td>3,525</td>
<td>2,409</td>
</tr>
</tbody>
</table>

Source: MINSALUD and Profamilia 2017 (Table 2.8, p. 84)

Table 4 outlines the main reasons for nonregistration that mothers of unregistered children surveyed in the 2010 and 2015 editions gave.
Table 4: Reasons for Not Registering a Child Under Five (Percentages), 2010 and 2015

<table>
<thead>
<tr>
<th>Reason</th>
<th>2010</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Too expensive</td>
<td>3.1</td>
<td>10.8</td>
</tr>
<tr>
<td>Registry office too far</td>
<td>1.6</td>
<td>13.6</td>
</tr>
<tr>
<td>Abandoned by father, absent father, father fails to acknowledge paternity</td>
<td>11.8</td>
<td>12.7</td>
</tr>
<tr>
<td>Undocumented parents</td>
<td>11.2</td>
<td>18</td>
</tr>
<tr>
<td>No time</td>
<td>11.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Mother still recovering</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Problems at the registry</td>
<td>5.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Problems at the notary’s office</td>
<td>1.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Child too small</td>
<td>9.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Child death</td>
<td>34.1</td>
<td>18.8</td>
</tr>
<tr>
<td>Lack of certificate of live birth</td>
<td>1.7</td>
<td>3.2</td>
</tr>
<tr>
<td>Not knowing where to register</td>
<td>0</td>
<td>2.7</td>
</tr>
<tr>
<td>Other</td>
<td>8.2</td>
<td>7.1</td>
</tr>
</tbody>
</table>

* Not included in the survey as a reason for nonregistration.

Sources: Profamilia 2011 (Table 3.17.1, p. 65); MINSALUD and Profamilia 2017 (Table 2.8, p. 84)

In 2010, the main reason for nonregistration was death of the child (27.5 percent), which was not included in the 2015 survey. Based on the Colombia Demographic and Health Surveys, the infant mortality rate (IMR) was 16 and the under-5 mortality rate (U5MR) was 19 per 1,000 live births for 2005–2010, and the IMR was 14 and the U5MR was 16 in 2010–2015 (for more information on infant mortality, see Box 1 at the end of Section 7.)

In 2015, the leading reason for nonregistration was “abandoned by father, absent father, father fails to acknowledge paternity,” accounting for 27 percent of all responses. This figure is somewhat related to the changes in the size, composition, and functioning of Colombian households in the past few years. Based on the National Demographic and Health Survey 2015, there has been an increase in single-parent households, with female-headed households in particular increasing from 30.3 percent in 2005 to 34.0 percent in 2010 and 36.4 percent in 2015. As stated in the National Demographic and Health Survey 2015, “the rise of female-headed households is highly consistent with the trends in marriage and civil unions, with the latter on the rise in most Latin American countries. In Colombia, some of the rise in female-headed households may have to do with excess male mortality and forced displacement and may indicate greater vulnerability of women and their households” (MINSALUD and Profamilia 2017). It may also be that the prevailing cultural view is that the function of registering the child is a male responsibility.

Other reasons for nonregistration reported in the National Demographic and Health Survey 2015 included “living too far from the Registry” and “having no time,” which are
interrelated and together account for 20.9 percent of the responses. The high percentage of respondents who indicated the former is consistent with the fact that they live in rural areas.

The next major reason is “mother still recovering,” which accounts for 14.6 percent of the national total (16.5 percent in urban areas, 12.8 percent in rural areas). The most commonly cited forms of lack of recovery were postpartum depression (11.3 percent), heavy vaginal bleeding (10.5 percent), fever and chills (9.3 percent), and vaginal discharge (8.2 percent) (MINSALUD and Profamilia 2017). The National Demographic and Health Survey 2015 indicated that 34.1 percent of women surveyed who reported having given birth during the five years before the survey developed postpartum conditions. This reason was not included in the 2010 survey.

An additional explanation for nonregistration could be the significant increase in caesarean sections in Colombia4 and their effect on maternal mortality: “The rise of C-section is associated with higher chances of future maternal morbidity and mortality, as C-section increases the risk of placenta previa and placenta accreta, which can lead to higher chances of developing obstetric hemorrhage … in addition to increased surgical and anesthetic risks … C-section patients may have a longer hospital stay (three to four days on average) than those who had vaginal births (one to two days on average). Nevertheless, women who are recovering properly, without fever or post-C section complications, should be discharged early with home-based follow-up” (Ministry of Public Health of Ecuador 2015).

Another reason with a high percentage of responses is “undocumented parents” (parents not having identity documents), accounting for 14 percent of the total in both surveys. There was an increase in the percentage of urban residents who indicated this reason (from 11.2 percent in 2010 to 13.1 percent in 2015), so it is important to understand the underlying causes. The percentage of rural residents who indicated the same reason decreased from 18 percent to 15 percent during the same period.

Another major reason reported was “child too small,” which accounted for 7.5 percent of total respondents, up from 6.5 percent in the 2010 survey. The percentage is significantly higher in urban areas (11.1 percent) than in rural areas (4.2 percent). One reason for this could be low birthweight (less than 2,500 g), which requires a series of care activities, procedures, and interventions at the health facility and at home (MINSALUD circa 1999). According to the 2016 Health Situation Analysis, between 2005 and 2014, approximately nine of every 100 babies born live in the country weighed less than 2,500 g, with an annual average of 60,128 (standard deviation 1.648) low-birthweight newborns (MINSALUD 2016a). Low birthweight is more common in urban (8.5 percent) than in rural areas (5.6 percent) (MINSALUD and Profamilia 2016), a characteristic consistent with the higher percentage of urban residents who indicated “child too small,” as mentioned at the beginning of this paragraph.

The percentage of “lack of certificate of live birth” doubled from 2.4 percent in 2010 to 4.8 percent in 2015, increasing significantly in urban areas in 2015 to 9.7 percent.

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4 The percentage of caesarean-section births grew from 26.9 percent in 2000 to 46.2 percent in 2014, one of the fastest rates of increase in the world (MINSALUD, 2017a).
Responses of “too expensive” decreased significantly during the period between the two surveys, from 6.4 percent in 2010 to 4.3 percent in 2015. It is important that campaigns informing people that birth registration is free be promoted. It is important to reinforce the provision of this service in remote rural areas. The next section provides an in-depth discussion of this.

2.6 Strategies to Increase Civil Registration

RNEC has been implementing various strategies to provide civil registration services to vulnerable populations living in hard-to-reach areas. Over the last two decades, RNEC has been hosting identification days for vulnerable populations, especially those affected by the armed conflict, through arrangements with the United Nations High Commissioner for Refugees for Colombia. In 2004, RNEC launched the Vulnerable Population Care Unit as an institutional response to the identification needs of vulnerable populations and people who are internally displaced as a result of violence. In 2009, RNEC strengthened the unit by establishing a coordinating entity within it. Since its inception, the unit has sent staff to more than 800 municipalities in Colombia to identify populations vulnerable populations who live in remote, hard-to-reach rural areas, which are also home to many indigenous peoples and Afro-Colombians (RNEC 2013).

RNEC has mobile units to support the campaigns of the Vulnerable Population Care Unit. The mobile units are equipped to perform civil registration and identification-related tasks and to provide passwords for citizen ID cards. Through its departmental missions, RNEC conducts campaigns to issue identity documents in schools, cities, small municipalities, and rural areas and at citizen service fairs (RNEC 2013).
PART III – INSTITUTIONAL ORGANIZATION OF CIVIL REGISTRATION AND VITAL STATISTICS SYSTEM

This section aims to describe the objectives and institutional organization of the civil registration and vital statistics system. It starts by describing the evolution of civil registration and vital statistics in Colombia.

3.1 EVOLUTION OF CIVIL REGISTRATION IN COLOMBIA

Civil registration was established for the first time in Colombia in Law 2159 of 1852, which empowered notary publics to register births, marriages, and adoptions and acknowledge children born out of wedlock, even though the Catholic Church continued to provide these services in practice, and the law was essentially kept unchanged (Escobar and Guzmán de Gaitán 2010). The Santander Code of 1859, later renamed the Cundinamarca Code, acknowledged the validity of civil status registered by the church even though notaries were in charge of these tasks. Law 84 of 1873 also reflects this dual system (DANE and RNEC 2000).

Because of Colombia’s Catholic tradition and the lack of legislative development, the Civil Code Law 57 of 1887 and the Concordat with the Holy See established that church certificates (baptism, marriage, death certificates) that priests issued would constitute the main proof of civil status (RNEC 2019c).

Law 92 of 1938 established that the state would be responsible for civil registration. This law assigned the function of civil registration to notaries, mayors of municipalities without notaries, and Colombian consuls abroad (RNEC 2019c). Nevertheless, church-issued certificates were still considered supporting evidence of civil status (DANE and RNEC 2000). The law also required that all registration entries be recorded at civil registry offices (RNEC 2019c).

The RNEC, which provides civil registration and identification services to Colombians and organizes voting, was created in 1948. It consists of two sections that participate in the design and implementation of plans and programs, with one section in charge at the central level with national jurisdiction and the other in charge at the subnational level with specific subnational divisions. The central section of RNEC has two divisions, one for a registry for civil registration and identification and another for voting-related matters. At the territorial level, the RNEC has district, municipal, and auxiliary registries (RNEC 2019b).

Decree 1260—the Organic Statute of Civil Status Registration of 1970—established the Superintendence of Notaries and Registry Offices as the coordinator of registry offices, which are required to send copies of all registration entries to the Superintendent (RNEC 2019c). Additionally, church-issued certificates were no longer recognized as supporting evidence of civil registration (DANE and RNEC 2000). Subsequent regulatory developments changed how civil registration was performed and regulated identification number assignment, ID card issuance, and birth registration, among other major changes (DANE and RNEC 2000).

Law 96 of 1985 established in Article 60 that RNEC would gradually take over the function of civil registration, and Decree 2241 of 1986 set the effective date of takeover as January 1, 1987. Under the precept of the Colombian Constitution of 1991 on the functions of
RNEC, the functions of the Legal Division of Civil Registration of the Superintendence of Notaries and Registry Offices would be transferred to RNEC in 1997 (Escobar and Guzmán de Gaitán 2010).

Resolution 5296 of 2000 authorized notaries to provide civil status registration services, a function shared with all civil registrars in the country (RNEC 2019c). As mentioned previously, Resolution 802 of 2002 established that the RNEC office was to provide civil registration services in hospitals and clinics. Law 395 of 2010 allowed civil registration to be completed in any part of the country regardless of place of birth, facilitating birth registration.

At present, notaries, civil registrars, and Colombian consuls abroad are the public employees in charge of civil registration. Under special circumstances, police inspectors and political administrators of the corregimientos authorized by RNEC can also conduct civil registration procedures.

3.2 EVOLUTION OF VITAL STATISTICS IN COLOMBIA

Created in 1953, the National Department of Statistics (Departamento Administrativo Nacional de Estadística (DANE)) was established to ensure the availability and quality of statistical information (DANE and RNEC 2000). DANE is the government entity “aimed at ensuring the production, availability, and quality of strategic statistical information, and leading, planning, implementing, coordinating, regulating, and evaluating the production and dissemination of basic official information” (DANE 2015).

Until 1987, birth statistics were generated based on information from notaries, mayor’s offices, and churches (DANE 2012). The entities involved in institutional strengthening went through several rounds of restructuring to improve the procedures and methodologies for collecting timely, good-quality birth and death statistics. The government also enacted standards to regulate medical certificates and to authorize other health professionals to issue birth and death certificates in places where there were no doctors.

In 1998, the creation of the civil registration and vital statistics system introduced the certificate of live birth and the death certificate. Each of these certificates has two parts, one with background information on civil registration and the other for statistical purposes.

In 2004, the Directorate of Census and Demography of DANE became responsible for producing statistical information on vital events such as births and deaths (DANE 2012). In 2005, DANE and the Ministry of Social Protection (currently MINSALUD) began a joint project to capture information on births and deaths online. The collaboration has continued to fine-tune processes to improve the quality of the data generated (DANE 2012). In 2008, the birth and death (nacimientos y defunciones (ND)) module of RUAF was implemented. The process will be explained in further detail below.

3.3 CIVIL REGISTRATION AND VITAL STATISTICS SYSTEM

The civil registration and vital statistics system was created in 1998 for civil registration and statistical purposes to recognize the rights and duties of individuals and to collect information on vital events throughout their lives (birth, adoption, recognition, marriage, legitimization, annulment, divorce, death).
The system consists of two subsystems: civil registration and vital statistics. The objective of the civil registration subsystem is to recognize the legal rights and obligations associated with vital events. The objective of the vital statistics subsystem is to produce, consolidate, review, and disseminate statistics on vital events. Information on vital statistics is used for demographic purposes, such as to inform the planning of socioeconomic development programs and projects and to facilitate comparison among countries and regions (DANE 2018).

Created in 2002, the Intersectoral Commission of Vital Statistics is the consultative and advisory division of DANE charged with strengthening and maintaining the civil registration and vital statistics system. Members of the commission are from DANE, MINSALUD, RNEC, the Superintendence of Notaries and Registry Offices, the National Institute of Legal Medicine and Forensic Sciences, the Colombian Institute for Family Welfare (Instituto Colombiano de Bienestar Familiar (ICBF)), the National Planning Department, Profamilia, and the Technical Investigation Bureau of the Public Prosecutor’s Office.

Created in December 2012, the Technical Committee of the Intersectoral Commission of Vital Statistics is responsible for implementing the policies and strategies that the Commission establishes for the functioning of the civil registration and vital statistics system. Committee members include the Director of Census and Demography of DANE, the Director of Epidemiology and Demographics of MINSALUD, and the Delegate Registrar for Civil Registration and Identification of the RNEC.

Departmental committees on vital statistics are responsible for technical and operational aspects of the civil registration and vital statistics system in each department. Local and district committees on vital statistics are in charge of the civil registration and vital statistics system.
PART IV – HEALTH AS A RIGHT IN COLOMBIA

In addition to the right to identity from early childhood, children’s rights to health are established in the Constitution, legislative development, and social policies.

4.1 CONSTITUTIONAL AND LEGAL FRAMEWORK FOR CHILDREN’S RIGHT TO HEALTH

The Colombian Constitution of 1991 contains various articles on children’s rights to social services. Article 44 establishes children’s fundamental rights, such as the rights to life, bodily integrity, health and social security, education, and recreation. Article 50 states that children under one year of age not covered by social security have the right to receive free care at state-funded health facilities. Article 49 establishes the right of all people to receive services that promote, protect, and regain health.

The Code of Children and Adolescents (Law 1098 of 2006) indicates in Article 27 that “children and adolescents are guaranteed to receive services, goods, and actions conducive to preserving or regaining health.”

This code establishes in Article 29 the right to comprehensive early childhood services (from birth to six years of age), which includes health care, nutrition, and scheduled vaccines and mandates that civil registration be guaranteed for children during their first month of life. Regarding immunization, Article 20 on the right to protection states that children and adolescents shall enjoy protection from the transmission of preventable infectious diseases during gestation and after birth.

Regarding state obligations, Numeral 13 of Article 41 states that children and adolescents shall be guaranteed timely access to Colombia’s SGSSS. This right becomes effective as soon as the newborn is enrolled in one of the legally required schemes, which is still the case despite significant regulatory and technological development (Sections 5 and 7) to support compliance with this precept. Nevertheless, additional regulatory and technological efforts are still needed and managed by benefit plan administrating entities (entidades administradoras de planes de beneficios (EAPBs)) to make this right effective.

Title III, Articles 17 to 21 of Law 1438 of 2011, which reformed the health system, addresses preferential and differentiated care for children and adolescents. These articles underscore that the health benefit plan (Section 5.1 for definition and scope) shall contain a special and differentiated section to ensure the prevention, early detection, and treatment of diseases for children and adolescents at different stages of their lives (prenatal to six years old, six to 14, 14 to 18). Article 22 establishes national portability of all EAPBs, which guarantees access to health services throughout the country with a citizen ID card or other identity document.

Law 1804 of 2016, State Policy on Holistic Early Childhood Development from Day 1, defines the attainment of holistic development (defined in Article 4 as having “the conditions and states in the life of each child to enable their holistic development”) as living and enjoying the highest standards of health and having and maintaining good nutrition. The responsibilities of MINSALUD include developing policies, programs, and projects to promote and manage health and to manage health risks.
Law 1751 of 2015, the Statutory Health Law, was a milestone in the development of the Colombian social security system, because it elevates health to the status of a fundamental right. It establishes the state’s responsibility to protect and ensure citizens’ health, to provide a full range of services and technologies to prevent and treat diseases, and to ensure access to and equity in the health system. Relevant to the topic of this study, the law contains an article on the principles of the right to health, establishing the primacy of rights to ensure comprehensive care for children and adolescents. The same article establishes the principle of continuity to ensure ongoing access to health. In other words, administrative or economic reasons do not justify interruption of health services to previous beneficiaries. Article 11 establishes that children and adolescents are special priority groups who have special protection, which implicitly establishes the importance of enrollment in health insurance for minors.

Decree 780 of 2016, the Unified Regulatory Decree on the Health and Social Protection Sector, was the outcome of an institutional effort by MINSALUD to consolidate into one regulation all the legislative developments in the health sector to streamline and simplify the processes involved. The following description of this regulation also mentions a previous regulation, Decree 2353 of 2015 on the enrollment requirements of the SGSSS.

4.2 SOCIAL POLICY FRAMEWORK OF THE RIGHT TO HEALTH

The section on the social policy framework of the right to identification provides a description of the various policies related to the right to health, such as CONPES 109 “National Public Policy on Early Childhood ‘Colombia for Early Childhood,’” the National Plan for the First 1,000 Days of Life 2012–2021, and the 10-Year Public Health Plan. In light of this, the study will proceed to describe the NDP with regards to health insurance coverage and the Sustainable Development Goals (SDGs).

The second strategy of the NDP highlights that, although there has been significant progress in achieving health insurance coverage, “from 24 percent in 1996 to 96 percent in 2013” (NDP 2015) barriers to access persist despite greater equity and financial protection for households. The second strategy stresses that one of the components of the Social Protection System is comprehensive social security, and one of its two priorities is universal access to health. The second objective of this strategy is to “improve health conditions of the Colombian population and facilitate the effective enjoyment of the right to health in conditions of quality, efficiency, equity, and sustainability” (NDP 2015). The text on the second objective begins by stating that “universal and quality health care is one of the basic preconditions for preserving human capital through promoting health insurance of the population, managing individual risks through people’s own means or subsidies, and managing collective risks facing the population through public health measures” (underline added) (NDP 2015).

To overcome operational challenges to enrollment in the SGSSS, the NPD establishes that MINSALUD shall develop an “online transaction system easily accessible by citizens to allow the various system stakeholders to complete the enrollment process and update information more efficiently…. the Ministry shall look for ways to mitigate deficiencies in the enrollment process within the framework of the RUAF of the Comprehensive Social Security System” (NPD 2015). The indicator associated with this NPD objective is percentage of the population enrolled in the health care system.
Colombia was one of the countries that spearheaded the 2030 world development agenda with the 17 SDGs. SDG 3 is to “ensure healthy lives and promote well-being for all at all ages.” The related objectives are 3.2, “end preventable deaths of newborns and children under five years of age,” and 3.8, “achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.” Given the cross-cutting nature of SDGs, the abovementioned goals are related to other health determinants, such as ending poverty, zero hunger, gender equality, clean water and sanitation, and climate action.

CONPES 3918, Implementation Strategy for SDGs, established strategies, indicators, and objectives for 2030; defined the institutional roadmap and the resources for implementation; formulated the territorial strategy and the monitoring and reporting scheme; and improved statistics (NPD 2018).

Goal 3.2 on infant mortality establishes the following indicators: neonatal mortality, mortality for children under one year of age, and mortality for children under five years of age.

Goal 3.8 on health insurance coverage establishes the following indicators: percentage of children under one year of age who have received the third dose of pentavalent vaccine (diphtheria, pertussis, tetanus, hepatitis B, haemophilus influenzae type B), percentage of children under one year of age who have received triple vaccination (diphtheria, pertussis, tetanus), and percentage of population enrolled in the SGSSS.

**PART V – SGSSS IN COLOMBIA**

This section provides a brief description of the SGSSS, its structure and main components, and its main achievements and challenges. There is also a section on the health care system enrollment process, with special attention given to newborns, highlighting the importance of identification as an essential requirement for enrollment. Given its relevance to the purposes of this study, the national health information system is described at the end of this section.

**5.1 STRUCTURE AND MAIN COMPONENTS OF SGSSS IN COLOMBIA**

The SGSSS in Colombia is “organized like a public service that serves to ensure access to services and financial protection of the population through social insurance. It calls for a high level of specialization of its various stakeholders and public–private partnership in providing insurance and ensuring service delivery” (ISAG 2012).

Law 100 of 1993 determined the direction, operation, and organization of the current health system. Subsequent laws defined competencies in the provision of health services (Law 715 of 2001), made adjustments to the system (Law 1122 of 2007 and Law 1438 of 2011), and declared health as a right (Law 1751 of 2015). Throughout the 25 years since the health care system was established, numerous regulatory standards of the aforementioned laws have been issued to facilitate implementation. The current health care system has five identifiable functions (ISAG 2012):
i. Regulation: conducted by public entities at the central level, with MINSALUD as the governing and regulatory body of the health care system. The ministry is responsible for defining health policies and standards. The National Health Superintendence is the national-level entity in charge of monitoring and oversight of the various stakeholders of the system. The Resource Administrator of the General Social Health Insurance System (Administradora de los Recursos del Sistema General de Seguridad Social en Salud (ADRES)) manages the resources of the health care system to ensure their timely flow. The National Health Institute (Instituto Nacional de Salud) monitors public health and conducts and promotes scientific research. Given Colombia’s decentralization, the territorial entities—departments, municipalities, districts—manage and take actions in the field based on their competencies (taking public health measures, promoting health insurance, building service provision networks with verified quality standards, inspection and monitoring).

ii. System financing: with resources derived from contributions by individuals and companies with formal employees, as well as state funding through general taxation, royalties\(^5\), and excise taxes (on spirits and gambling) that subnational governments collect. In this regard, the health system is a solidarity system, with one of the lowest out-of-pocket costs in the region.

iii. Public health: which it promotes through collective intervention in health determinants. In addition to MINSALUD, territorial authorities, institutional health system stakeholders, and institutions of other sectors (e.g., water, environment, housing, food, nutrition security) intervene to achieve health outcomes. Colombia prepares 10-year public health plans that outline strategic objectives, priorities, cross-cutting issues, stakeholder responsibilities, and public health financing. The time horizon of the current plan is 2012 to 2021.

iv. Insurance: focused “primarily on individual health and conceived as a form of financial and health risk management, of coordination of services to ensure effective access, and of quality assurance in health service provision” (ISAG 2012). EAPBs include public and private institutions that represent beneficiaries and manage health risks by coordinating the services needed as determined under the benefit plan. A premium known as the Capitation Payment Unit (Unidad de Pago por Capitación (UPC)) is recognized per beneficiary. In Colombia, the EAPBs manage, depending on their nature, one of two beneficiary schemes: subsidized or contributory. Some health insurers administer both types of schemes. These three concepts—benefit plan, UPC, and beneficiary schemes—will be explained in further detail below, because they clarify the enrollment process of the population, especially of minors.

The Benefit Plan refers to the full range of services and technologies provided to ensure the right to health, making health care more comprehensive by preventing, alleviating, and treating diseases and facilitating rehabilitation (Law 1751 of 2015, Article 15). Law 1751

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\(^5\)The royalties are resources of economic compensation in favor of the state that come from the exploitation of nonrenewable natural resources such as hydrocarbons and minerals. The national system of royalties has had several reforms over time, through which the distribution that corresponds to the state, the territorial entities producing or not producing, and the companies that exploit these resources is established.
also defines the criteria for services and technologies not eligible for financing with resources from the health care system, with MINSALUD as the entity in charge of establishing said screening criteria.

The Benefit Plan, which is constantly updated, included in 2018, a set of 9,763 procedures, 68,524 medicaments and all devices according to the correspondent procedure; this allows institutional actors like EAPBs and IPSs and also general public to be informed of the authorized health services and benefits, avoiding misinterpretations and ambiguities (MINSALUD 2018b).

The **UPC** is the rate recognized for each person who enrolls in the SGSSS through the contributory or subsidized scheme to cover the services defined in the Benefit Plan. MINSALUD conducts annual reviews of UPC in light of information on the use of health services and technologies reported by EAPBs and updates the Benefit Plan. For 2018, MINSALUD added 32 new procedures, 78 medications, and two devices in its update of the Benefit Plan. UPC has different risk-based rates for different age groups and according to sex. For example, the rate is higher for children under one year of age, individuals older than 70, and women aged 19 to 44. The rate varies according to geographic area; people living in sparsely populated areas are assigned a higher percentage in the UPC (MINSALUD 2017b).

People with a labor relationship—those with payment capacity who are formally or self-employed, pensioners, and their families—enroll in the contributory system. Employers and employees make contributions based on the employees’ salaries, and self-employed workers make contributions based on their income (MINSALUD 2019b).

The subsidized scheme aims to provide health services and technologies through demand-side state subsidy to poor and vulnerable populations who are unable to pay (MINSALUD 2019c).

The **SISBEN** is used for selecting beneficiaries of the subsidized scheme by “scoring and classifying the population based on their socioeconomic conditions. SISBEN helps identify poor and vulnerable groups quickly and objectively to target social investment and ensure that it is used for people who need it the most. The score is automatically calculated using an application in SISBEN based on information reported by households in the survey and takes on a value between zero (0) and one hundred (100)” (NPD 2017).

There are two other schemes with fewer members in Colombia: an exceptional scheme and a special scheme. The Teachers’ Fund, Ecopetrol, the Military Health Directorate, and the Health Directorate of National Police administer the exceptional scheme. Public universities with special health care schemes administer the special scheme.7

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6 Based on Article 15 of Law 1751 of 2015, the criteria are services and technologies whose primary purpose is cosmetic or sumptuary and is unrelated to the recovery of maintenance of the patient’s functional or vital capacity, that lack scientific evidence of safety or clinical efficacy, that lack scientific evidence of clinical effectiveness, that the appropriate authority has not authorized, that are at experimental stages, and that are only provided abroad.

7 These universities are the University of Antioquia, University of Cartagena, Nueva Granada Military University, University of Cauca, University del Valle, Tunja-UPTC Pedagogical and Technological University (Tunja, Boyacá), and the Industrial University of Santander.
v. Health, hospital, or ambulatory care services that public or private entities that the EAPBs hire to provide to members or entities that territorial authorities hire to undertake collective interventions in public health. These entities (hospitals, clinics, self-employed professionals) must comply with quality standards.

5.2 ACHIEVEMENTS IN AND CHALLENGES TO THE HEALTH SYSTEM

Colombia has achieved remarkable progress in health insurance coverage, with the main goal of reaching 98 percent of the national population as beneficiaries of the health benefit plans described in the previous section. Out-of-pocket expenses are 15 percent of total health expenditures in Colombia, similar to Organization for Economic Cooperation and Development levels and lower than in other Latin American countries. Colombia has also seen a considerable increase in life expectancy at birth for females and males, which were 79 years and 72 years, respectively, in 2016 (WHO 2016), with a total life expectancy of 75.1 years in 2016 year. Infant mortality decreased from 18.4 per 1,000 live births in 2010 to 16.9 per 1,000 live births in 2016, as will be discussed in Section 5.3.

Thanks to its vaccination coverage, Colombia was the first Latin American country declared free of rubella, congenital rubella, and measles (albeit reporting several confirmed cases in 2017–18 because of immigration of people with measles). The maternal mortality ratio decreased from 97.9 deaths per 100,000 live births in 2001 to 51.3 in 2016, albeit not to levels on par with other Latin American countries and failing to achieve the Millennium Development Goal (45 deaths per 100,000 live births). Deaths from acute respiratory infection in children under five have decreased from 30 to 10 per 100,000 live births in the past two decades.

Multiple information systems have been developed to support the functions of the insurance, public health, service provision, financing, and human capital sectors. Information systems have made it possible to obtain more-accurate information for formulating policies, improving management, and generating administrative data on enrollment, births, and deaths, among others. Section 5.4 describes these information systems, particularly the one for births and deaths.

Since then, there have been more achievements in the health sector, but the health care system still faces significant challenges. One of the main challenges is financial sustainability, not only in light of technological innovation with expensive medication and devices that create financial pressure, but also considering services not included in the benefit plan, many of which are the results of rulings that ordered service provision for patients. Costs of the latter reached three billion Colombian pesos in 2016, equivalent to 10 percent of total expenditures on social health insurance for the same year (Gutiérrez 2018). In addition, corruption affects the financing of the system and compromises its legitimacy.

Population aging—with people aged 60 and older making up 11 percent in 2016, up from 7 percent in 2001—creates pressure due to higher demand for health services and higher costs. Likewise, the epidemiological transition—with the fall in communicable diseases and rise in chronic, noncommunicable diseases—creates pressure because the latter entail larger health investments. The growing influx of Venezuelan immigrants has begun to place financial and institutional stress on the health care system due to increased demand for care and public health incidents (with cases of measles, malaria, dengue,
tuberculosis, HIV, and perinatal, neonatal, and maternal mortality, among others). The majority of the Venezuelan immigrant population needs health care upon arrival at the border and after settling in Colombia because of their vulnerabilities.

Implementing the Integrated Model of Health Care (Modelo Integral de Atención en Salud (MIAS)), a new primary care-based model, is a challenge. The fundamental objective of MIAS is to “incorporate social and environmental determinants into public health, couple detection and prevention with treatment through dividing the system into territories, coordinating the agents in the system, and enabling integrated operation through care pathways that must be coordinated from an insurance point of view, with specific monitoring and follow-up measures” (Ruiz 2018).

MIAS faces the following challenges: clarifying various responsibilities in the model and improving stakeholder coordination; strengthening local institutional capacity to fulfill responsibilities; and enhancing information systems, infrastructure, and human resources (Gutiérrez 2018). MIAS also needs significant investment in the near future, but outcomes will not be evident for five to 10 years (Gutiérrez 2018).

One of the main challenges of the information system is to continue to enhance the quality and ensure timely reporting of data, optimize interoperability of multiple databases, and improve data processing through machine learning technology.

5.3 HEALTH SYSTEM ENROLLMENT PROCESS

As mentioned above, the civil registry is the gateway to accessing social services, with health being the first with which human beings have contact. Timely registration and identification of people facilitates the affiliation to social security in health to achieve universal health coverage and thus improve health outcomes of the population through the benefit plan.

Below is a description of the enrollment process of the health system in Colombia, with emphasis on newborns, based on Decree 780 of 2016.

Birth registration or certificate of live birth for children under three months of age, birth registration for children aged three months to seven years, ID card for children aged seven to 18, and citizen ID card for adults are required to enroll in one of the health insurance schemes and to update information. Identification document updates are required upon issuance of a new identification document (birth registration, ID card, or citizen ID card).

All newborns are to be enrolled in the health system from birth and assigned their UPC. Enrollment is done with birth registration or certificate of live birth. Parents or guardians must complete birth registration within three months of birth.

A child is enrolled in his or her mother’s EAPB, even when the father is enrolled in a different EAPB or a special or exceptional scheme. If the mother dies during childbirth, the child is enrolled in the father’s or guardian’s EAPB. Decree 780 of 2016 (Article 2.1.3.10) highlights the importance of coordination between EAPBs and the IPS network and of the mechanisms to promote identification and enrollment of the minor. The decree establishes, in its other articles, additional enrollment requirements for newborns under different circumstances—born to parents not enrolled in the health care system or not in a health facility.
The procedure for enrolling a newborn whose parents are not enrolled in the health care system (Article 2.1.3.11) is as follows. The IPS (e.g., hospital, clinic, health post) must consider the following on the day of the child’s birth: If one parent meets the requirements for enrolling in the contributory scheme, the child will be registered in the Enrollment Transaction System and enrolled in an EAPB, to which the eligible parent and child will both be required to contribute. If neither parent meets the eligibility requirements for the contributory scheme, and both are ranked level one or two in SISBEN, the IPS shall register and enroll the mother, the newborn child, and the family nucleus in the subsidized scheme. If neither parent meets the eligibility requirements for the contributory scheme and is not ranked level one or two in SISBEN or did not participate in the SISBEN survey, the newborn child will be enrolled in an EAPB of the subsidized scheme that operates in the municipality.

For children not born in a health facility, the decree establishes that, when the parents or guardians need health services for the child, the IPS must issue the certificate of live birth, report to the EAPB within two days, register the child in the Enrollment Transaction System, and enroll him or her in the mother’s EAPB.

Likewise, the decree indicates that the EAPB shall perform this procedure in the presence of the parents or guardians or someone with custody of the child, to remind them of the obligation to complete birth registration for the child. If birth registration is not completed within three months, the EAPB shall report to the territorial authority for the latter to make a case before the Superintendence of Notaries and Registry Offices to complete birth registration. The EAPB shall also report the situation to the Colombian Institute for Family Welfare or the Family Offense Unit. In the absence of registration, the EAPB shall ensure continuity in the provision of health care services stipulated in the benefit plan.

5.4 Social Protection Integrated Information System

The Social Protection Integrated Information System (Sistema de Información Integral de la Protección Social (SISPRO): www.sispro.gov.co) is a tool to obtain, process, and consolidate information from the social protection system in Colombia. The information facilitates decision-making on policy, formulation of public policies, regulatory monitoring, provision of information to citizens, access to services, and support of system functioning in the main areas of the social protection sector, such as insurance, financing, service use, and demand (MINSALUD 2019d).

SISPRO has been developing gradually and progressively since 2005, with information applications to respond to the needs of the sector, of regulation, and of the legal and policy framework. SISPRO has a data warehouse with information drawn from external and internal sources that is used to create indicators and transaction applications, develop e-governance, and enable citizens to access information (MINSALUD 2017c).

Likewise, the Statutory Health Law has specified that timely information is critical to ensuring access to health, because timely information enables traceability of individuals in the health system and facilitates information exchange among various systems and integration of data from all sources (MINSALUD 2017c).

Given the volume of the registries and data, the ministry standardizes, protects, and ensures confidentiality of data to facilitate information exchange by the entities involved.
SISPRO has four components (insurance, financing, supply, demand and use) as well as 28 information systems and applications and a Platform for SISPRO Integration file transport platform (Annex 1).

As mentioned above, SISPRO has a data warehouse for consolidating, integrating, and making available information drawn from various sources. The warehouse contains more than 27 billion registries, with periodic information updates, new dynamic query services, predefined queries, and maps to help users locate indicators geographically.

One of SISPRO’s applications is RUAF, which manages information that the various entities that administer different components of the social protection sector, such as health, pension, unemployment, compensation fund, occupational risks, social assistance programs, and birth and death registries in Colombia, generate.

The next section provides a detailed description of RUAF (MINSALUD 2010).
PART VI – RUAF: ND MODULE

This section describes the objectives of the ND module of RUAF: uploading information based on live birth and death certificates. It concludes by presenting and analyzing information in the ND module.

6.1 ND REGISTRATION MODULE: OBJECTIVES AND PROCESSES FOR UPLOADING INFORMATION

With the 081 Circular that DANE and the Ministry of Social Protection (currently MINSALUD) jointly issued in November 2007, it became possible to manage certificates of vital events such as births and deaths through the RUAF in real time. Thus began a process of technological improvement for issuing live birth and death certificates. In this process, departmental, district, and municipal health divisions; the National Institute of Legal Medicine and Forensic Sciences; and IPSs needed to take measures to improve the quality of vital statistics. The objective of this process was to reduce the time it took to produce statistics on vital events such as births and deaths (MINSALUD 2019a).

The circular also presented information regarding changes to the questions used in the certificates, the order of the questions, and the submission of answers, among others. The circular established the certificate of live birth as the background document required for birth registration and the death certificate as the background document required for death registration, because they “contain the essential variables for completing civil registration of vital events at registry offices” (DANE and MINSALUD 2007). The live birth and death certificates also serve statistical, public health, and demographic purposes.

The ND module manages birth and death information in Colombia, which supports production of vital statistics (DANE and MINSALUD 2007). Vital statistics have been produced through online registration and updates of live birth and death certificates since 2008. In places with spotty Internet access, there is a local application for registering and updating information.

The ND module allows for registration of births and deaths, management of information, and changing of passwords. In the birth module, the doctor is responsible for entering information from the certificate of live birth into the system. Similarly, in the death module, physicians (for death by natural causes\(^8\)) or forensic physicians (for violent deaths\(^9\)) fill out information on the death certificate. Other stakeholders can access data on birth and death certificates, submit queries, obtain reports and data on indicators, and modify data in accordance with an established protocol. These stakeholders include employees of IPSs, DANE, offices authorized to perform civil registration, departmental secretariats, MINSALUD, medical auditors, and epidemiologists.

DANE consolidates, validates, and processes information from certificates of live births entered digitally or filled out manually by authorized health professionals and civil registry employees (DANE 2019a).

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\(^8\) Natural causes refer to illness, old age, and expected incidents (based on medical history).

\(^9\) Violent deaths refer to deaths by external causes: homicide, suicide, accident, and unexpected incidents (for healthy individuals).
Certificate of Live Birth

The certificate of live birth has the following general objectives (DANE 2012, p. 21):

1) Legal instrument: The certificate is proof of birth and enables registration of the vital event in civil registry offices.
2) Public health instrument: Statistical information in the certificate can be used for postpartum health care programs and for planning vaccination, nutrition, and social programs.
3) Demographic input: Statistical information in the certificate can help analyze fertility patterns and make demographic projections.

The certificate of live birth has another important objective: supporting enrollment in the SGSSS. The background form used to prepare the certificate of live birth used for civil registration is the document required for registering births in authorized civil registration offices. The paper form is filled out manually and given to the newborn’s parents for completing the civil registration procedure. As the instructions on the form indicate, the certificate of live birth has the primary objective of “collecting birth information” and enabling birth registration. The certificate is processed online through RUAF’s birth module.

The Certificate of Live Birth has three parts (DANE 2012, p. 20):

Part 1 (questions 2 to 18) is about birth-related information, which is indispensable for birth registration at the Civil Registry.
Part 2 (questions 19 to 33) collects information on the newborn’s parents.
Part 3 (questions 34 to 40) contains data on the person who certified the birth.

Death Certificate

The death certificate has the following general purposes (DANE 2012, p. 21):

1) Legal instrument: The certificate is proof of death for death registration and enables issuance of a burial or cremation license.
2) Public health instrument: Statistical information in the certificate can be used for medical studies and identifying diseases under epidemiological surveillance, among other purposes.
3) Demographic input: Statistical information in the certificate can help identify number of deaths according to sex, age, and other demographic variables.

Once entered into the RUAF ND module, the death certificate enables the different entities involved in the social security (health care and pension) system to verify data and avoid payment to deceased persons, which will be further explained in Section 7. The death certificate has six parts (Dane, 2012, p. 21):

Part 1 (questions 2 to 24): general information on death.
Part 2 (questions 25 to 36): information on fetal death or death of a child under one year of age.
Part 3 (questions 37 to 39): information on maternal death.
Part 4 (questions 40 to 42): information on violent death.
Part 5 (questions 43 to 46): information on causes or probable causes of death in the event that nonmedical professionals provide cause-of-death information.

Part 6 (questions 47 to 53): information on person who certified the death.

The death certificate contains a background certificate for civil registration purposes, which is filled out and given to the family of the deceased to complete the registration. The death certificate also contains a statistical certificate that the territorial health division must send to DANE for quality control and data consolidation and processing. The statistical certificate is produced electronically in the RUAF ND module.

Civil registration of death is used to register deaths occurring in Colombia of Colombian citizens by birth or adoption, of foreign residents in Colombia, and of people declared dead in absentia by the legal authority because of disappearance.

As with birth registration, copies of death registration certificates must be sent to the National Registration Service of the RNEC, and proof of death registration must be submitted to the National Registration Service to deactivate the identification document of the deceased person. Figure 2 summarizes the process for issuing certificates of live births and death certificates and illustrates their uses for civil registration and statistical information purposes.
6.2 BIRTHS AND DEATHS REGISTERED IN THE ND MODULE\textsuperscript{10}

Ninety-nine percent of births in Colombia during 2012 to 2016 were registered in the ND module (figure 3), mainly because most births take place in health facilities. The total number of births decreased from 676,618 in 2012 to 647,521 in 2016 (4.3 percent).

\textsuperscript{10} The data sources for the table and figures of this section are: for births: DANE (\url{https://www.dane.gov.co/index.php/estadisticas-por-tema/demografia-y-poblacion/nacimientos-y-defunciones}); and for ND module, data was provided by the Office of Information and Technology (OTIC) of MINSALUD in 2018.
Figure 3: Births Registered in the Nacimientos y Defunciones (ND) Module and Total Births in Colombia, 2012–2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Births Registered in the ND Module</th>
<th>Total Births (DANE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>670,618</td>
<td>676,835</td>
</tr>
<tr>
<td>2013</td>
<td>658,574</td>
<td>658,835</td>
</tr>
<tr>
<td>2014</td>
<td>668,767</td>
<td>669,137</td>
</tr>
<tr>
<td>2015</td>
<td>659,406</td>
<td>660,999</td>
</tr>
<tr>
<td>2016</td>
<td>646,832</td>
<td>647,521</td>
</tr>
</tbody>
</table>

Sources: MINSALUD (OTIC); DANE

The ND module is used for recording data from live birth registration, and one of the variables recorded is the social security enrollment information of the mother, the type of beneficiary scheme (contributory, subsidized, exceptional, special), and the name of the IPS. Table 5 shows the beneficiary scheme of the mother for births occurring between 2012 and 2016 registered in the ND module. In general, all schemes show similar enrollment patterns during the period, with only one significant decrease (42 percent), in the number of mothers classified as “uninsured.”
Table 5: Mother’s Beneficiary Scheme, Nacimientos y Defunciones (ND) Module 2012–2016

<table>
<thead>
<tr>
<th>Mother’s beneficiary scheme (ND)</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributory or subsidized scheme</td>
<td>611,942</td>
<td>610,177</td>
<td>628,570</td>
<td>625,246</td>
<td>615,144</td>
</tr>
<tr>
<td>Special or exceptional scheme</td>
<td>18,010</td>
<td>17,485</td>
<td>17,430</td>
<td>17,166</td>
<td>16,611</td>
</tr>
<tr>
<td>Uninsured</td>
<td>40,666</td>
<td>30,912</td>
<td>22,767</td>
<td>16,994</td>
<td>15,077</td>
</tr>
<tr>
<td><strong>Total births in the ND</strong></td>
<td><strong>670,618</strong></td>
<td><strong>658,574</strong></td>
<td><strong>668,767</strong></td>
<td><strong>659,406</strong></td>
<td><strong>646,832</strong></td>
</tr>
</tbody>
</table>

Source: MINSALUD (OTIC)

Enrollment in the health care system is an administrative process that the insurance company and the newborn’s mother (or father or guardian) jointly complete, because it is necessary to compare this information in the ND module with the health care system beneficiary information database, as will be done in Section 7.

For deaths, figure 4 compares deaths registered in the ND module with total deaths in Colombia registered by DANE from 2012 to 2016. The number of deaths registered in ND as a percentage of total deaths was between 86 percent and 91 percent. The main reason for the gap is that not all deaths that the National Institute of Legal Medicine and Forensic Sciences (violent deaths such as homicides and road accidents) verify have been entered into the ND module since its implementation. The institute has its own information system, and efforts to enter data into the ND module have been inconsistent. Data migration tests are underway, and the institute is developing procedures and standardized coding.
Figure 4: Deaths Registered in the Nacimientos y Defunciones (ND) Module and Total Deaths in Colombia, 2012–2016

Deaths registered in the ND Module: 209,029, 223,652, 239,718, 252,671, 249,274
Total deaths, fetal and non-fetal (DANE): 242,772, 248,865, 257,301, 267,423, 271,697

Source: MINSALUD (OTIC); DANE
PART VII – CONTRIBUTION OF THE ND MODULE (FOR BIRTH REGISTRATION) TO ACHIEVING HEALTH OUTCOMES IN COLOMBIA

This section analyzes how the ND module contributes to achievement of health outcomes by interacting with other health information systems for insurance, vaccination, and access to health services and technologies that the benefit plan does not cover. Removing deceased persons from insurance databases and cross-checking information with pension administrators can help increase efficiency by avoiding payments to deceased persons. The section also shows how the information contained in the ND module could be useful for analyzing health performance and formulating public policies. The section concludes by showing infant mortality reduction in Colombia.

7.1 INSURANCE COVERAGE AND REMOVAL OF DECEASED PERSONS FROM THE UNIFIED HEALTH BENEFICIARY DATABASE INFORMATION SYSTEM

Insurance is the gateway to the health care system, allowing access to a range of health services and technologies defined in the benefit plan. Hence, it is important that the insurance process be reflected in the correct enrollment of citizens with their given and family names, ID card type, and number in the Unified Health Beneficiary Database (*Base de Datos Única de Afiliados* (BDUA)).

The BDUA is a database with information on all beneficiaries of the SGSSS enrolled in different schemes, including contributory, subsidized, exceptional, and special schemes, as well as IPSs of voluntary health plans and for the prison population. BDUA supports the transfer of resources in the health care system; it recognizes the UPC for each beneficiary enrolled with health insurers, as described in Section 5.

The entities that administer these schemes are responsible for reporting truthful, good-quality information requested of beneficiaries to ADRES and updating and correcting the information in a timely manner in accordance with regulations (Resolution 4622 of 2016) (ADRES 2019). These entities in charge of enrollment are “responsible for ensuring the full identification of beneficiaries based on identity document required in the current laws and regulations regarding Colombian citizens and foreign residents, and maintaining up-to-date information on the type of document, ID number, vital events such as deaths, and making the necessary modifications to ensure correct registration in BDUA” (Resolution 4622 of 2016, Article 6).

For each scheme, BDUA registers each beneficiary’s full name, identification (type and number), date of birth, sex, residence (municipal and departmental code), EAPB code, area (urban/rural), and primary IPS code. The contributory scheme contains data on independent contributors that are employers or contributors that are employed. The

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11 The data sources for the tables and figures of all section #7 were provided by the Office of Information and Technology (OTIC) of MINSALUD in 2018. For figure 6, data for vaccines was provided by the Subdirection of Communicable Diseases of MINSALUD in 2018. For elaboration of figure 7, data source is DANE (https://www.dane.gov.co/index.php/estadisticas-por-tema/demografia-y-poblacion/nacimientos-y-defunciones).
The subsidized scheme also has information on the beneficiary’s SISBEN level and ethnicity, among other important information.

The resolution established time-bound (with various processes throughout the month) processes and terms so that the scheme administrators can conduct updates, such as new entries, including births, moves, withdrawals, changes of contributors, and correction of information.

Once it receives the files, ADRES processes the information and provides the results to the administrators of each update process of the BDUA. ADRES also compiles statistics that must be made available in SISPRO.

One of the validation processes performed in the BDUA is validation of enrollment of children under one year of age, which is done by crossing-checking the mother’s identification type and number against the same information in the ND module.

The BDUA cross-checks information on deaths against the ND module, with the latter providing the name and identification of the persons who died during the week to BDUA to avoid paying the health premium—UPC—to the insurance company.

Figure 5 shows the total number of beneficiaries and the number of beneficiaries under one year of age in the health care system for 2012 to 2017 based on BDUA data. There has been an increase in membership in these years (with the exception of 2015–16, when there was a decrease of 0.59 percent). Membership of children under one year of age also increased, albeit with a decrease of 8.8 percent from 2014 to 2015. A comparison of 2012 membership data with that from 2017 shows higher growth in enrollment of children under one year (15.5 percent) than of the general population (8.3 percent). The simple average of enrollment of children under one year of age is 1.06 percent of the total enrollment during this period, and was 1.05 percent in 2012 and 1.12 percent in 2017. Some decreases in affiliates reported in several years in the total affiliation of the population and in those under one year are due to debugging of the database.
Comparing enrollment in one of the health insurance schemes based on BDUA data with births registered in the ND module for 2012 to 2017 shows a general trend of year-on-year percentage growth except for 2014–15, reaching approximately 80 percent in 2017 (table 6). Despite this progress, there is still a long way to go to reach a 100 percent enrollment for children during their first year of life.

Table 6: Enrollment in One of the Health Insurance Schemes for Children Under One Year of Age (Unified Health Beneficiary Database (BDUA)) and Births Registered in the Nacimientos y Defunciones (ND) Module, 2012–2017

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDUA enrollment</td>
<td>451,875</td>
<td>461,477</td>
<td>487,414</td>
<td>444,496</td>
<td>499,122</td>
<td>521,729</td>
</tr>
<tr>
<td>Contributory or subsidized ND</td>
<td>611,942</td>
<td>610,177</td>
<td>628,570</td>
<td>625,246</td>
<td>615,144</td>
<td>620,203</td>
</tr>
<tr>
<td>Special or exceptional ND</td>
<td>18,010</td>
<td>17,485</td>
<td>17,430</td>
<td>17,166</td>
<td>16,611</td>
<td>15,983</td>
</tr>
<tr>
<td>Uninsured ND</td>
<td>40,666</td>
<td>30,912</td>
<td>22,767</td>
<td>16,994</td>
<td>15,077</td>
<td>17,241</td>
</tr>
<tr>
<td>Total births (ND) with enrollment in any scheme</td>
<td>670,618</td>
<td>658,574</td>
<td>668,767</td>
<td>659,406</td>
<td>646,832</td>
<td>653,427</td>
</tr>
<tr>
<td>Percentage of BDUA and ND enrollment</td>
<td>67.4</td>
<td>70.1</td>
<td>72.9</td>
<td>67.4</td>
<td>77.2</td>
<td>79.8</td>
</tr>
</tbody>
</table>

Source: MINSALUD, OTIC

Table 7 illustrates enrollment in one of the health insurance schemes for children under one year of age for 2012 to 2017, according to type of document. There was a significant...
annual increase in enrollment in this age group between 2015 and 2017, as recorded in this database.

In addition, many children were enrolled with “unreported documents” in 2015 (26.7 percent) and 2016 (35.4 percent); between 2016 and 2017, this number decreased dramatically from 176,773 to 17,671 (equivalent to 3.4 percent of all children under one year of age in 2017). This is directly related to the 54 percent increase in the number of minors enrolled with civil registration data entered into the BDUA, from 317,690 in 2016 to 489,167 in 2017.

The increase in the number of children enrolled with certificates of live birth (from 3,598 to 13,582) is also remarkable. Even though they represent less than 3 percent of the enrollment of children under one year of age, the effect of the rule that has allowed for their enrollment in one of the health insurance schemes since 2015 is clear. Children whose data the entities in charge of enrollment have entered into BDUA with the certificate of live birth must update their information when they complete their birth registration.

Table 7: Enrollment in One of the Health Insurance Schemes for Children Under One Year of Age According to Type of Document (Unified Health Beneficiary Database)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate of live birth</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>53</td>
<td>3,598</td>
<td>13,582</td>
</tr>
<tr>
<td>Birth registration</td>
<td>312,025</td>
<td>314,083</td>
<td>326,045</td>
<td>324,603</td>
<td>317,690</td>
<td>489,167</td>
</tr>
<tr>
<td>Unidentified</td>
<td>924</td>
<td>824</td>
<td>902</td>
<td>951</td>
<td>889</td>
<td>1,015</td>
</tr>
<tr>
<td>Unreported document</td>
<td>138,824</td>
<td>146,462</td>
<td>160,340</td>
<td>118,731</td>
<td>176,773</td>
<td>17,671</td>
</tr>
<tr>
<td>Another foreign document</td>
<td>102</td>
<td>108</td>
<td>120</td>
<td>158</td>
<td>172</td>
<td>294</td>
</tr>
<tr>
<td><strong>Enrollment of children under one</strong></td>
<td><strong>451,875</strong></td>
<td><strong>461,477</strong></td>
<td><strong>487,414</strong></td>
<td><strong>444,496</strong></td>
<td><strong>499,122</strong></td>
<td><strong>521,729</strong></td>
</tr>
</tbody>
</table>

Source: MINSALUD (OTIC)

Resolution 4622 of 2016 (Article 9) states that beneficiaries who are “unidentified adults” or “unidentified minors” who enrolled using an “unidentified” document type as classified in table 7 shall remain in BDUA with this classification until the data are cleaned and identification information corrected based on census lists that the proper authority provides.

The census list is the mechanism that the MINSALUD uses to identify population groups with special characteristics, such as indigenous peoples, displaced persons, demobilized persons, abandoned children, people living in extreme poverty, and protected senior citizens (MINSALUD 2013).

“Unidentified minors” include street children, vulnerable children in state institutions such as orphanages, indigenous minors, demobilized minors or minors who are parties to the peace agreements, and minors deprived of liberty. The aforementioned resolution

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12 “Unidentified adults” include older adults living in nursing homes, indigenous adults, adults living in the streets, demobilized adults and adults who are parties to the peace agreements, and adults deprived of liberty under the responsibility of territorial authorities.
establishes the technical parameters for the entities responsible for creating census lists to ensure health insurance for this population on an exceptional basis while verifying the full identity of these individuals with documents that RNEC deems valid for enrolling and updating information in BDUA.

**7.2 Annual Immunization Plan—Expanded Program on Immunization—Paiweb**

According to the Pan American Health Organization, nominal vaccination records are “those that identify each person’s vaccination information and allow access to their vaccination history to facilitate active recruitment, in addition to supporting monthly planning for people who should receive vaccination and following up on people who lag behind on their vaccinations or fail to vaccinate” (PAHO 2017).

In 2012, Colombia implemented the Nominal Vaccination Information System for the Expanded Program on Immunization, building and launching a platform (Paiweb) to show the vaccination status of all children in the country, monitor those who have been vaccinated, and verify the logistical operation of vaccines in all municipalities. The system consists of six modules: Immunization Application Management, Inventory and Input Management, Resource Management, Information for Analysis, Information Dissemination, and Cross-cutting Services (MINSALUD 2012).

Previously, IPSs filled out vaccination information in spreadsheets and sent it to municipal secretariats, which in turn passed the information to departmental secretariats for final submission to the ministry. This process took seven to 10 days but is now completed online. The system also has an offline application for sites without Internet connectivity.

Some of the objectives of Paiweb are to minimize recording errors, reduce reporting time, and improve the quality of the information (MINSALUD 2014). To accomplish this, there have been trainings to teach staff how to use the software, monitor data quality, and clean data, all of which have been implemented in parallel with vaccination campaigns to promote the Expanded Program on Immunization.

One of the premises of the system is that it registers people from the target population, such as children, and that their “inclusion must be done early and in coordination with the unit responsible for birth registration, be it the live births registry or the Civil Registry (PAHO 2017).”

The Nominal Vaccination Information System in Colombia interacts with the ND module, which provides ongoing, daily birth data to the vaccination system to track registration of vaccination according to age over time.

Paiweb receives live birth registration numbers along with the mother’s name or birth registration information and information on the vaccines administered to ensure children’s rights, such as access to vaccination. In the event of enrollment done with live birth registration, the child’s name can be updated over time based on information provided in the birth registration certificate.

Paiweb allows for queries, and the EAPBs and municipal health secretariats can access it and follow up on the vaccination schedule for all children. Newborns receive their first dose of vaccination—such as hepatitis B vaccination—within their first 12 hours of life.
Figure 6 compares hepatitis B vaccination levels with numbers of births registered in the ND module from 2012 to 2016:

**Figure 6: Newborns Receiving a Dose of Hepatitis B Vaccine and Births Registered in the Nacimientos y Defunciones (ND) Module, 2012–2016**

![Graph showing hepatitis B vaccination levels and births registered in ND module from 2012 to 2016.](image)

*Source: MINSALUD (OTIC and Subdirection of Communicable Diseases)*

Although the graph shows a decrease in coverage of this vaccine, it remains above 98 percent for all years (95 percent being the reference coverage for all vaccines).

According to MINSALUD, there were 2,286 IPSs connected to the Paiweb as of May 2018. In accordance to the website “Datos Abiertos,” there were 10,386 IPSs registered by January 2018 (MINTIC 2018).

### 7.3 Access to Services and Technologies Not Covered Under the Benefit Plan

As part of implementation of the Statutory Health Law, an automated tool called *Mi Prescripción* (MIPRES) was created to provide services and technologies that the benefit plan with the UPC funds does not cover (MINSALUD 2018a). MIPRES became operational in 2017 to ensure the right to health through timely access to these services and technologies and to optimize the reimbursement procedure to increase truthfulness and transparency.

In addition to providing services and technology, MIPRES allows IPSs to look up the prescriptions that their health professionals have written, allows EAPBs to look up prescriptions of their beneficiaries, and grants access to government health institutions and government institutions responsible for policy and technical and financial analysis.
Health professionals oversee prescriptions from these services and technologies through a web application called Report on the Prescription of Services or Technologies Not Covered by the UPC. These health services and technologies include medications, procedures, and medical devices. Health professionals (e.g., doctors, dentists, optometrists) must register with the Health Care Professionals Registry (Registro de Talento Humano en Salud) (MINSALUD 2018a). To obtain a username and password, independent health professionals who work for an IPS must activate their credentials; if the health professionals work in house for an EAPB, the EAPB must activate the credentials (MINSALUD 2018a).

Health professionals must enter a beneficiary’s identification type and number to prescribe medications, procedures, and supplies. Prescriptions are placed in a single order, as long as the medications, procedures, and supplies involved correspond to the same diagnosis and the same reasons for prescription (MINSALUD 2018a).

MIPRES interacts with several databases, one of which is the ND module. MIPRES uses the module to verify birth information (to ensure the right to health for newborns) and to verify death information (to avoid paying for health services for people who have died).

Table 8 shows the total number of beneficiaries between April 2017 and April 2018 with approved prescriptions. Of 1,784,384 people, 11,516 (0.6 percent) were children under one year of age. Of these, 7,025 (61 percent) were identified with their certificates of live birth, and the remaining 4,491 (39 percent) were identified with birth registration.
Table 8: Mi Prescripción (MIPRES): Children Under One Year of Age Who Received Care Between April 2017 and April 2018

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who received care based on MIPRES</td>
<td>1,784,384</td>
<td></td>
</tr>
<tr>
<td>Children under one year of age who received care based on MIPRES</td>
<td>11,516</td>
<td>0.6</td>
</tr>
<tr>
<td>Children registered with certificate of live birth</td>
<td>7,025</td>
<td>61</td>
</tr>
<tr>
<td>Children registered with birth registration</td>
<td>4,491</td>
<td>39</td>
</tr>
</tbody>
</table>

Source: MINSALUD (OTIC)

Table 8 demonstrates the relevance of the birth module for ensuring access to health for children under one year of age. It also demonstrates that the certificate of live birth is important for enrollment in the health system and the accessing of its services.

7.4 Pension Fund Administrator Database and Other Programs

Another important service that the ND module provides regarding death information is the cross-checking function it makes available to pension fund administrators and to the Senior Citizens Program to avoid making payments to deceased persons. The ND module also interacts with the RNEC death records database to verify a person’s existence without requiring personal information or certificates as proof of life.

7.5 Public Health and Demographic Information

Live birth and death certificates contain important data on births and deaths, making it possible to monitor the variables in these certificates over time and develop public policies, programs, and projects.

For example, below are some of the variables in the certificate of live birth for the stated purposes:

- Sex, weight, size, and time and date of birth
- Information about birth attendants (if several options are listed: doctor, nurse, nursing assistant, health promoter, midwife)
- Weeks of gestation before birth, number of prenatal visits, type of delivery (natural, caesarean-section, or instrumental), and whether the pregnancy was single, double, triple, quadruple, or more
- Newborn’s blood type and Apgar score one and five minutes after birth
- Parents’ cultural and group affiliation (indigenous, Romani, Raizal, Palenquero, Afro-Colombian)
- Mother's name, identification type and number, age on date of delivery, marital status, highest level of education obtained (preschool, primary, secondary, university, graduate studies), place of residence (country, department, municipality), area of residence (municipal capital, population center, sparsely populated rural area), address, and number of previous live births; date of birth of previous child, number of previous pregnancies, social health insurance beneficiary scheme (contributory, subsidized, exceptional, special, uninsured), and type and name of her EAPB
- Father's age and highest level of education obtained
The death certificate also contains useful information. Figure 7 shows maternal mortality patterns in Colombia, because they are one of the main indicators at the global level of health system performance. As mentioned in the section on achievements and challenges of the health system, the Millennium Development Goal target was 45 deaths per 100,000 live births by 2015. The SDG 3 maternal mortality ratio target benchmark is 32 per 100,000 live births by 2030.

**Figure 7: Maternal Deaths at 42 Days by Year (per 100,000 live births)**

Source: Elaboration based on DANE
Figure 8 summarizes the interaction between the ND module and information systems and health outcomes.

**Figure 8: Summary of Interaction Between the ND Module and Information Systems and Health Outcomes**

<table>
<thead>
<tr>
<th>ND Module</th>
<th>Information system</th>
<th>Health outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paiweb (vaccination)</td>
<td></td>
<td>Follow-up on vaccination coverage</td>
</tr>
<tr>
<td>Births</td>
<td>Unified Health Beneficiary</td>
<td>Enrollment in health insurance system</td>
</tr>
<tr>
<td>&amp;</td>
<td>Database (membership)</td>
<td>avoiding undue payments</td>
</tr>
<tr>
<td>Deaths</td>
<td>MIPRES (Prescriptions)</td>
<td>Prescriptions not included in the benefit plan</td>
</tr>
<tr>
<td>benefit plan</td>
<td>DANE (statistics)</td>
<td>Health statistics</td>
</tr>
<tr>
<td>system</td>
<td>Pension funds</td>
<td>Avoid undue payments in the pension</td>
</tr>
</tbody>
</table>
**Box 1: Progress in Reducing Infant Mortality**

Infant mortality (under one year of age) in Colombia decreased from 18.4 per 1,000 live births in 2010 to 16.9 in 2016 (figure 9).

**Figure 9: Infant Mortality in Colombia (2010-2016)**

![Graph showing infant mortality in Colombia from 2010 to 2016](image)

*Source: DANE, Vital Statistics (2016)*

This trend is consistent with the one found in the National Demographic and Health Survey 2015 (figure 10), which depicts infant mortality over time. The National Demographic and Health Survey is a benchmark for comparison with DANE vital statistics (MINSALUD and Profamilia 2017), as shown in figure 9.

**Figure 10: Infant Mortality in Colombia Over 25 Years**

![Graph showing infant mortality in Colombia over 25 years](image)

*Source: MINSALUD and Profamilia 2017 (Table 6.2 and Chart 6.1, pp. 245 and 246)*
The progress made on this important indicator as part of the Millennium Development Goals and now part of the SDGs is due to policies and programs described above and to improvement in health factors that reduce infant mortality, such as poverty alleviation, education, and access to health services (e.g., prenatal doctor's visits, institutional delivery service, access to quality perinatal health services, expanded vaccination coverage).

Despite progress at the national level, there are significant differences in infant mortality according to area (urban/rural), region, and ethnicity, reflecting inequitable conditions of access and quality of care. Figure 11 shows neonatal mortality (defined as probability of dying during the first month of life), postneonatal mortality (difference between infant and neonatal mortality), and infant mortality (probability of dying during the first year of life).

Mortality is much higher in rural than urban areas, reflecting, as affirmed by the United Nations Children’s Fund (UNICEF), Ministry of Health of Chile and others, “problems of access to specialized neonatal care concentrated in large cities, which limits care options of high-risk newborns (premature or low birthweight) in rural areas or areas far from large urban centers, with other health determinants—such as congenital malformations—playing a role” (MINSALUD and Profamilia 2017, Vol. I).

Figure 11: Neonatal, Postnatal, and Infant Mortality (urban/rural), 2015

A comparison according to region reveals that infant mortality is highest in the Caribbean and the Orinoquia and Amazon regions, which have dispersed rural populations and inadequate quality and quantity of health services.
Table 9: Infant Mortality (Per 1,000 Live Births) According to Region, 2015

<table>
<thead>
<tr>
<th>Region of Colombia</th>
<th>Caribean</th>
<th>Easter</th>
<th>Bogotá</th>
<th>Central</th>
<th>Pacific</th>
<th>Orinoquía and the Amazon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality Rate (per 1,000 live births)</td>
<td>21</td>
<td>12</td>
<td>15</td>
<td>14</td>
<td>15</td>
<td>24</td>
</tr>
</tbody>
</table>

*Source: MINSALUD and Profamilia 2017 (Table 6.3.2, p. 247)*

According to the Health Situation Analysis Colombia 2016, infant mortality was 160 per 1,000 live births among the Romani people in 2014; 43.5 among the Palenqueros of San Basilio; 32.8 among the Raizals in the Archipelago of San Andrés, Providencia, and Santa Catalina; 28.8 among indigenous peoples; and 15.6 among Afro-Colombians, all of which are higher than the national average.
PART VIII – CONCLUSIONS

The identification of Colombian citizens since birth is a constitutional and legal priority, and an institutional and regulatory framework to comply with this provision has been developed. Through identification, the different social services of the state are accessed throughout citizens’ lifetimes. The institutional organization of the civil registration and vital statistics system has focused on the issuance of civil birth registration.

It is also important to point out the legislative development and social policies in Colombia, particularly regarding the right to health care access from childhood. This report has highlighted the process of affiliation with the health care system, with particular emphasis on newborns, including the importance of identification as an essential requirement in this process.

This institutional development around the rights to identification and health, has been supported by information systems that have facilitated the civil registration and the affiliation to the health system in the moments after the occurrence of birth.

In this sense, the ND module of the RUAF, as one of the pillars of the civil registry and vital statistics system in Colombia, contributes not only to registration of these vital events, but also to coverage and health outcomes through interaction with other health information systems, such as affiliation with the health system, application of the vaccination scheme, and access to health services and technologies that the plan of benefits does not cover. It also allows for provision of timely information to avoid unnecessary payments in the health system, which contributes to its financial sustainability.

8.1 LESSONS LEARNED

- Coordination among several government agencies such as MINSALUD, DANE, and the RNEC, whose primary missions involve the health system, statistics, and civil registry, respectively, has been important to strengthen the registry system civil and vital statistics in Colombia, regarding the design of policies, objectives, strategies, and implementation of them.

- A significant achievement has been implementation of the UPIN to maintain a single identification number throughout a person’s life to avoid inconsistencies in data on identity documents and therefore inconveniences in access to social services.

- Having developed the RUAF ND module within an information system such as SISPRO, which is composed of several subsystems related to various social security issues, has allowed interaction of databases and is therefore important for achieving coverage and health outcomes.

- Inclusion in the RUAF ND module of the information contained in birth and death certificates allows generation of statistics and demographic indicators, which have a variety of uses, such as monitoring and follow-up of these vital events (which permits analysis of such things as health determinants and causes of death) and elaboration of social policies.

- The issuance of norms for implementation of the civil registry of birth in hospitals has been positive to access identification from an early age
8.2 RECOMMENDATIONS

Within the process of continuous improvement of the civil registration and vital statistics system and health information systems such as RUAF ND, there are several institutional, technological, and regulatory challenges. The following recommendations are made.

- There is a critical need to continue with efforts to close historical gaps in coverage of the state’s social services, including in identification and enrollment in one of the health insurance schemes in rural, sparsely populated areas.

- Connectivity with municipal hospitals, most of which are public, needs to be improved to facilitate transmission of RUAF data.

- There is a need for better coordination between local registry offices, notary offices, and hospitals so that newborns can obtain their birth registration before leaving the hospital.

- Progress needs to be made on the regulatory and technological front that will enable compliance with the law on automatic enrollment of children in the health system as soon as they are born. Although the certificate of live birth has facilitated this process, many children are still not enrolled.

- It is necessary to explore the regulatory feasibility of automatically uploading information to BDUA from the ND module, including possible modifications to the civil registry or to EAPB so that the latter can send updates, as regulations require.

- While working on the above, an immediate step can be taken that does not require major technological efforts, which is to provide the EAPB in which the mother is enrolled with the child’s birth information from the ND module. In this way, the EAPB could manage the child’s enrollment before he or she leaves the health facility.

- The National Institute of Legal Medicine and Forensic Sciences needs to work on the interface between its information system and MINSALUD’s ND module to improve recording of violent deaths.

- Improving the national identification system and health enrollment will facilitate implementation of other important systems, such as those for electronic medical records and electronic invoicing.
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ANNEX 1: COLOMBIA OVERVIEW

Colombia is in the north of South America, with access to the Pacific Ocean and the Caribbean Sea; it has approximately 2,900 km of coastline. It is the fourth largest country in South American, with approximately 1,139,000 square kilometers of territory. It has a land border with Venezuela, Peru, Brazil, Ecuador, and Panama (figure 12) and maritime connections with Costa Rica, Nicaragua, Honduras, Jamaica, the Dominican Republic, and Haiti.

Figure 12: Map of South America

The Republic of Colombia (its official name) has 32 departments (figure 13) and 1,102 municipalities and has a wide variety of climates, which contributes to its agricultural capacity and biodiversity; Colombia contains approximately 10% of the world's biodiversity.
Political administrative organization of Colombia

The Colombian Constitution of 1991 states that the Republic of Colombia is a social state of law and establishes diverse participatory mechanisms of citizens to support democracy. This Constitution establishes the decentralization and autonomy of territorial entities so that they can manage their own resources, levy local taxes, and have autonomy to administer their social, economic, tourist, planning, environment, transport, and communication routes.

Colombia has an executive branch, headed by a President. The President and regional leaders (governors and mayors) are elected by popular vote every 4 years (although at different times: the current presidential term began in August 2018 and ends in 2022, and the current gubernatorial and mayoral term began in January 2016 and ends in 2019).

The legislative branch is bicameral, made up of the Senate and the House of Representatives. Congress has 280 members (108 senators, 172 representatives) elected by popular vote every four years. There are Congress seats for indigenous communities, Afro-descendant communities, Colombians who live abroad, and the former guerrilla group FARC (Revolutionary Armed Forces of Colombia—People's Army), today the political party FARC (Alternative Revolutionary Communal Force) (according to the provisions of the peace agreement).
The judicial branch is made up of the Supreme Court of Justice, the Constitutional Court, the Council of State, the Superior Council of the Judiciary, the Special Jurisdictions, and the General Prosecutor's Office of the Nation. The Control bodies are the Public Ministry (Attorney General's Office, Ombudsman's Office) and the Office of the General Controller of the Republic.

Demography

The preliminary results of the 2018 census indicate that Colombia has a population of 45.5 million inhabitants (51.4 percent female, 48.6 percent male). The population is mostly concentrated in the mountainous area of the Cordillera de los Andes that crosses the country from southwest to northeast. The eastern departments on the periphery of the country have low population density; some are jungle areas, with a humid climate, and are poorly developed socioeconomically. Eighty-four percent of the population is mestizo, 10 percent Afro-Colombian, 3 percent indigenous (more detailed information regarding the Afro-Colombian population and indigenous peoples provided below), and the remaining 3 percent is composed of the Rom and other ethnic groups such as the Raizales of the Archipiélago of San Andrés, Providencia, and Santa Catalina and “Palenqueros” in the department of Bolivar.

Colombia, like other countries in Latin America, has experienced rapid urbanization, with more than 76 percent of the population living in urban areas.

According to the Health Situation Analysis of Colombia in 2016 of the Ministry of Health and Social Protection, Colombia and most Latin American countries are experiencing the second phase of the demographic transition, with a marked decrease in birth rates and low mortality. According to the ECLAC 2017, the percentage of children and adolescents in the region fell from 40 percent in 1950 to approximately 25 percent in 2017. Table 10 illustrates the indexes of youth, aging, and demographic dependence in the last 50 years, reflecting changes in the Colombian demographic structure.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth ratio (population younger than 15 years old per 100 persons older than 64)</td>
<td>1,556</td>
<td>1,405</td>
<td>921</td>
<td>763</td>
<td>487</td>
<td>245</td>
</tr>
<tr>
<td>Old-age ratio (population older than 64 per 100 persons younger than 15)</td>
<td>6</td>
<td>7</td>
<td>11</td>
<td>13</td>
<td>21</td>
<td>41</td>
</tr>
<tr>
<td>Dependency ratio (dependant population (younger than 15 and older than 64) per 100 productive population)</td>
<td>99</td>
<td>90</td>
<td>67</td>
<td>64</td>
<td>59</td>
<td>46</td>
</tr>
</tbody>
</table>

Source: DANE 2019b

According to the Health Situation Analysis—2016, the birth rate fell from 28.8 live births per 1,000 people in 1985 to 1990 to 18.0 in 2015 to 2020, a 37 percent reduction. A decrease in mortality is also expected, from 6.8 deaths per thousand inhabitants in 1985 to 1990 to 5.9 in 2015 to 2020. In terms of net migration, according to the projections of this report, greater emigration than immigration was expected, although this situation has dramatically changed because of an influx of immigrants from Venezuela, given its political and socioeconomic situation, estimated at 1,348,198 people, including returning Colombians and migrants of Venezuelan nationality, as of June 2018.

Because of improvements in living conditions, life expectancy has been increasing in Colombia and is projected to reach 76.2 in 2015 to 2020, although there are regional differences (78.9 years in Bogotá, the capital of the country, vs. 70.5 years in the department of Caquetá, in the southeast of the country in the Amazon region).

Poverty, equity, and education

Regarding the main social indicators, Colombia has registered a significant reduction in the percentage of its population living in poverty and extreme poverty, from 49.7 percent in 2002 to 26.9 percent in 2017 for poverty and from 17.7 percent to 7.4 percent for extreme poverty. This has meant that more than 7 million people have ceased to be poor in Colombia, and approximately 4 million have ceased to be extremely poor. In Latin America, according to the ECLAC 2017, from 2002 to 2017, these percentages decreased from 45.9 percent to 30.7 percent of people living in poverty and from 12.4 percent to 10.2 percent of people living in extreme poverty, although in the region, there has been an
increase in both measures of financial poverty since 2015. The risk of falling back below the poverty line is latent mainly in the face of possible economic shocks.

There are significant internal contrasts within the country, with regions that had less than 20 percent of their population in poverty in 2017, such as Bogotá (12.4 percent), Cundinamarca (14.7 percent), Risaralda (16.3 percent), and Santander (18.9 percent), and departments with percentages higher than 40 percent, such as Cesar (40.7 percent), Cauca (48.7 percent), Chocó (58.7 percent), Córdoba (45.8 percent), La Guajira (52.6 percent), Magdalena (48.5 percent), Nariño (40.2 percent), North of Santander (40 percent), and Sucre (41.6 percent), illustrating the inequality between territories. In the main 13 cities of the country and its metropolitan areas, poverty was 15.7 percent in 2017, in contrast to 36 percent in rural areas.

Similarly, in terms of inequality in income distribution, the Gini coefficient for 2017 was 50.8. Although it has been decreasing in recent years (in 2002 it was 55.8), it is one of the highest in the Americas, a region that by itself is characterized as one of the most unequal in the world.

Colombia has advanced in providing primary basic education (grades 1 to 9), reaching almost 100 percent, although there are challenges in preschool coverage, which was 84.0 percent in 2016, and in middle education (grades 10 and 11, the last before higher education), which is 79.5 percent, indicating a high dropout rate after grade 9 and that many young people will not enter university and could be trapped in the cycle of poverty.

Colombia’s performance in reading, science, and mathematics had improved according to the most recent evaluation of the International Program for Student Assessment, but despite the advances, it ranked 59 of 72 countries evaluated. In the region, it surpassed Brazil, Peru, Mexico, and the Dominican Republic, but its performance was poorer than that of Chile, Uruguay, and Costa Rica.

The illiteracy rate is 5.8 percent, and although it is lower than in some countries in the region, such as Brazil (14.0 percent), Mexico (7.2 percent), Guatemala (23.2 percent), and Peru (6.3 percent), others perform better, such as Argentina (1.9 percent), Uruguay (1.7 percent), Chile (4.3 percent), and others that have been declared free of illiteracy.

Higher education coverage is very low (52.8 percent in 2017). Of 484,664 graduates of grade 11 in 2015, only 184,013 (38 percent) entered higher education in 2016. The rate of university drop-out has been decreasing—from 12.9 percent in 2010 to 9 percent in 2016, but given the low coverage of education, the dropout of about 10 percent of students further affects the outcome statistics for university graduates.

Peace in Colombia

In 2016, the Colombian government signed a peace agreement with the Revolutionary Armed Forces of Colombia—People’s Army (FARC) after more than five decades of armed conflict. The positive effects of the end of the conflict in social, economic, and security terms are evident. For example, according to Centro de Recursos para el Análisis de Conflictos in 2017 there were no combat deaths (public forces, guerrilla civilians), compared with 2,799 in 2002 (El Espectador 2018).
Nevertheless, the armed conflict in Colombia continues as a consequence of armed actions and human rights violations that other groups outside the law commit, such as the National Liberation Army, the paramilitary groups that did not demobilize in 2005, and other criminal groups participating in drug trafficking that have sought to fill the void that the FARC left. There are challenges in terms of security and sociopolitical violence and concerns about impunity for crimes committed during the armed conflict. Likewise, continues violence against social leaders; human rights defenders; and women, who are victims of sexual violence in particular.

Estimated post-conflict costs (reparation to victims, reinsertion of combatants into society, implementation of the peace agreement) will have a large effect on the national budget, because resources of COP129.5 billion (Revista Semana 2018) will be required, which can be estimated at 0.7 percent of gross domestic product (GDP) annually (Fedesarrollo 2017 ) until 2032. In that sense, economic growth as a result of the peace agreement is estimated at more than 0.3 percent of GDP. In this sense, a challenge that the country will face will be achievement of post-conflict resources that will have fiscal effects.

Economy

In 2016, Colombia was ranked as the fifth most competitive country in Latin America (after Chile, Costa Rica, Panamá and Mexico) (COMPITE 2017). . Colombia climbed five places in macroeconomics with respect to 2016, which is the result of foreign trade (climbed four places) and foreign investment indexes. According to COMPITE, tourism was one of the sectors with more growth, with an income increase of 65.3 percent between 2010 and 2016 (El País 2017).

Because 62 percent of Colombia’s goods exports are commodities, such as coffee, oil, coal, and ferronickel, Colombia is vulnerable to external shocks if world demand and prices fall, although conservative management of its economy has allowed Colombia to overcome various global economic crises.

Although the global economic slowdown in 2017 resulted in Colombia falling five places in the Global Competitiveness Index of the World Economic Forum, ranking 66 of 137 countries and fifth in Latin America ranks, behind Chile, Costa Rica, Panama, and Mexico, GDP has continued to grow moderately (2 percent in 2016, 1.8 percent in 2017, 2.7 percent in 2018). Unemployment (9.7 percent in 2018) is one of the highest in Latin America.

The Colombian economy faces several challenges (COMPITE 2017) that must be addressed. The fight against corruption is of great importance; corruption weakens state institutions and affects governability and reliability. The minimum wage is one of the lowest in Latin America, and informality has direct effects on productivity. (The rate of labor informality for the June-August quarter of 2018 was 48 percent, and although it has declined—from 52.4 percent for the same quarter of 2012—it has not done so as rapidly as desired).

Colombia has a great diversity of indigenous peoples. According to indigenous organizations, there are 102 indigenous peoples, of which 18 are in danger of extinction. According to the 2005 Census, there were 1,392,623 indigenous people in Colombia (representing 3.4 percent of Colombia’s total population that year), giving Colombia the fifth highest indigenous population in Latin America, after Mexico, Guatemala, Peru, and Bolivia (MINSALUD 2016b).

Although there is indigenous presence in almost all of Colombia, 79 percent of the indigenous population lives in rural areas and departments with high poverty rates (although there are signs of migration to urban areas in a search for better living conditions and because of violence, forced displacement, and drug trafficking). Almost 60 percent of the indigenous people of Colombia are in the departments of La Guajira, Cauca, Nariño, and Córdoba. In departments located in border areas and with difficult access, the indigenous population represents a significant percentage of the total departmental population, such as Amazonas (43 percent), Vichada (44 percent), La Guajira (45 percent), Guainia (65 percent), and Vaupés (67 percent) (MINSALUD 2016b).

The indigenous people of Colombia, as in Latin America as a whole, have higher infant and maternal mortality than the rest of the population. Thus, although there was a reduction in maternal mortality in Colombia between 2009 and 2013, it increased in the indigenous population, from 243.07 deaths per 100,000 live births to 355.65, and was even higher in rural areas (MINSALUD 2016b). In 2013, infant mortality in the indigenous population was 1.7 times as high as in the nonindigenous population (MINSALUD 2016b). Child mortality in 2013 for the indigenous population was 2.1 times as high as for nonindigenous children (MINSALUD 2016b). This indicates that there are barriers to access to health services and other types of social services such as education, drinking water, and sewage treatment, which exposes them to greater risk than the rest of the Colombian population.

In the 2005 Census, Afro-Colombians accounted for 10.3 percent of the total population of Colombia—4,273,722 people located mainly in the departments of the Pacific coast (Cauca, Chocó, Valle) in rural areas along the river banks; the archipelago of San Andrés and Providencia in the Caribbean; and in cities such as Cali, Quibdó, Cartagena, Barranquilla, and Santa Marta. (These last three are capitals of departments on the Caribbean coast in northern Colombia). The Afro-Colombian population faces challenges similar to those mentioned for indigenous peoples, with those who live in rural areas being particularly vulnerable because of the difficulties in accessing social services. The interaction of the social determinants of health, such as poverty, ethnicity, and rurality, affect several indicators (MINSALUD 2016a).

The armed conflict in Colombia and violence from drug trafficking forced internal displacement. By 2016, 10,190,655 victimizing acts had been recorded as being committed against 7,014,531 people (1.45 per person), of which 80 percent of events were classified as forced displacement of 6,294,465 people. Approximately, 48 percent of the displaced persons are under 25 years old, and 52 percent are women. More than one million displaced persons were indigenous (210,159) and Afro-Colombian (881,028). "Forced internal displacement in Colombia generates situations of vulnerability in people that affect their health and can lead to the development of chronic respiratory diseases (MINSALUD 2016a)."
ANNEX 2: SISTEMA DE INFORMACIÓN INTEGRAL DE LA PROTECCIÓN SOCIAL APPLICATIONS AND PLATFORMS

The Sistema de Información Integral de la Protección Social (SISPRO) consists of 28 applications and the Platform for Sispro Integration file transport platform (table 11).

Table 11: Applications or platform and description of services and the regulatory framework

<table>
<thead>
<tr>
<th>Application or platform</th>
<th>Description of service and the regulatory framework</th>
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<tbody>
<tr>
<td>1. Health Enrollment Transaction System (Sistema de Afiliación Transaccional (SAT))</td>
<td>This system, which became operational on December 23, 2015, allows citizens to register, identify, and verify family group and to look up health care services received during the past two years. <a href="http://www.miseguridadesocial.gov.co">www.miseguridadesocial.gov.co</a>. The SAT was created within the framework of Decree 2353 of 2015 on enrollment in the health care system.</td>
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<tr>
<td>2. Unified Health Beneficiary Database (Base de Datos Única de Afiliados a Salud)</td>
<td>The database provides information on beneficiaries of the Sistema General de Seguridad Social en Salud (SGSSS), with data on basic information, beneficiary scheme, member type, contributor type, and population type; it allows for updates of income information, mobility between different schemes, and withdrawal from the health system. Decree 2280 of 2004 and Resolution 195 of 2005 provide the legal framework for the contributory scheme; Decree 971 of 2011 provides the legal framework for the subsidized scheme.</td>
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<tr>
<td>3. Unified Social Protection Beneficiary Registry (Registro Único de Afiliados a la Protección Social)</td>
<td>The registry provides information on beneficiaries’ health, pension, unemployment, occupational risks, family compensation, social assistance programs, and Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales data, with national coverage and monthly updates. Law 797 of 2003 (Art. 15), Decree 1637 of 2006, and Resolution 3336 of 2013 provide the legal framework.</td>
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<tr>
<td>4. Integrated Payroll for Settlement of Social Security Contributions (Planilla Integrada de Liquidación de Aportes a la Seguridad Social (PILA))</td>
<td>A virtual one-stop shop for collecting contributions to the General Social Security System, this instrument has made it easier for citizens and companies to settle and pay their monthly contributions to health, pension, occupational risk, and compensation funds through a single electronic transaction and to control evasion and avoidance. Law 797 of 2003, Article 15, paragraph b; Decree 1465 of 2005; and Decree 1931 of 2006 provide the legal framework.</td>
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<tr>
<td>5. Birth and death registration</td>
<td>Allows for online registration of certificates of live births and death certificates by municipalities and health care facilities (IPSs) since 2008.</td>
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<td>6. Proof of life</td>
<td>Launched on July 1, 2012, the application allows online query by social security entities that must verify that a beneficiary is alive, which beneficiaries previously did themselves. Decree-Law 019 of 2012, Art. 21; Decree 1450 of 2012; and Resolution 1708 of 2012 provide the legal framework.</td>
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<tr>
<td>7. Registry of Location and Characterization of Persons with Disabilities (Registro de</td>
<td>Online registry to monitor the health of people with disabilities that has made it possible to identify and define their sociodemographic profile at the municipal level. Law 1618 of 2013, Circular 17 of 2014, and Agreement No. 002 of 2013 provide the legal framework.</td>
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<td>Application or platform</td>
<td>Description of service and the regulatory framework</td>
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<tr>
<td><strong>Localización y Caracterización de Personas con Discapacidad</strong></td>
<td>Database with information on health care benefits since 2009, available for queries and information on procedures, emergencies, hospitalizations, medications, newborns, and users. Information on health care is available according to scheme and <em>entidad administradora de planes de beneficios</em> (EAPB). Resolution 3374 of 2000, Resolution 959 of 2002, Resolution 1531 of 2014, and Resolution 4449 of 2014 provide the legal framework.</td>
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<tr>
<td><strong>8. Record of Individual Health Benefits (Registro Individual de Prestaciones en Salud)</strong></td>
<td>The system provides information for drug market regulation, with records of drug sale prices, records of drug purchase prices, and reimbursement records. Law 100 of 1993, Art. 245 and Circular 4 of 2006 provide the legal framework.</td>
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<td><strong>9. Drug pricing information system (sistema de información de precios de medicamentos)</strong></td>
<td>The system consolidates and integrates drug pricing information and makes it available through a single repository (data warehouse), with data drawn from different sources relevant to the sector. The system provides periodically and constantly updated information on health, pensions, occupational risks, work, employment, and social promotion. Users can submit queries using the different information services available on the SISPRO portal (<a href="http://www.sispro.gov.co">www.sispro.gov.co</a>), with the options of predefined queries, on-demand queries, and geographical modules. Law 100 of 1993, Art. 193; Law 797 of 2003; Law 1122 of 2008; Law 1438 of 2011; and Law 1751 of 2015 provide the legal framework.</td>
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<tr>
<td><strong>10. Data Management System (Sistema de Gestión de Datos)</strong></td>
<td>The system consolidates and integrates drug pricing information and makes it available through a single repository (data warehouse), with data drawn from different sources relevant to the sector. The system provides periodically and constantly updated information on health, pensions, occupational risks, work, employment, and social promotion. Users can submit queries using the different information services available on the SISPRO portal (<a href="http://www.sispro.gov.co">www.sispro.gov.co</a>), with the options of predefined queries, on-demand queries, and geographical modules. Law 100 of 1993, Art. 193; Law 797 of 2003; Law 1122 of 2008; Law 1438 of 2011; and Law 1751 of 2015 provide the legal framework.</td>
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<tr>
<td><strong>11. Web portal of the Ministry of Health (MINSALUD), with procedures, services, and mobile applications</strong></td>
<td>Citizens can access the MINSALUD web portal to complete procedures, receive automated services, or use its mobile applications. This is part of the online government strategy developed in accordance with the guidelines and phases established first in Decree 1151 of 2008 and currently based on Decree 2573 of 2014.</td>
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<td><strong>12. Master accounts</strong></td>
<td>This application facilitates monitoring of resources of the subsidized scheme by requiring financial entities to report on activities and balances of master accounts at the territorial level and requiring health insurers of the subsidized scheme to report to MINSALUD. Resolution 3042 of 2007, Art.29 and Resolution 1128 of 2013 provide the legal framework.</td>
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<tr>
<td><strong>13. Direct transfers to IPSs from the subsidized scheme</strong></td>
<td>Application for consolidating monthly information that EAPBs of the subsidized scheme report, making it available to the Solidarity and Guarantee Fund (<em>Fondo de Solidaridad y Garantía</em>) to enable direct transfers to IPSs and speeding the flow of health resources. Law 1438 of 2011 Art. 29, Decree 971 of 2011 Art. 6, and Resolutions 2320 and 2977 of 2011 provide the legal framework.</td>
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<tr>
<td><strong>14. Direct transfers to IPSs from the subsidized scheme with invoice</strong></td>
<td>Application for receiving information on EAPBs’ direct transfers from the subsidized scheme to IPSs with invoices paid through the transfer. Launched in August 2016 within the framework provided by Resolution 1587 of 2016.</td>
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<td>Application or platform</td>
<td>Description of service and the regulatory framework</td>
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<tr>
<td><strong>15. Direct transfers to IPS from the contributory scheme</strong></td>
<td>Application for transferring and validating the information that EAPBs of the contributory scheme send weekly to enable direct transfers to health service provider institutions and to speed the flow of health resources. Law 1608 of 2013 Art. 10, Decree 2464 of 2013, and Resolutions 654 of 2014 and 1569 of 2014 provide the legal framework.</td>
</tr>
<tr>
<td><strong>16. Debt consolidation for the subsidized scheme</strong></td>
<td>Application for receiving and consolidating information on recognized unpaid debts (invoices) for settlement among the parties involved. Decree 1080 of 2013 provides the legal framework.</td>
</tr>
<tr>
<td><strong>17. Debt consolidation for subsidized scheme contracts</strong></td>
<td>Application for receiving and consolidating debts from subsidized scheme contracts according to Resolution 260 of 2015.</td>
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<tr>
<td><strong>18. Portfolio consolidation by entities responsible for issuing payments to IPS</strong></td>
<td>Application for receiving and consolidating information on debts and invoices that various stakeholders pay through direct transfers from the subsidized scheme for settlement. Law 1438 of 2011, Art. 114, 121, 122, 126, 133, and 135, and Circular 30 of 2013 provide the legal framework.</td>
</tr>
<tr>
<td><strong>19. Consolidation of employer contributions</strong></td>
<td>Application for receiving debts from each stakeholder—administrators and public IPSs—and for providing information on debt settlement. Resolution 4906 of 2014 provides the legal framework.</td>
</tr>
<tr>
<td><strong>20. Portfolio acquisition</strong></td>
<td>Application for managing portfolio acquisition invoices and supporting acquisition processes of EAPBs’ portfolios. Resolution 3029 of 2014 provides the legal framework.</td>
</tr>
<tr>
<td><strong>21. Technologies that the Mandatory Health Plan (Plan Obligatorio de Salud) does not cover in the subsidized scheme</strong></td>
<td>Application for receiving information on services provided in the subsidized scheme that the Plan Obligatorio de Salud does not cover. Territorial authorities report this information every six months. Resolution 1479/15 provides the legal framework.</td>
</tr>
<tr>
<td><strong>22. Health Care Professionals Registry (Registro de Talento Humano en Salud)</strong></td>
<td>Application for receiving information on health care professionals. It allows for online searches for information on each person’s education and training, consolidated queries on institutions, higher education programs, work-related training, and human development; queries on compulsory social services provided; and disciplinary sanctions for violations of code of ethics that the courts hand down. Resolution 3030 of 2014 provides the legal framework.</td>
</tr>
<tr>
<td><strong>23. SI Estandares de Medicamentos</strong></td>
<td>Application for managing unique drug identification codes to facilitate standardized drug management by the National Institute for Food and Drug Safety (Instituto Nacional de Vigilancia de Medicamentos y Alimentos), drug manufacturers, drug importers, and all SGSSS stakeholders. Resolution 3166 of 2015 provides the legal framework.</td>
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<tr>
<td><strong>24. Non-Health Benefit Plan (Non-Plan de Beneficios de Salud (PBS) Mi Prescripción</strong></td>
<td>Application for online prescription of health services or technologies not covered in the Health Benefit Plan (Plan de Beneficios de Salud (PBS)) funded through Unidad de Pago por Capitación - non-PBS Mi Prescripción, including procedures, medications, nutritional support, and complementary social services. Launched on December 1, 2016, for all EAPBs of the contributory scheme with</td>
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<td>Application or platform</td>
<td>Description of service and the regulatory framework</td>
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<tr>
<td>26. Financial Plans of Territorial Authorities (Planes Financieros de Entes Territoriales)</td>
<td>Territorial authorities register their financial plans for query and monitoring by MINSALUD.</td>
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<td>27. Denied services</td>
<td>Application with information on denied health services that EAPBs report in accordance with Resolution 1683 of 2015 and Order 19 of Ruling 760 of 2008. Information that EAPBs report is available to the Superintendence of Health and the Ombudsman's Office.</td>
</tr>
<tr>
<td>Platform for Sistema de Información Integral de la Protección Social Integration</td>
<td>Secure file transport platform for transferring all files legally required to be sent to MINSALUD or that MINSALUD must send to territorial authorities. More than 12,000 entities, including EAPBs, IPSs, municipalities, wholesalers, pharmaceutical laboratories, compensation funds, PILA information operators, and financial institutions, use it for ongoing file transfers.</td>
</tr>
</tbody>
</table>

Source: MINSALUD 2017c, pp. 4-6  
Notes: Applications for birth and death registration are highlighted in green
This case study on Colombia describes how the civil registration and national identification system and the health information system have facilitated progress toward universal health coverage. The study includes a description of Colombia’s General Social Health Insurance System (Sistema General de Seguridad Social en Salud [SGSSS]), assignment of a unique personal identification number (UPIN) at birth, and the interoperability of the civil registration and health information systems. It explains how the civil registration system and the UPIN have helped improve health outcomes and explains the role of death registration. The study finishes with conclusions, lessons learned, and recommendations. A brief overview of Colombia is presented in Annex 1. This study focuses on identification of and access to health services, which are considered rights in Colombia. This report emphasizes the importance of establishing an individual’s legal identity in childhood to facilitate early access to social and other services and for greater accuracy in population statistics.

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