

Colombia: Struggling for Access and Quality in Social Services¹

Context

1. Colombia cannot be understood without analyzing the ongoing armed conflict and its consequences, which have directly affected the respect for human rights, and indirectly impacted the way specific social needs are addressed. Forty years of political stress have resulted in intense internal displacement, social conflict and negative impacts on the economy, drifting governments' attention away from social policies. This situation has accompanied and reinforced a scenario of stark poverty and inequality, reflected in different social development indicators between different segments of the population. These disparities are still not properly addressed in the design of social policies, with social guarantees and pre-guarantees variegating according to income, residency and race.

2. The matrix below captures key elements of existing social guarantees and pre-guarantees in the country, concerning health and education. Utilizing the sub-dimensions of social guarantees discussed above, the subsequent analysis explores how rights based norms and procedures have, or have not, been integrated into the delivery of social services in each of these areas in order to understand and respond to how the country is and is not effectively meeting its population's social needs.

Sub-Guarantees	Basic Health Care	Social Security in Health	Education Provision
Access			
<i>Are the beneficiaries and services clearly defined?</i>	All citizens shall have basic access guaranteed: basic assistance, environmental sewage, emergency care and vaccination.	Yes, all citizens affiliated to the contributing regime are beneficiaries. Each beneficiary has a mandatory health plan with different levels of coverage.	Education is constitutionally mandatory and free for children between 5 and 15 years old: Pre-primary school (at least 1 year), Basic Education (Primary, 5 years and Secondary, 4 years).
<i>Are there institutional procedures for monitoring access?</i>	There is monitoring of vaccination services and epidemiologic vigilance, but only partial vigilance to basic service provision to the public	No, there is no monitoring of the right to social security with regard to health. However, there is an incipient monitoring of the coverage and quality of services.	No, there is no monitoring of the right to education. However, there are monitoring mechanisms concerning quality. With the exception of few municipalities, there is no monitoring regarding access to education.

¹Adapted by Flavia Carbonari from original reports: Vargas, Jorge. 2007. *Colombia: La educación desde la perspectiva de los derechos humanos* (unpublished) and Vargas, Jorge. 2007. *Colombia: La salud y la seguridad social en salud desde la perspectiva de los derechos humanos* (unpublished). The original reports were commissioned by the World Bank's Social Development Department as part of a wider research project on Rights, Guarantees and Social Policy. Summaries of all case studies and related documents from this project are available at <http://go.worldbank.org/P2LXPQU1Z0>.

	health. Emergency care cases are also monitored to identify causes and establish corrections in the system.		
<i>Are there legal or institutional mechanisms that ensure non-discrimination in the access to services?</i>	There are no specific mechanisms that assure non-discrimination. During emergency care there is discrimination and the legal mechanisms to control it are not respected.	No, there are deep levels of discrimination. A great number of people are outside the mandatory plans. The Government has set the goal of achieving universal coverage by 2010.	Yes, the Constitution guarantees access to education without discrimination. Laws 115/94 and 715/01 have incorporated references to ensuring non-discrimination for specific groups, such as women, minorities, youth, etc. The allocation of resources to education is generally geographically misbalanced, discriminating against some regions.
<i>Are services guaranteed for the amount of time needed?</i>	Services of disease prevention and health promotion are continuous do not have time limit.	Yes.	No, the nine years of mandatory education are not guaranteed due to insufficient educational supply, lack of resources to afford services and different social factors such as internal displacement due to conflict, and child labor.
<i>Is there a maximum waiting period for receiving the service?</i>	There are no explicit norms for this in promotion and prevention. Yes, in emergencies, depending on their character. Yes in vaccination (established periods to receive the vaccines and reinforcement).	Yes in some services, but it is not monitored.	Constitutionally, the right to education needs to be guaranteed in any case, even when a child in age of graduation from the elementary cycle has not yet attended school.
<i>If service is unavailable within this waiting period, is there a guaranteed</i>	No.	No.	No.

<i>alternative (in the same time period)?</i>			
Financial Protection			
<i>Do beneficiaries need to contribute to the cost of service?</i>	No, services are free of charge.	Yes, the fiscal regime establishes contributions according to wage levels.	Yes, families need to contribute with monthly fees, tuition and supplies. Unlike many other Latin American countries, primary education is not free in Colombia.
<i>Are services accessible to beneficiaries who cannot contribute to the cost?</i>	Yes, services are free.	The mandatory health plan comprises several services and medicines that are free of charge.	Yes, there are partial subsidies for poor population. Scholarships also exist based on merit.
<i>Is this information effectively communicated to the public?</i>	Yes, in general, the population knows that they do not need to make special contributions to receive benefits from promotion and prevention actions.	In the contributing regime, the information is known because it is compiled in the bidding documents. In the subsidized regime, the information is not appropriately disseminated to the public.	Parents learn actual costs before enrolling their children.
Quality			
<i>Are there clear quality standards?</i>	No, for services of promotion and prevention. To a certain extent for emergency services. Yes for vaccination services.	Yes, service providers and administrators need to maintain quality standards with regard to technology, financial soundness, and administrative capacity.	Yes, there are quality standards with regard to all basic teaching subjects and pedagogical methods.
<i>Are programs being evaluated on a regular basis?</i>	Services of prevention and promotion have a weak evaluation system. Vaccination services respond to international	A Mandatory System of Guaranteed Quality in Health has started to be implemented.	No, programs are not evaluated. However, there are biannual standardized tests to measure academic achievement for students of 5 th and 9 th grades. In addition, teachers and institutions are evaluated on a regular basis.

	standards. Emergency services have auto-evaluation done by the service provider itself.		
<i>Are the standards and evaluation results effectively communicated to the public?</i>	No.	So far no. Minimum information is available on the web, but is not widely accessed by beneficiaries.	Yes, increasingly in the last couple of years. However, information is difficult to understand and therefore not widely consumed by citizens.
Mechanisms of Redress			
<i>Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?</i>	No. Among other reasons because the responsible entities are not clearly defined.	No, mechanisms of redress and enforcement are very weak. Citizens usually recur to the judiciary to claim for the realization of their rights.	No. The Constitution and the germane laws do not create any mechanisms. Some incipient mechanisms have been created at the municipality level. In general, the only available mechanism is the Judiciary, although poor population can hardly access it.
Participation and Continuous Revision			
<i>Do civil, parent, or community organizations have a concrete role in the design, implementation, and monitoring of the program.</i>	There are not pre-defined mechanisms of community participation.	Collective participation can play a role in some institutions in the form of incipient social accountability mechanisms.	Yes, beneficiaries can participate at different institutional levels, from parents associations to formal participation in the school council. Increasing interest of civil society in participating in the educational process is observed at every level.
<i>Which law or institution guarantees citizens' involvement?</i>	Law 100 of 1993	Law 100 of 1993	Law 115 of 1994 and Law 715 of 2001
<i>Are there mechanisms that allow for the continuous revision of service standards?</i>	Dissemination campaigns and plans are periodically revised based on epidemiological profiles, availability of	No, services are not monitored. However, administrative procedures are constantly revised. Periodically, the mandatory Health Plans are revised to include new and additional services. The law stipulates	Yes, but they hardly ever work. The National Government determines quality improvement plans and strategies that are seldom applied at the local level due to lack of incentives.

	<p>resources, and technological advances.</p> <p>Vaccination follows international standards.</p> <p>Emergency health care is subject to national quality controls.</p>	<p>that this process be of special concern for the subsidized regime so as to achieve a level of coverage similar to the contributing regime.</p>	
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Education

2. In 1968 Colombia signed the International Covenant on Economic, Social and Cultural Rights, which establishes free education as an essential element of human rights. Almost four decades later, education in the country is still neither free nor universal.² According to the World Bank,³ Colombia is the only country in Latin America where primary education is in reality not free, despite all the normative guarantees, as it will be demonstrated below.

3. The Colombian Constitution assures its citizens ten years of free and mandatory education. The right to education needs to be guaranteed in any case, even when a child in age of graduation from the pre-primary cycle has not yet attended school. Nonetheless, the Constitution of 1991 opened space for governments to regulate fees in public schools, allowing them to charge those that “are able to pay”. As a result, in practice even in the public system families need to contribute with fees, tuition and supplies, which makes Colombia a special case in Latin America where primary education is in fact not free..

4. Since 1994 Colombia has introduced legal, institutional, instrumental and financial mechanisms to actualize the education guarantee. The normative advances have set administrative procedures and enhanced the attention to certain social groups, as well as created minimums of coverage and quality. Despite some progress, universal access to these minimums has not been fully realized. In 2005, for example, 22 percent of the children aged between 5 and 6, 8 percent of those between 7 and 11, and 15 percent of those between 12 and 15 were not attending school. This means that 1.2 million children were not having **access** to the mandatory elementary and primary education grades guaranteed by the law. Also, despite its decreasing trend, illiteracy in 2005 was still significant, reaching 10 percent of the population older than 15, 4 percent of those between 16 and 24, and 12 percent of those older than 24. Thus, in practice, the nine years of mandatory education are not guaranteed. Insufficient educational supply, lack of resources to afford services and different social factors such as internal displacement and child labor are some of the reasons that explain this gap. Administrative conditions are also a key factor; in several municipalities, complex processes of registration and enrollment, long waiting lists and the requirement of civil registration work as significant barriers to access.

² Report from Especial Narrator, Katarina Tomasevski. Consejo Económico y Social de las Naciones Unidas. Comisión de Derechos Humanos. Mission to Colombia, October 1st-10th, 2003.

³ World Bank, User fees in primary education: Draft for review, Washington D.C., February 2002, p. 7.

5. The most prominent barrier to access is **financial**. Colombia has high poverty rates, with approximately 50 percent of the population being poor and 20 percent being considered extremely poor. Sixty percent of the poor are younger than 18 and therefore entitled to be in the education system. Many children are not able to attend school because of their families' economic situation and inability to afford costs such as transportation, school supplies and uniforms; others need to start working early in life to help with the family income. Some estimates show that almost 1.5 million children aged between 7 and 17 work in Colombia, 90 percent of them in the informal sector.⁴ Those identified as poor through the Social Service Beneficiaries' Identification System (*Sistema de Identificación de los Beneficiarios de los Servicios Sociales*, SISBEN) are eligible to receive subsidies to help cover school monthly fees, tuition and supplies, yet citizens are not well informed of this mechanism for **financial protection**. Scholarships also exist, but are based on merit.

6. The necessary resources to actualize the aforementioned guarantees are formalized by law. The national Constitution created a General System of Shares (*Sistema General de Participaciones*), which concentrates the resources that the central government transfers to states and municipalities to the financing of social services. This system declares that 58.5 percent of the resources should be directed to education. With a constitutional reform approved in 2007, the Constitution now also states that the amount of funds destined to education, health and basic sewage coming from the General System should be annually increased according to the inflation rate of that year plus four percentage points in 2008, 3.5 in 2010 and 3 points between 2011 and 2016. Between 1993 and 2001, total public expenditures in education increased from 2.8 to 4.5 percent of the GDP. According to a Decennial Plan for Education this proportion should have been raised to 6.5 percent of the GDP in 2005, but this goal has not been achieved until today. In addition, the allocation of resources to education is geographically misbalanced, discriminating against some regions.

7. In terms of the institutional design, there is not a unified and overarching educational system that could coordinate both public and private providers in order to guarantee universal provision of the mandatory education. This generates significant disparities between the public and private systems with regard to most sub-guarantees, especially access and quality. In general, the private educational system is used by people with higher and middle incomes, and the public by lower income groups. Education authorities have distinct relationships (orientation, financing, supervision, vigilance, etc.) with institutions and representatives of the two systems. Quality of service provision differs significantly as well, as demonstrated by the results of exams taken by children in private and public schools. Furthermore, in the public system not all schools attend the standards of infrastructure, personnel and management required by the Minister of Education. The educational system in Colombia is therefore very unequal, with significant disparities in **access** and **quality** primarily based on people's level of income. Nonetheless, the poorest people have been increasingly accessing more educational services, especially in primary education. Furthermore, in the past few years the quality of the public education has improved, along with the expansion in coverage. This expansion in coverage is resulting in the migration of people from higher incomes from the private to the public system.

8. Disparities are also based on area of residency. There is a clear difference between continued school attendance in urban and rural areas. Among the barriers to access to school in rural areas are: insufficient offer of services; lack of cultural adaptation to the specific needs and environments in that area; presence of the armed conflict; high poverty rates; and, in general, lower wealth and economic activity. In order to deal with this problem, Colombia has created a

⁴ UNICEF (2007): Situación de la Infancia – Niños y niñas que necesitan protección especial. www.unicef.org.co.

program targeting this segment of the population, which has reached 27 states and 115 municipalities so far. The Rural Educational Program, REP (*Programa de Educación Rural, PER*), is based on an approach that creates incentives for local communities to contribute with their own educational projects, and with pedagogic models that respond to the particularities of their environment. In this sense, REP is an illustrative case of social program that can be implemented to address problems of access and quality in areas with special circumstances.

9. If Colombia still has a long way to go regarding the sub-guarantee of access, with regards to quality the country has been making considerable improvements. In order to guarantee and monitor the **quality** of education, the government created a national system of evaluation in 1998 to examine periodically learning results and to verify that students are achieving the established levels of competency. These standards are measured by two exams, called SABER, taken by every student at the end of the last year of primary education and after finishing secondary school. Despite the limited capacity of the state to design policies and strategies to improve quality based upon the results of these exams, an increasing number of schools have started to formulate institutional projects and plans to improve their services based on the scores of their students. The state exams also serve the purpose of monitoring the disparities in the educational system. Wealthier children, who usually attend private schools, tend to get higher scores, reaffirming that education has not been accomplishing its role of correcting inequalities and leveling opportunities for all.

10. Another advance in the sub-guarantee of **quality** is the participation of the country in international evaluations, which has allowed the use of another set of standards for comparison. Furthermore, each school is also required to produce an annual review of its infrastructure, personnel and pedagogic resources, and teachers are evaluated by the state every six years. The creation of prizes based on quality and improvement have also been inducing educational institutions to pursue improvement plans. Notwithstanding the challenges that still need to be overcome in other sub-guarantee levels, Colombia brings an illustrative case of instrumental policies adopted to advance the quality of the guarantee of education rights.

11. Aside from the common economic, institutional, political and social problems that usually influence the provision of social services in Latin America, Colombia has to deal with the effects of decades of armed conflict. More than forty years of internal violence have resulted in severe internal displacement, which affects the fulfillment of a number of human rights, including the right to education. The consequences of the violence are so intense that the Constitutional Court has established that expenditures on displaced people should even be considered more urgent than public social expenditures. Some statistics say between 1.8 and 3.4 million have been internally displaced in the past ten years, and more than half of this total is younger than 18 years old. Several international organizations, NGOs and public institutions give support to the displaced families, emphasizing the reestablishment of the rights to education. However, these efforts are insufficient, and a definitive solution will only take place when the violence ends. Aside from the post-trauma syndromes, children involved in the armed conflict face problems of discrimination and stigmatization in schools, and can rarely afford education expenses such as enrollment fees, uniforms and school supplies. Some punctual initiatives have been undertaken to guarantee their access to school. In Bogota, for example, displaced kids do not have any costs on their first year in school. Yet displaced children have not been formally exonerated from all education costs in most of the country.

12. There are no effective **mechanisms for redressing** inequalities within the educational system in Colombia. The state's responsibility in the matter is diluted into so many instances that it is hard to define the responsible institution that should respond for violation or negligence of the

rights to education. For instance, there is no record of the application of sanctions to educational authorities that did not guarantee minimums of coverage and quality.

13. Monitoring is focused on processes and results, but not on access. The Colombian Constitution does declare that educational institutions and the Ombudsman (*Defensor del Pueblo*) should be responsible for promoting human rights, including the right to education. However, these agencies don't work as mechanisms of redress, but more as enforcement and informative tools. The Ombudsman is responsible for educating citizens about their rights and for giving guidance on how to claim them. Until today the entity has not managed to put in the political agenda a discussion about economic, social and cultural rights.

14. As in other countries in the region, Colombia experiences a boom of institutions and mechanisms of citizen **participation** in the educational system. Increasing interest of civil society in participating in the educational process is observed at every level. Beneficiaries can participate at different institutional stages, from parents associations to formal participation in the school councils. The types and systems of citizen participation established by the law allow citizens to oversee public management in different administrative degrees and its results. They have also induced important forms of mobilization, such as education forums. A national consultation about the new Education Decennial Plan has been recently conducted and resulted in the mobilization of several social actors, which formulated more than 300,000 proposals.

Health

15. The Colombian Constitution does not guarantee the right to health services for all its citizens. Nevertheless, it does assert social security as a public service and as an essential right, declaring mandatory the affiliation to the General System of Social Security in Health (*Sistema General de Seguridad Social en Salud, SGSSS*), created in 1993. Thus, in Colombia health services are not seen as rights, but rather as free public services. According to the law, the SGSSS should regulate the basic health public services and create the conditions for the entire population to have access to a comprehensive variety of health services. The state should assure the mandatory character of the Social Security in Health. The SGSSS is directed and regulated by the Ministry of Health Protection and the National Council for Social Security in Health. Other entities are in charge of vigilance and control (*Superintendencia Nacional de Salud*), financial issues (*Fondo de Solidaridad y Garantía*) and service provision (*Instituciones Prestadoras de Servicios de Salud*).

16. The system is divided in two regimes, contributive and subsidized. In the former, every employer has the obligation to affiliate their workers to the system; in the latter, the state should facilitate the affiliation of those who are not associated to an employer or who are not able to contribute due to lack of income. According to the Ministry of Social Protection, in 2006 15.5 million people, the equivalent of 36 percent of the Colombian population, were affiliated through the contributive regime, whereas 18.6 million, or 42 percent of the population, were affiliated through the subsidized regime. Notwithstanding the mandatory aspect of the affiliation to the SGSSS, 20 percent of the population is not associated to any of them. Thus, despite the normative guarantee, universal coverage does not exist in practice.

17. The SGSSS has two plans of complementary protection: the Basic Care Plan, BCP (*Plan de Atención Básica, PAB*) and the Obligatory Health Plan, OHP (*Plan Obligatorio de Salud, POS*). The BCP should promote health and prevent diseases through interventions directed to the entire population, e.g. through vaccinations campaigns. It should be universal and its services free. However, indicators show some problems with **access** to the benefits provided by the plan. For example, the number of deaths due to malaria and dengue are still high Colombia. Some of these

problems are related to lack of information. The OHP, on the other hand, includes full maternity health care, provision of essential medications, diagnosis, treatment and disease rehabilitation. It is based on the individual contributions to the SGSSS, and therefore its coverage is different for the contributive and the subsidized regimes. Those affiliated to the subsidized system have **access** to half of the coverage provided by the OHP relative to those affiliated to the contributive system, which reveals a significant disparity in **access** to health services. According to the 1993 law that created the SGSS, by 2001 every citizen should have been covered by the OHP, which has not happened until today.

18. There is also an Emergency Care Plan and an Expanded Immunization Plan (*Plan Ampliado de Inmunizaciones, PAI*) and medical attention for those not affiliated to the system. Unlike the OHP, the Emergency Care Plan includes coverage for all citizens in all public and private health institutions, independent of their capacity of payment. The costs of these services are shared among several entities, often leading to confusions. As a result, it is common for patients to be rejected or for emergency care to be delayed. Thus, in the case of emergency care too the law is not sufficient to guarantee universal provision.

19. Medical care to those who are not affiliated to the SGSSS is provided by public health institutions or by private entities that have contracts with the government to provide such services. There is no registry that could provide information about how many of the non-affiliated actually have **access** to these services. Thus, there are no clear guarantees or standards for this segment of the population.

20. As in the case of the education sector, the Colombian health system is very unequal not only in terms of access to services, as demonstrated above, but also in terms of **quality**, presenting significant disparities depending on whether citizens are affiliated to the contributive or subsidized system or not affiliated at all. The contributive regime is assisted by large insurance companies, with high liability and investment rates and a large number of affiliates, which helps to mitigate risks. The subsidized, on the other hand, is assisted by small service providers, with weak structures, low solvency and few affiliates. As a consequence, the two regimes offer different guarantees to citizens, and quality disparities abound. This situation exposes the limitations of a system that has been conceived as a mandatory service and not as an essential right. The government has proposed to equalize the plans of benefits of both regimes by 2019.

21. Attempts to decrease problems with quality of services have yet to be successful. The law that created the SGSSS in 1993 established mechanisms of control to supervise the provision of services and guarantee **quality**. Nonetheless, these mechanisms have been very deficient. For example, the Obligatory System of Health Quality Guarantee, (*Sistema Obligatorio de Garantía de Calidad de Salud*) was created only in 2006, and recently started to be implemented. Yet there is no system to serve as an incentive for institutions to adequately implement the process. The first reports on this health quality guarantee system have administrative value, but have not been communicated efficiently to the public or relevant civil society groups.

22. The law that created the SGSSS also declares that the Ministry of Health Protection should define **quality** and user satisfaction norms. In addition, a decree of 1997 had established that indicators of quality in the provision of health services should be defined and applied. Nonetheless, this has not occurred, and standards, indicators or controls related to these issues are not clear until today. Thus, it is still not possible to know if services have been improving or not, and to evaluate the progress of users' satisfaction with SGSSS services. Citizens are also not informed about their rights with respect to quality of health services or about existent mechanisms to claim for these rights.

23. The budget of SGSSS is protected by the law, which ensures the financial dimension of the health care guarantees, if such are to be established. The Constitution declares that 46.5 percent of the taxes collected in the country should be directed to education, health and basic sewage. These expenditures should be managed by the states, districts and municipalities, division that composes the General System of Shares (*Sistema General de Participaciones*) mentioned in the previous section. With a constitutional reform approved in 2007, the Constitution now also states that the amount of resources destined to these sectors coming from the General System of Shares should be annually increased according to the inflation of that year plus four percentage points in 2008, 3.5 in 2010 and 3 points between 2011 and 2016. Relatively to the GDP, the percentage directed to health and social security increased from 7.5 percent to 10.3 percent between 1994 and 1997. Since then it has oscillated around 9 percent.

24. Notwithstanding advances in transfers of resources, there are several disparities in their distribution. The division of funds allocated in each department through the General System of Shares shows that in some states the poor population receives almost half the amount of transfer per capita of others. In addition, despite the normative guarantees of the laws that regulate the SGSSS, few people benefit from the **financial protection** they are supposed to have under this system. According to a national poll (*Encuesta Nacional de Demografía y Salud*) conducted in 2005, at least 20 percent of the people that got ill looked for solutions outside the SGSSS. More than 50 percent of those who did not receive medical care argued that the reason for that was lack of money and problems with the provider. The relation between costs assumed by the people and those carried by the SGSSS is 1:3. Hence, as in the case of education, there is **financial conditioning** that works as a barrier to access to health services. Even though the law states that the system will provide the institutions and resources necessary to guarantee health allowances for all, in practice the extent of the guarantee is limited by the capacity of payment of the families and by the financial solvency of the system.

25. The Colombian health system also presents problems regarding **mechanisms of revision and redress**. The inspection, vigilance and control of SGSSS are done over services (mechanisms and provision) and not over rights (exercise of entitlement). For this reason, citizens usually appeal to the judicial system to claim their rights. In practice, these mechanisms of control are very deficient because the responsibilities are divided among a number of agencies and levels of power, making it hard for citizens to know which institution they can refer to; frequently functions of vigilance and control are not separated from those of operation; control is usually legal, financial and operational, and not over service coverage or quality.

26. An example of the lack of control over affiliation coverage is the fact that most Colombian municipalities do not know how many people need to be in the subsidized system and how many of them are not affiliated to the SGSSS. It is also not clear the number of evasions of people that do have capacity to contribute to the system but prefer to stay out and use private health care. There are also no systematic investigations about bad practices and even though the National Superintendence of Health (*Superintendencia Nacional de Salud*) has powers to investigate and punish, there are no antecedents of sanctions.

27. Information about the evolution of the SGSSS is minimal, only published under pressure by the authorities, and thus does not contribute significantly to the transparency or accountability of the system. Generally, service providers decide what kinds of information they want to make available to the public. For example, information on registered sanctions or statistics of intra-hospital mortality are not publicly available. There are also no direct **mechanisms for redressing** inadequacies within the system.

28. Citizen **participation** in the implementation and decision-making of health programs is not actively encouraged. There are no systematic records of such civil organizations or of their actions, which could be seen as an evidence of their lack of importance within the SGSSS. Nonetheless, in some municipalities and states civic organizations have received ample support by citizens and local authorities, and have the potential to contribute through their negotiation capacity, to the protection of rights and community participation of the affiliates to the SGSSS.

Overview and Lessons

29. The two social sectors reviewed in this case study expose the lack of clarity that still underlies the social sector in Colombia, and suggest different limitations to the implementation of a social policy that fulfills fundamental social and economic rights. In the case of the education sector, universal access to free and mandatory services, as declared by the law, is limited by the lack of effective financial protection, and influenced by weak and unclear mechanisms of redressing inadequacies within the system. Few of the existing laws stipulate in detail the institutional responsibilities and procedures for each stage of social program development. On the other hand, the country has improved significantly with regard to the establishment of quality standards, and the results have been quite positive. As to the health sector, disparities in access and quality of services abound. Colombians' capacity of intervention to claim improvements in quality is restricted by weak mechanisms of redress and enforcement, and citizens usually recur to the judiciary to claim for the realization of their rights. Only an incipient monitoring of coverage and quality of services can be found. Unlike the educational system, there are almost no mechanisms or incentives for citizen participation in the design, monitoring or implementation of policies in the health sector.

30. An analysis of formally protected social services and their functioning, according to a sub-guarantee framework as suggested above, could be deepened and used by civil society groups and policy-makers to diagnose areas that prevent social programs from fulfilling their objectives adequately and universally. In this way, Colombia could build on its progress, for instance in educational quality and coverage, to include various mechanisms for monitoring of access and quality, enforcing financial protection, and designing accessible channels for claiming entitlements. Improvements in these spheres would not only help the state increase accountability in its stated obligations, but would also help it move towards the fulfillment of social, economic and cultural rights as stipulated in national and international legal commitments.