

SANTANDER

ACCELERATING PROGRESS TOWARDS THE MDGS

*REGIONAL DOCUMENT FOR ACCELERATING PROGRESS
TOWARDS THE MDGS: SANTANDER DEPARTMENT*



REGIONAL DOCUMENT FOR ACCELERATING THE MDGS:

DEPARTMENT OF SANTANDER, COLOMBIA

June 2011

This publication is the outcome of a working partnership between the Regional Government of Santander the UNDP Colombia, the UNDP/BDP/Poverty Group/MDG Support Cluster and other regional partners whom we thank for their co-operation. The opinions and interpretations expressed in the report do not necessarily reflect the opinions of the regions represented, the partners and organizations in question.

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Acknowledgements (the following institutions participated at various points in this process):

The Santander Health Department, the Industrial University of Santander (UIS), Public Health Observatory (OSPS) , Regional Observatory for Sustainable Human Development, and the UNDP.

Design:

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**REGIONAL DOCUMENT FOR
ACCELERATING PROGRESS TOWARD
THE MDGS: DEPARTMENT OF
SANTANDER, COLOMBIA**



JUNE 2011

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ACRONYMS:

- AIEPI:** INTEGRAL CARE OF ILLNESSES PREVALENT IN EARLY CHILDHOOD
(*ATENCIÓN INTEGRAL DE ENFERMEDADES PREVALENTES DE LA PRIMERA INFANCIA*)
- IAMI:** INSTITUTIONS FRIENDLY TO WOMEN AND CHILDREN
(*INSTITUCIONES AMIGABLES DE LA MUJER Y DE LA INFANCIA*)
- DNP:** NATIONAL PLANNING DEPARTMENT OF COLOMBIA
(*DEPARTAMENTO NACIONAL DE PLANEACIÓN*)
- MESEP:** MISSION TO LINK EMPLOYMENT, POVERTY AND INEQUALITY SURVEYS
(*MISIÓN PARA EL EMPALME DE LAS SERIES DE EMPLEO Y POBREZA*)
- ESAP:** SCHOOL OF PUBLIC MANAGEMENT
(*ESCUELA SUPERIOR DE ADMINISTRACIÓN PÚBLICA*)
- PAISOFT:** INFORMATION SYSTEM OF THE EXPANDED PROGRAMME ON IMMUNIZATION
- SENA:** NATIONAL LEARNING SYSTEM
(*SISTEMA NACIONAL DE PARENDIZAJE*)
- INS:** NATIONAL INSTITUTE OF HEALTH
(*INSTITUTO NACIONAL DE SALUD*)
- SEV:** ESSENTIAL STATISTICS SYSTEM
(*SISTEMA DE ESTADÍSTICAS VITALES*)
- DANE:** NATIONAL STATISTICS ADMINISTRATIVE DEPARTMENT
(*DEPARTAMENTO ADMINISTRATIVO NACIONAL DE ESTADÍSTICA*)

PROLOGUE

Ever since taking office, Santander's provincial government has had the stated aim of being at the forefront of achieving the Millennium Development Goals (MDGs) in Colombia, and we have been very successful in this regard.

According to the national government's statistics, Santander now has the lowest levels of poverty and extreme poverty of any department in the country. We have managed to reduce malnutrition amongst infants under the age of one. Investment aimed at reducing regional disparities has helped us to increase access to safe drinking water and basic sanitation. There has been a significant increase in the number of protected natural areas.

In the area of health, our MMR and DTP vaccination coverage is very high, making Santander one of the most efficient departments in terms of child immunization. We are also observing a decline in child mortality (children aged one to five) that has even surpassed the targets set for the country.

There has been a decline in maternal mortality, and institutional childbirth is now almost universal. Moreover, there has been not one death from malaria in recent years.

Education policies have brought about a decline in the rate of illiteracy among the 15 to 24 age group. Alongside this, new spaces have been opened up for women, for whom the provincial government now has an approved public policy.

Also noteworthy, and something that has contributed to an improvement in housing quality indicators, is the department's house building and home improvements policy, which is receiving the technical support of UNDP.

An evaluation of the progress being made towards the Millennium Development Goals has shown that we need to accelerate progress in basic education coverage and curb the drop-out rate in lower secondary education. Achieving these two aspects would enable us to increase the average number of years' schooling among the population.

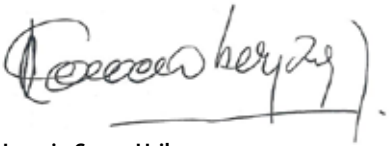
This evaluation also highlighted difficulties in terms of the number of ante-natal checks being carried out at municipal level in Santander, due to the fact that expectant mothers living in rural areas have difficulty in accessing services and have to travel to medical centres located in the urban centres.

Other issues that we have not yet brought fully under control are the mortality rate from cervical cancer and teenage pregnancies, rates of which remain on a similar level to the country as a whole.

It is clear that we have made great progress towards achieving the MDGs but that we still need to overcome a number of bottlenecks that are affecting wide sectors of the population, particularly in the area of health. It is therefore in this area that the acceleration methodology designed by UNDP is being implemented, and it is also being managed on a municipal level due to the persistence of uneven

development and large pockets of poverty that cannot be concealed by statistical averages.

We are redoubling our efforts to ensure that fewer families in Santander go hungry and that fewer people suffer from poverty, and so we welcome strategies such as the Millennium Municipalities, which has enabled us to improve the targeting of our investment; and methodologies such as MAF (MDG Acceleration Framework), which is helping us to ensure more rapid and secure progress in implementing the projects that form part of my government's priority public policies.

A handwritten signature in black ink, appearing to read 'Horacio Serpa Uribe', written over a horizontal line.

Horacio Serpa Uribe
Governor of Santander

FOREWORD

At the Millennium Summit in September 2000, the leaders of 189 countries made a universal commitment to reduce extreme poverty and to work towards achieving a series of minimum development goals by 2015. These were the Millennium Development Goals or MDGs.

In 2010, the world reviewed its progress towards these goals. Whilst numerous achievements have clearly been made, many countries run the risk of missing the 2015 deadline unless they take immediate action.

In an effort to help the countries achieve their MDG targets, UNDP and other UN agencies have established the MDG Acceleration Framework, or MAF. This framework offers the countries and the UN system a systematic approach by which to identify and analyse the bottlenecks that are hindering MDG achievement.

Like other countries with a high development index, Colombia seems to be on the right track to achieving the MDGs. And yet a closer inspection reveals inequalities within the country that mean that the MDGs may not be achieved in some regions and by some sectors of the population where social indicators are below the national average.

This clearly highlights the need for rapid corrective measures to ensure that all Colombians can be brought out of poverty and that the country can achieve the 2015 targets not only on the basis of averages but right across the whole population.

UNDP Colombia is therefore grateful that the Bureau for Development Policy (BDP) has offered it the opportunity of being one of the first countries to test this new methodology, which enables our local partners to identify and analyse bottlenecks that are preventing or hindering the implementation of actions aimed at achieving the MDGs at departmental level in the country.

This document describes the progress made by Santander Department in terms of achieving the MDGs, particularly MDG 5, and bears witness to the local government's commitment to achieving them.

My sincere thanks go to all the staff of the Santander provincial government, particularly those in the provincial health department, the Santander Industrial University (UIS), the departmental public health observatory, the departmental development and human rights observatory, and my colleagues in the BPD and the UNDP Colombia office for all their hard work.

I sincerely hope that these efforts will help the department make progress towards achieving the MDGs.



Bruno Moro

Resident Representative and Coordinator of the United Nations System in Colombia

INTRODUCTION

Colombia, as a signatory to the Millennium Declaration, is committed to the Millennium Development Goals (MDGs). This commitment is embodied in the document Social Conpes 091, 2005, through which the National Council for Economic and Social Policy established strategies, targets and indicators to monitor MDG achievement in Colombia. In the first semester of 2011, Conpes 91 was amended by means of Conpes 140. The document was revised to include new additional indicators, and to adjust baselines and targets for some of the indicators initially adopted. This country's strategy to move towards achieving the MDGs thus incorporates a total of 58 indicators and 58 goals for the eight national objectives, of which 43 are applicable at the department level and 34 at the township level.

On the basis of national statistics, the UNDP country office, together with other stakeholders, including government actors has been drawing attention to the fact that although the country may show progress for many of the 58 indicators on the basis of averages, great inequities mean that many territories are far below the average and, thus, far from meeting the goals by 2015. It is therefore necessary to focus all efforts on the departments and municipalities where such disparities are evident.

On the basis of an MDG gaps analysis, and supported by the political commitment of the local government, the department of Santander has identified work on the MDGs directly related to health issues as a priority.

Although many of the department's health indicators are above the national average, the current departmental administration (2008–2011) produced a departmental health policy entitled 'Health Responsibility for All'. The aim of this was twofold: firstly, to maintain the good results and consolidate the efforts made thus far, and secondly, because cases of death from cervical cancer, teenage pregnancies and antenatal checks were all showing wide discrepancies in relation to the country's 2015 targets, to the extent that if no decisions and/or measures were taken, it was highly probable that the 2015 outcomes for MDG 5, 'Improve Maternal Health And Sexual And Reproductive Health', would be compromised.

It should be noted that none of these issues are included within the universal MDG targets; the country included them within its own 2015 targets for MDG 5, since the poor results achieved thus far were considerably affecting maternal and child health and development in the country. A standard was therefore included that went further than those generically defined on a global level, placing particular emphasis on departments such as Santander where the outcomes required special attention and coordinated work among the different actors.

This document presents the acceleration proposals that emerged from discussions with local actors in Santander department in relation to health issues that are critical for MDG 5, analysing the indicators that require the planning and implementation of priority actions because they are furthest from achieving the 2015 targets.



SECTION 1:

THE REGION

Photo: UNICEF Colombia



REGIONAL CONTEXT: Santander department

Capital: Bucaramanga

Total population: 2,437,151

Administrative structure:
87 municipalities, 6 provinces

Surface area: 30,537 km²

Population density: 79.81 inhabitants/km²

Colombia is divided into 32 departments which are in turn subdivided into 1,070 municipalities. Santander is one of these 32 departments.

Regardless of this administrative division, it is common to find groups of municipalities within the same department that have very different cultural, social and economic features, in addition to great distances and geographical barriers between them. This is why, in a new administrative design, the departments have established subregions, which enable an integrated response to needs, addressing the particular characteristics of each group of municipalities.

Santander department comprises the provinces of Soto, Guanenta, García Rovira, Comunera, Vélez and Mares, and is located in the southern part of the Cordillera Oriental mountain range. Its area represents 2.7 percent of the total land mass of the country.

In terms of the area's natural wealth and climate, the department's 2008–2011 Development Plan highlights that "it has a variable climate [and] due to the topography and humidity of each sub-region, there are climate areas ranging from warm, at heights of 100 metres or more above sea level and average temperatures of more than 28°C, to the high plateaux around 4,000 metres above sea level and with temperatures below 4°C. The department's relief is flat to undulating in the Magdalena Medio Valley, of alluvial origin. The rest corresponds to the western flank of the Cordillera Oriental mountains, where an

area of table mountains and plateaux of sedimentary origin can be identified, and which to the south of the department becomes cundí boyacense high plateau (altiplano), heavily folded, and the Santander massif, of igneous metamorphic origin."

Added to the diversity of soils and availability of water, this means the area offers great possibilities for agriculture and livestock rearing, with some variations within each of the provinces. In addition, within the department, a whole system of natural protected areas has been recognized in which progress is being made towards implementing policies and programmes that will provide for their care and protection.

Demographic dynamic

According to the 2005 census of the National Statistics Administrative Department (Departamento Administrativo Nacional de Estadísticas, DANE), the projected population for 2010 is 2,010,404 inhabitants, or 4.4 percent of the Colombian population, of which 49 percent are men and 51 percent women. Almost 27 percent live in rural areas.

The percentage growth in the population has fallen from 1.79 percent (1985–1993) to 1.75 percent (1993–2005). The urban population increased from 63.5 percent in 1985 to 73 percent in 2005; this urban concentration can be clearly seen in Bucaramanga and its metropolitan area (which includes the

municipalities of Bucaramanga, Floridablanca, Girón and Piedecuesta), where 53.5 percent of the department's population live (1,075,112 inhabitants).

The Raizal and Roma populations, along with settled indigenous groups, represent 0.124 percent of the total population (2,400 people), while Afro-Colombians account for 3.12 percent (around 59,700 people).

The demographic structure of Santander has undergone a number of changes over the last two decades (1985 to 2005), particularly with regard to the following age groups:

- The under-four age group fell from 12.5 percent in 1985 to 9 percent in 2005 (Colombia 2005: 9.9 percent).
- Women of childbearing age (15–49 years) represent 27.2 percent of the department's population, this figure being 26.9 percent nationally.
- The proportion of the department's population aged between 30 and 64 increased from 28.3 percent in 1985 to 37.5 percent in 2005.
- The Santander population over the age of 65 represented 6.9 percent of the total population in 2005 (3.8 percent women, 3.1 percent men), the national equivalent for the same year being only 6.2 percent (3.4 percent women, 2.8 percent men).

The average age of fertility has exhibited a downwards trend over the last 15 years (DANE 2005). Between 1985 and 1990, the average age at which a woman had her first child was 28.3 years, falling to 26.91 years for the period 2000–2005; for the country as a whole this figure fell from 27.2 years to 26.63 years over the same period. The number of children under the age of 5 per woman fell from 0.53 in 1985 to 0.34 in 2005, while for the country as a whole it fell from 0.53 to 0.38. The decline in the average

number of children under the age of 5 per woman was therefore greater in Santander over this period than in Colombia as a whole.

The department's overall fertility rate (the average number of children per woman) fell from 3.3 in 1985–1990 to 2.4 in 2000–2005. The equivalent average national rate fell from 3.34 to 2.6 children per woman, thus also declining but not as sharply as in the department.

According to the DANE 2005 Census, the department's under-15 age group represents 30 percent of the total population (Colombia: 31 percent); the same group accounted for 36.7 percent in the 1985 census.

Life expectancy at birth in the department was 68.9 years over the 1985–1990 period, and the DANE forecast is 74.3 years for 2005–2010; in Colombia as a whole the figure was 67.99 for the 1985–1990 period, with a projected figure of 74 for 2005–2010.

The gross mortality rate per 1,000 inhabitants in Santander fell from 6.17 deaths per thousand individuals over the period 1985–1990 to 6.03 for 2000–2005; in Colombia as a whole the rate was 6.77 for 1985–1990, falling to 5.95 for 2000–2005.

Economic dynamic

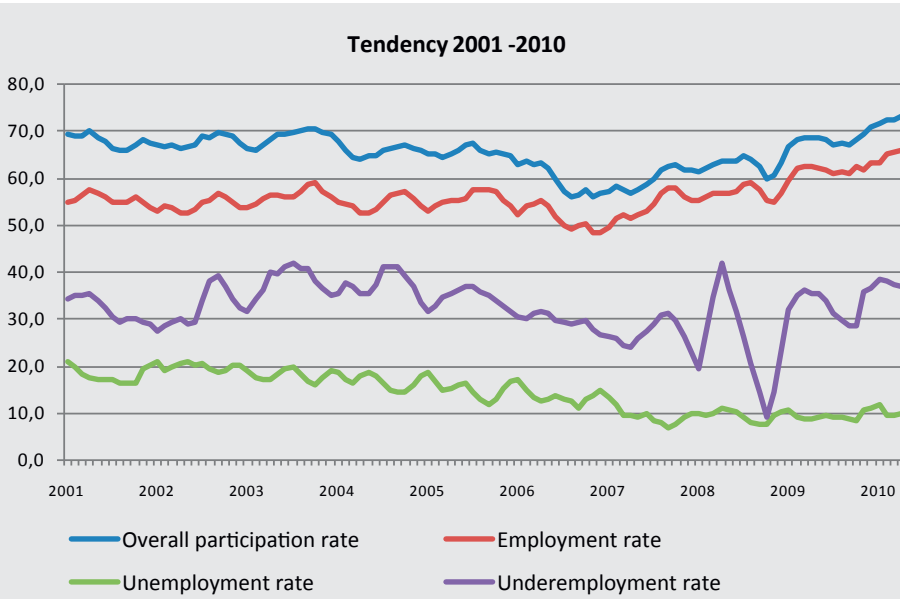
Santander has reduced poverty in recent years, but not at a speed that will enable it to achieve the MDG target by 2015. In 2005, half of the population (48.9 percent) was living in poverty and 14.6 percent in extreme poverty.

There are 498,648 households in the department, of which 162,842 suffer from some form of housing deficit (49 percent in urban areas and 51 percent in rural areas). 37 percent of this deficit is quantitative (60,049) and 63 percent is qualitative (102,793).¹

1) A qualitative housing deficit refers to the percentage of homes with low-quality flooring or walls, i.e., earth floors and walls that are unstable or unable to resist the elements. A quantitative housing deficit refers to the total number of households without a home.

FIGURE 1

OCCUPATION IN SANTANDER DEPARTMENT



Source: Bucaramanga Chamber of Commerce on the basis of DANE, quarterly rolling

According to DANE, the trend in unemployment was downwards in the metropolitan area, which has been a defining feature of the department overall, over the period 2001 to 2007. In 2001, the rate of employment was 56.1 percent, with an unemployment rate of 16.4 percent and a subjective underemployment rate² of 30.1 percent; for 2009, unemployment was 8.5 percent, below the national average (12

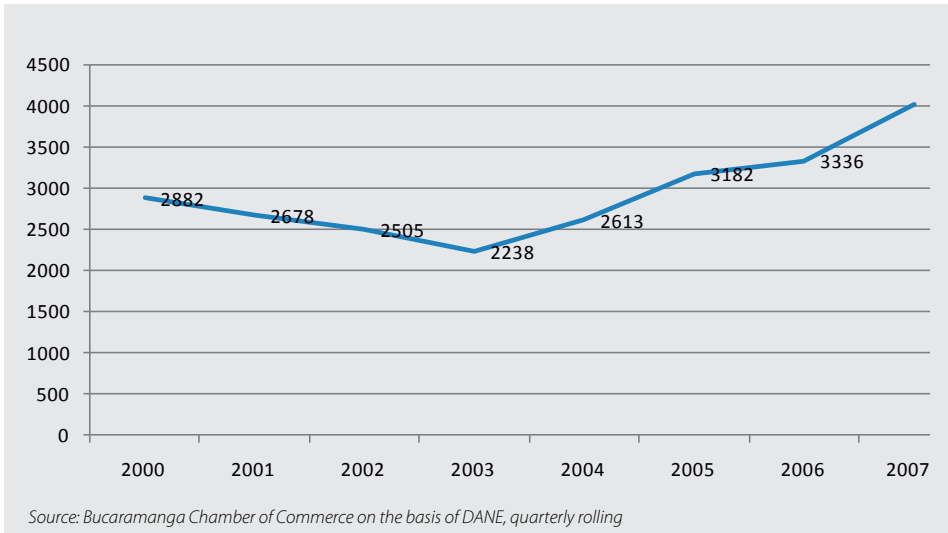
percent), and subjective underemployment was 28.7 percent, also below the national level for the same year (29.7 percent). The marked dip in subjective underemployment in 2008 is noteworthy, most likely explained by factors such as workers for some reason feeling happier with their income, with the number of hours worked or with the relevance of the work they were doing.

²) People who although they have a job, express their interest in changing jobs to improve their income, working hours or better match their occupation with their job profile.

Gross Domestic Product for the department (GDP) in 2007 (DANE provisional figures) showed an increase of 6.8 percent over the previous year and average growth of 5.8 percent over the 2000–2007 period; the mining, trade and services sectors, in that order, contributed most to this figure.

Per capita GDP for the year 2007, estimated in constant 2000 values, was \$4,019; however, the available data does not permit an evaluation of trends in this indicator in recent years, nor of the consequent effects of the global economic crisis.

FIGURE 2 PER CAPITA GDP IN SANTANDER



THE MDGS IN THE REGION

This section provides a general overview of the area's situation analysis. The main indicators for the area are given for each MDG and these are compared with the national or regional averages.

TABLE 1. STATUS AND TRENDS OF THE MDGS IN SANTANDER

MDG	Indicator	Country baseline	Santander baseline	Latest Santander data	2015 country target
1: Eradicate Extreme Poverty And Hunger	1.1 Proportion of people below poverty line	52.5% (1991)	48.8% (2002)	33.3% (2009)	28.5%
	1.2 Proportion of people below extreme poverty line	18.7% (1991)	15.3 (2002)	9.1 (2009)	8.8%
	1.3 Percentage of children under five years of age suffering general malnutrition, and underweight for their age	10% (1990)	4.8% (2005)	3% (2010)	3%
2: Achieve Universal Primary Education	2.1 Gross rate of coverage in preschool education	44.9% (1992)	ND	88.4% (2009)	85.3%
	2.2 Gross rate of coverage in basic primary education	114.6% (1992)	ND	107.6% (2009)	111.9%
	2.3 Gross rate of coverage in basic secondary education	75.5% (1992)	ND	101.9 (2009)	93.5%
	2.4 Illiteracy rate for persons between 15 and 24 years of age	2.4% (1992)	ND	1.92 (2005)	1%
	2.5 Gross rate of coverage in higher secondary education.	74.4% (1992)	ND	76.4 (2009)	93.2%
	2.6 Repetition rate in basic and higher secondary education	6.1% (1992)	ND	3.0 (2009)	2.3%
	2.7 School attendance, average years of education for persons between 15 and 24 years of age.	7 (1992)	ND	9.00 (2005)	10.6

MDG	Indicator	Country baseline	Santander baseline	Latest Santander data	2015 country target
3: Promote Gender Equality And Empower Women	3.1 Percentage of women in relationships having experienced physical abuse from their partners in the last year	19.9% (2000)	ND	26.2% (2005)	No target
4: Reduce Infant Mortality	4.1 MMR vaccination coverage	80% (2000)	84.2% (2007)	103.0% (2009)	95%
	4.2 DTP vaccination coverage	79% (2000)	70.9% (2002)	96.6% (2009)	95%
	4.3 Mortality among under-five children per 1,000 live births	37.4 (1990)	ND	12.10 (2008)	17.0
	4.4 Mortality in children less than one year old per 1,000 live births.	30.8 (1990)	ND	9.9 (2008)	14.0
5: Improve Maternal Health	5.1 Maternal mortality rate per 100,000 live births	104.9 (2000)	63 (2000)	33.71 (2008)	45.0
	5.2 Percentage of women receiving four or more antenatal checks	67% (1990)	ND	ND	90%
	5.3 Attendance at birthing centre	76% (1990)	ND	98.3 (2008)	95%
	5.4 Birth attended by skilled health personnel	81% (1990)	ND	99.4 (2008)	95%
	5.5 Rate of use of modern contraceptive methods among women currently in relationships including sexually active single women	59.3% (1995)	ND	68.4 (2005)	75%
	5.6 Percentage of expectant mothers aged between 15 and 19 years of age	36.7% (1995)	ND	20.19 (2008)	< 15%
	5.7 Deaths due to cervical cancer per 100,000 women	12.6 (1990)	9.44 (2005)	6.9 (2008)	5.5

MDG	Indicator	Country baseline	Santander baseline	Latest Santander data	2015 country target
6: Combat HIV/AIDS, Malaria and Other Diseases	6.1 Deaths due to malaria	180 (1990)	0 (2005)	0 (2010)	1.06
	6.2 Number of cases of malaria per 1 million inhabitants.	180 (1990)	304 (cases 2004)	69.64 (cases 2010)	9.6
	6.3 Deaths due to dengue fever	16 (1990)	ND	29 (2010)	1.43
	6.4 Prevalence of HIV/AIDS infection among the general 15 to 49 age group	0.7 (2004)	0.7 (2004)	ND	< 1.2%
	6.5 Deaths due to HIV/AIDS per hundred thousand inhabitants	3.7 (1998)	ND	6.13 (2008)	Reduce by 20%
7: Ensure Environmental Sustainability	7.1 Coverage of urban water supply	94.6% (1993)	97.4 (2003)	97.5 (2005)	99.4%
	7.2 Coverage of urban drainage system	81.8% (1993)	90.2 (2003)	93.9 (2005)	97.6%
	7.3 Coverage of rural water supply	41.4% (1993)	ND	66 (2003)	81.6%
	7.4 Coverage of basic rural sanitation	51% (1993)	ND	57.9 (2003)	70.9%
	7.5 Hectares reforested annually	121,848 (2003)	30,462 (2003)	1200 (2005)	938
	7.6 Percentage of parks with socially agreed management plans	0% (2003)	ND	6% (2005)	1%
	7.7 Percentage of households living in slum accommodation	16% (2003)	16% (2003)	6.6% (2005)	2020: 4%

THE MDGS IN THE POLICY CYCLE

UNDP Colombia's strategy for achieving the MDGs focuses on narrowing the gaps within the country, concentrating its actions at the departmental and municipal levels where these inequalities are most evident.

In its 2008–2011 Development Plan, Santander department identified the need for a regional public health policy that would direct public management towards maintaining the achievements in the sector but, above all, that would establish lines of action aimed at providing an integrated response to the issues that are causing the department to lag behind in terms of achieving the 2015 MDG targets in health.



SECTION 2:

**ACCELERATING MDG
ACHIEVEMENT**

Photo: UNICEF Colombia

PROGRESS AND CHALLENGES IN ACHIEVING THE PRIORITY MDGS

Given the critical nature of the department's health issues, the aim of the public policy that was drawn up was "to improve the health conditions of the Santander population in order to contribute to their integral development in all life cycles through intra- and inter-sectoral strategies and alliances and with local involvement, aimed at promoting the effective enjoyment of rights to health."

In order to establish which MDG would form the focus of the acceleration measures, the indicators for MDGs 4, 5 and 6 were considered insofar as they corresponded to health issues. The respective indicators for each MDG were analysed, with the exception of indicators on the use of methods of contraception, for which insufficient information was available.

The first action was to validate and reconcile the information for each health indicator. The following institutions were involved in applying the MAF methodology: the Santander health department and Bucaramanga city health department, the Public Health Observatory³, the Regional Observatory for Sustainable Human Development of the Industrial University of Santander⁴, PROFAMILIA⁵ and the UNDP MDG at the local level team, MDGL.

On the basis of the latest available information for each of the indicators and the targets set for compliance with the MDG targets, those showing gaps (i.e., indicators not being achieved) were identified and these were chosen for priority intervention.

The indicators for MDG 4 are very close to achieving the 2015 targets in Santander, as are those for MDG 5 with regard to maternal mortality, the percentage of births taking place in birthing centres and the percentage of births attended by skilled personnel. However, a number of local Colombian indicators considered important for improving the sexual and reproductive health of women and expectant mothers that were proposed through the Council for Social and Economic Policy (CONPES document 091, 2005) are currently lagging seriously behind in relation to the 2015 targets set by the country. These relate to the percentage of women receiving four or more antenatal checks, deaths due to cervical cancer and teenage pregnancies.

Of the indicators corresponding to MDG 6, the indicator for death due to dengue fever is also trailing considerably; it was, however, noted that this disease occurs cyclically in the region, meaning that its incidence will decline in some years only to reappear later.

3) The Santander Public Health Observatory (OSPES) is a body (privately run in order to retain its independence and autonomy but financed primarily through public resources) that has been established in the department as a single point of information that will be used as an input for decision-making, policy formulation and to guide actions aimed at improving people's health status and integrating the different sectors of the region's health system.

4) The Regional Observatory for Sustainable Human Development is a part of the Industrial University of Santander's Faculty of Social Work and its objective is to contribute to human development through observation, research and social action within the framework of the municipalities' public policy and, in general, the targets proposed by the UNDP with regard to the MDGs.

5) PROFAMILIA is the Association for the Well-being of the Colombian Family, a private not-for-profit organization specializing in sexual and reproductive health and which provides medical services, education and the sale of products to the Colombian population.

TABLE 2. GAP ANALYSIS OF THE 2015 TARGETS FOR HEALTH INDICATORS IN SANTANDER

Indicator	Latest data	Year of latest data	Source	Target
MMR vaccination coverage	103%	2009	PAISOFT	95%
DTP vaccination coverage	97.40%	2009	Departmental PAI report	95%
Mortality rate in under-fives per 1,000 live births	14.61	2007	DANE –Vital Statistics	17
Mortality rate for children under one year of age per 1,000 live births	11.89	2007	DANE –Vital Statistics	14
Maternal mortality rate per 100,000 live births	40.67	2009	Public health surveillance office Santander Department	45
Percentage of women receiving four or more antenatal checks	75.43%	2007	Public health surveillance office Santander Department	90%
Delivery in birthing centres	97.37%	2007	Public health surveillance office Santander department	95%
Birth attended by qualified staff	99%	2007	DANE –Vital Statistics	95%
Mortality rate due to cervical cancer per 100,000 women.	6.1	2007	DANE –Vital Statistics	5.5
Deaths due to malaria	0	2009	INS	34
No. of cases of malaria per 1,000 inhabitants.	0.031333333	2009	INS	9.6
Deaths due to dengue fever	4	2009	INS	2.04
Prevalence of HIV/AIDS infection among the General 15–49 age group	0.052450794	2009	INS	1.2
Women aged 15–19 who are pregnant or have given birth	20.24%	2007	ODHS calculations Based on Vital Statistics	15%

In light of the above, acceleration measures were implemented for MDG 5, and in relation to the following indicators: percentage of women receiving four or more antenatal checks, deaths due to cervical cancer, and teenage pregnancies.

1: STRATEGIC INTERVENTIONS

INTERVENTIONS ON THE PERCENTAGE OF WOMEN RECEIVING FOUR OR MORE ANTENATAL CHECKS:

Identified interventions:

- Manage consultancy work regionally and train the local health teams who identify expectant mothers and channel them towards the health services: early identification.
- Increase extramural (outreach) teams for antenatal care (medical and paramedical staff who travel to rural areas far from the health centres)⁶.
- Follow-up and monitor service providers at municipal level.
- Produce planning matrices that calculate the number of expectant mothers and, on this basis, plan interventions on a year-by-year basis.
- Define a policy that creates rules and regulations (bye-laws from the departmental assembly and agreements from the municipal councils), strategies and action plans.
- Improve the quality of antenatal checks via technical assistance from specialist staff at different levels in the care system, incorporating the strategies established in national public policies: Women- and Child-Friendly Institutions

(Instituciones Amigables de la Mujer y de la Infancia, IAMI); and Integral Care of Illnesses Prevalent in Early Childhood (Atención Integral de Enfermedades Prevalentes de la Primera Infancia, AIEPI).

- Coordinate with universities that have faculties of health in the department so that they can conduct ongoing training of the medical staff that are providing care and assessment of expectant mothers in the municipalities.
- Insurance for expectant mothers not affiliated to the health services (population not covered by the contributory health care system or the subsidized health system)⁷.
- Consolidate or set up youth and teenager-friendly services in sexual and reproductive health.
- Incorporate strategies into educational establishments aimed at providing sexuality education and instilling a sense of citizenship.

Priority interventions:

- Put in place extramural monitoring of expectant mothers.
- Produce planning matrices that calculate the number of expectant mothers and, on this basis, plan interventions on a year-by-year basis.
- Define a policy that creates rules and regulations, strategies and action plans.
- Set up insurance for expectant mothers not affiliated to the health services.

6) Extramural care is care that takes place outside of health institutions, reaching out to where vulnerable target groups are to be found, even right into their homes, with the aim of providing a package of care to priority and dispersed groups who fall within the sphere of influence of the health centre.

7) In Colombia, there are two forms of cover in the general system for social security in health care: the contributory system and the subsidized system. Although the country is progressing towards universal coverage, there are still people not covered by either of these two systems, and they are called 'linked population' ('población vinculada'); these are people who the State has identified as vulnerable but who have not yet obtained a place in the subsidized system and who receive priority care in the public health service system.

INTERVENTIONS ON TEENAGE PREGNANCIES:

Identified interventions:

- Design and implement strategies to establish youth clubs and teenage pregnancy prevention networks.
- Work with the child and teenage beneficiaries of the youth clubs so that they are recognized as subjects of rights, develop skills and competences that will enable them to define their life project and are able to exercise their sexuality responsibly.
- Design and implement communicational materials and games that provide teachers, families and community education workers with educational tools with which to promote sexual and reproductive rights and duties.
- Intersectoral coordination with the actors involved in order to produce a coordinated work proposal that includes processes of social mobilization and communication to prevent teenage pregnancies.
- Strengthen participatory sexual and reproductive health care programmes.

- Identify critical points in remote rural areas where problems and a lack of knowledge have been identified in relation to behaviour, attitudes and practices in sexual and reproductive health and rights amongst children, youths and adolescents, in order to intervene directly with programmes.

- Create and strengthen pregnancy prevention programmes that include sexuality education classes, medical clinics at schools, family planning surgeries and integrated community prevention programmes.

Priority interventions:

- Design and implement communicational materials and games so that teachers, families and community education workers have educational tools with which to promote sexual and reproductive rights and duties.
- Identify critical points in remote rural areas where problems and a lack of knowledge have been identified in relation to behaviour, attitudes and practices in sexual and reproductive health and rights amongst children, youths and adolescents in order to intervene directly with programmes.

INTERVENTIONS TO REDUCE THE DEATH RATE DUE TO CERVICAL CANCER:

Identified interventions:

- Raise awareness among and train health teams on sexual and reproductive health, specifically the issue of cervical cancer.
- Strengthen academic thought within health-related faculties of universities on issues of sexual and reproductive health.
- Promote greater demand among the population for health services that conduct cervico-uterine cytology.
- Establish effective surveillance parameters for appropriate interpretation of cytology and timely provision of results.
- Guarantee the full provision of cytology results, referrals for diagnosis confirmation and access to treatment, should it be required.
- Strengthen public and private Information, Education and Communication strategies on issues of sexual and reproductive health rights and duties.

- Ensure that health service providers and the governing bodies (departmental and municipal health departments) define responsibilities with regard to identifying the target population for cytology tests, using available databases.

- Coordinate alliances between educational establishments to strengthen sexual and reproductive health programmes, specifically for conducting and interpreting tests and providing the results of cervico-uterine cytology.

- Ensure adequate logistics (infrastructure, equipment, human resources) on the part of health service providers and regional authorities.

Priority interventions:

- Raise awareness among and train health teams in areas of sexual and reproductive health, specifically the issue of cervical cancer.
- Guarantee the full provision of cytology results, referrals for diagnosis confirmation and access to treatment, should it be required.

TABLE 3. TABLE SUMMARIZING THE PRIORITY INTERVENTIONS IN SANTANDER DEPARTMENT IN RELATION TO MDG 5

MDG	Indicator	#	Priority interventions	#	Activities
Priority Area: Health					
Objective 5: Improve Maternal Health	5.2 Percentage of women having four or more antenatal checks	5.2.1	Extramural antenatal check	5.2.1.1	Manage consultancy work regionally and train local health teams who identify expectant mothers and channel them towards the health services
				5.2.1.2	Extramural monitoring of expectant mothers
				5.2.1.3	Strategies for early identification of expectant mothers
				5.2.1.4	Follow-up and monitoring of insurance companies to ensure fulfilment of health promotion and disease prevention activities
		5.2.2	Produce planning matrices that calculate the number of expectant mothers and, on this basis, plan interventions on a year-by-year basis	5.2.2.1	Consolidate the matrices produced by the different bodies responsible (insurance companies and service providers)
				5.2.2.2	Set targets
				5.2.2.3	Monitor targets
		5.2.3	Define a policy that creates rules and regulations (bye-laws from the departmental assembly and agreements from the municipal councils), strategies and action plans	5.2.3.1	Implementation of the AIEPI strategy
				5.2.3.2	Implement the IAMI strategy
		5.2.4	Insurance cover for expectant mothers not covered by the Social Security System for Health.	5.2.4.1	Conduct the Sisben survey
				5.2.4.2	Prioritize mothers for affiliation to the subsidized system
				5.2.4.3	Affiliation to the entidades Prestadoras de Salud, EPS (health-promoting bodies)

5.6 Percentage of expectant mothers aged between 15 and 19 years of age.	5.6.1	Design and implement communicational materials and games so that teachers, families and community education workers have educational tools with which to promote sexual and reproductive rights and duties	5.6.1.1	Design materials
			5.6.1.2	Produce communicational materials and games
			5.6.1.3	Popularize the materials among teachers, families and community
			5.6.1.4	Implement the strategy using the educational tools produced
	5.6.2	Identify critical points in remote rural areas where problems and a lack of knowledge have been identified in relation to behaviour, attitudes and practices in sexual and reproductive health and rights amongst children, youths and adolescents in order to intervene directly with programmes	5.6.2.1	Analyse information on victims of violence and displacement
			5.6.2.2	Pinpoint the intervention's target groups
5.7 Death rate from cervical cancer	5.7.1	Raise awareness among and train health teams on the main issues relating to cervical cancer	5.7.1.1	Workshops to train and update staff who take cervico-uterine cytology samples
			5.7.1.2	Train cytotechnologists
			5.7.1.3	Train health prevention coordinators so that they can provide prompt results to all women who are tested
			5.7.1.4	Train and update doctors in the protocol for patients with positive cytology
	5.7.2	Guarantee the full provision of cytology results	5.7.2.1	Design logistics to trace the results and deliver them to women
			5.7.2.2	Design and implement a follow-up protocol for women with positive cytology results

2: ANALYSIS OF BOTTLENECKS

BOTTLENECKS IN THE 'NUMBER OF ANTENATAL CHECKS' INDICATOR

Intervention (5.2.1): Extramural antenatal check

Bottlenecks identified:

- insufficient and inadequately qualified human resources;
- difficulty in accessing the service for women, and transportation difficulties for outreach teams reaching expectant mothers;
- lack of security and changes in public order;
- no standardized model of care;
- insufficient financial resources;
- constant administrative barriers;
- cultural barriers to attending antenatal checks.

Priority bottlenecks:

- Difficulty in women accessing the service and transportation difficulties for the outreach teams reaching expectant mothers;
- Insufficient and inadequately qualified human resources.

(5.2.2) Produce planning matrices that calculate the number of expectant mothers and plan interventions accordingly on a year-by-year basis

Bottlenecks identified:

- data not contextualized nor correctly geo-referenced. The data provided by the national statistics authority does not correspond to observations on the ground;
- difficulties in accessing information system reports because only one or a few regional-level civil servants know how to use and operate the system;
- no homogeneity or standardization across municipal-level systems for gathering, analysing and processing information;
- inadequate problem-solving capacity to adjust service provision to changes in the natural population growth rate and migratory flows observed yearly
- difficulties in identifying minority groups such as indigenous and black peoples, displaced groups and Roma population.

Priority bottlenecks:

- inadequate problem-solving capacity to adjust service provision to changes in the natural population growth rate and migratory flows observed year-on-year.

(5.2.3) Define a policy that creates rules and regulations (bye-laws from the departmental assembly and agreements from the municipal councils), strategies and action plans

Bottlenecks identified:

- relevant authorities are unaware of their tasks and responsibilities and there has been a failure to adopt centrally established standards at the municipal or regional authority level;

- sectorization of health responsibilities, whereas intersectoral work is required.

Priority bottlenecks:

- relevant authorities are unaware of their tasks and responsibilities and there has been a failure to adopt centrally established standards at the municipal or regional authority level.

(5.2.4) Insurance for expectant mothers not affiliated to the Social Security System for Health

Bottlenecks identified:

- lack of knowledge of the regulations on the part of those responsible (mayors) for registration with the Social Security System for Health
- failure to identify all expectant mothers;
- geographical distance, dispersal of the population and difficulties in accessing insurance;

- excessive bureaucracy involved in registering;
- lack of knowledge of rights and duties on the part of expectant mothers;
- little sense of joint responsibility on the part of members of the family unit and close circle of the expectant mother, particularly teenagers.

Priority bottlenecks:

- lack of knowledge of the regulations on the part of those responsible (mayors) for registration with the Social Security System for Health;
- little sense of joint responsibility on the part of members of the family unit and close circle of the expectant mother, particularly teenagers.
- difficulties in identifying all expectant mothers in the municipalities, particularly in dispersed rural areas.

BOTTLENECKS IN THE 'TEENAGE PREGNANCIES' INDICATOR

(5.6.1) Design and implement communicational materials and games so that teachers, families and community education workers have educational tools with which to promote sexual and reproductive rights and duties

Bottlenecks identified:

- materials and activities aimed at the different target groups are written in excessively technical language and are not child- or youth-friendly;
- staff responsible for implementing the tools are not adequately trained; lack of follow-up, monitoring and supervision of the actions implemented;
- little interest among the target group in participating or obtaining information;
- lack of a baseline for the actions to be implemented.

Priority bottlenecks:

- materials and activities aimed at the different target groups are written in excessively technical language and are not child- or youth-friendly;
- little interest among the target group in participating or obtaining information.

(5.6.2) Identify critical points in remote rural areas where problems and a lack of knowledge have been identified in relation to behaviour, attitudes and practices in sexual and reproductive health and rights amongst children, youths and adolescents in order to intervene directly with programmes.

Bottlenecks identified:

- lack of a municipal-level geographic information system containing disaggregated demographic data that could be used as the intervention's baseline;
- lack of impact studies, by population, geography and scope;
- high number of sexual and reproductive health projects with irrelevant content and ill-adapted to the context of youth in Santander department;
- lack of tools with which to identify behaviour, attitudes and practices in sexual and reproductive health amongst children, youths and adolescents.

Priority bottlenecks:

- lack of impact studies, by population, geography and scope;
- high number of sexual and reproductive health projects with irrelevant content and ill-adapted to the context of youth in Santander department

BOTTLENECKS IN THE 'CERVICAL CANCER' INDICATOR

(5.7.1) Raise awareness among health teams and train them in the main issues relating to cervical cancer

Bottlenecks identified:

- weaknesses in identifying the required profiles of professional trainers with recognized expertise and knowledge in cervical cancer;
- high turnover of trained staff;
- low requirements in terms of the technical specifications for the outputs provided during the training (training to be contracted by the department and aimed at the administrative and medical staff of municipal-level health institutions);
- insufficient resources for training, in both human and financial terms, and in terms of training materials;
- lack of continuing education programmes that are coordinated between academia (universities) and the health departments;
- difficulties in planning and producing timetables for training on priority public health issues.

Priority bottlenecks:

- weaknesses in identifying the required profiles of professional trainers with recognized expertise and knowledge in cervical cancer;
- low requirements in terms of the technical specifications for the outputs provided during the training (training to be contracted by the

department and aimed at the administrative and medical staff of municipal-level health institutions).

(5.7.2) Guarantee the full provision of cytology results, referrals for diagnosis confirmation and access to treatment, if required

Bottlenecks identified:

- lack of a system that analyses delays in interpreting and returning test results and referring patients, and identifies the causes at municipal level;
- weaknesses in the Information, Education and Communication (IEC) strategy with regard to testing and providing users with the results at departmental and municipal level;
- delays in conducting tests and providing their results;
- weak follow-up and monitoring by service providers in positive cases of cervical cancer encountered;
- lack of interest on the part of service providers to provide care for the illness, given the high costs of treatment.

Priority bottlenecks:

- delays in conducting tests and providing their results;
- weak follow-up and monitoring by service providers in positive cases of cervical cancer encountered.

TABLE 4. SUMMARY OF BOTTLENECKS IN THE PRIORITY INTERVENTIONS FOR MDG 5:
IMPROVE MATERNAL HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH IN SANTANDER DEPARTMENT

MDG	MDG Indicator	Priority interventions	Priority bottlenecks	Category of Bottleneck
Objective 5: Improve maternal health and sexual.	5.2 Percentage of women having four or more antenatal checks	5.2.1 Extramural antenatal check	Physical barriers: Difficulty for women in accessing the service and transportation difficulties for the outreach teams reaching expectant mothers	Service provision (supply)
			Human resources: Insufficient and inadequately qualified human resources	Service provision (supply)
		5.2.2 Produce planning matrices that calculate the number of expectant mothers and, on this basis, plan interventions on a year-by-year basis	Information systems: Inadequate problem-solving capacity to adjust service provision to changes in the natural population growth rate and migratory flows observed year-on-year	Policy and planning
		5.2.3 Define a strategy that creates rules and regulations and action plans	Human resources and follow up/monitoring: Lack of knowledge of tasks and responsibilities on the part of relevant authorities and a failure to adopt centrally established standards at the municipal or regional authority level	Service provision (supply) Policy and planning
		5.2.4 Insurance for expectant mothers not affiliated to the Social Security System for Health	Human resources: Lack of knowledge of the regulations on the part of those responsible (mayors) for registration with the Social Security System for Health	Policy and planning
			Social commitment and sensitivity: Little sense of joint responsibility on the part of members of the family unit and close circle of the expectant mother, particularly teenagers	Service use (demand)

MDG	MDG Indicator	Priority interventions	Priority bottlenecks	Category of Bottleneck
Objective 5: Improve maternal health.	5.6 Percentage of expectant mothers aged between 15 and 19 years of age.	5.6.1 Design and implement communicational materials and games	Demographic differentiation: Materials and activities aimed at the different target groups are written in excessively technical language and are not child- or youth-friendly	Service provision (supply)
			Participation: Little interest among the target group in participating or obtaining information	Service provision (supply)
		5.6.2 Identify critical points in remote rural areas where problems and a lack of knowledge have been identified in relation to behaviour, attitudes and practices in sexual and reproductive health and rights amongst children, youths and adolescents in order to intervene directly with programmes	Information systems: Lack of streamlined data for identifying the psychosocial state of target groups on the part of institutions involved	Policy and planning
Objective 5: Improve maternal health.	5.7 Death rate from cervical cancer	5.7.1 Raise awareness among and train health teams in the main issues relating to cervical cancer	Service provision: Low requirements in terms of the technical specifications for the outputs provided during the training (training to be contracted by the department and aimed at the administrative and medical staff of municipal-level health institutions)	Service provision (supply)
			Human resources: Weaknesses in identifying the required profiles of professional trainers with recognized expertise and knowledge in cervical cancer	Service provision (supply)
		5.7.2 Guarantee the full provision of cytology results, referrals for diagnosis confirmation and access to treatment, should it be required	Physical barriers: Delays in conducting tests and providing the results	Service provision (supply)
			Information systems: Weak follow-up and monitoring by service providers in positive cases of cervical cancer encountered	Policy and planning

3: ACCELERATING PROGRESS TOWARDS THE MDGS: IDENTIFYING SOLUTIONS

This section focuses on solutions of proven efficacy at the local level and which have the potential to be expanded or strengthened. It also recognises the possibility of planning and implementing solutions which may not yet have been implemented in Colombia but, given their feasibility and possible outcomes in the short or medium term, should be given consideration in order to accelerate achievement of the 2015 targets.

The proposed solutions presented here are the result of an analysis undertaken by local experts and officials from the departmental and municipal authorities of Bucaramanga, the Industrial University of Santander (UIS), the Higher School of Public Administration (ESAP), the Observatory for Development and Human Rights, the Santander Public Health Observatory, Profamilia, the Santander Ophthalmological Foundation (FOSCAL) and professionals with recognised expertise and knowledge who participated in the working groups. They took into account criteria of viability, governability, short-term effects, equality, and availability of actors to contribute to the solution and financial resources.

SOLUTIONS TO PRIORITY BOTTLENECKS IN THE 'NUMBER OF ANTENATAL CHECKS' INDICATOR

Priority intervention 5.2.1: Extramural antenatal check

Bottleneck:

- difficulty for women in accessing services and transportation difficulties for the outreach teams reaching expectant mothers.

Proposed solutions:

- identify typical critical areas in order to adapt and provide medicalized forms of transport, such as motorized ambulances, that are appropriate and adapted to the geographical conditions;
- establish clinics that provide basic care, risk identification and referral in areas of poor access;
- establish drop-in centres in urban districts of the municipalities where critical access areas have been identified;
- set up a community alert and communication network for emergencies, with established protocols;
- educational strategies in the communities to encourage demand, raise awareness of rights and duties and identify risk factors.

Proposed priority solutions:

- identify typical critical areas in order to adapt and provide medicalized forms of transport, such as motorized ambulances, that are appropriate and adapted to the geographical conditions;

- set up a community alert and communication network for emergencies, with established protocols;
- educational strategies in the communities to encourage demand, raise awareness of rights and duties and identify risk factors.

Bottleneck:

- insufficient and inadequately qualified human resources.

Proposed solutions:

- strengthen academic programmes via training on technical standards for health professionals, linked to regional universities;
- Form strategic alliances between the regional authority, service providers and insurance companies in order to strengthen the quality and quantity of the teams;
- provide support to health service providers, both public and private, in order to improve the quality of care for expectant mothers and infants, via integral strategies such as IIAMI-AIEPI;
- coordinate and strengthen community and institutional groups for promotion and prevention measures;
- review the curricula for professional courses related to the health sector in order to include the needs of expectant mothers and families;
- knowledge management in order to identify and address public health issues affecting expectant mothers and newborn babies;
- identify priority public health issues and promote scientific research in this regard;

- transfer skills to remote health teams via the use of Information and Communication Technologies (ICT), specifically telemedicine.

Proposed priority solutions:

- strengthen academic programmes via training on technical standards for health professionals, linked to regional universities;
- provide support to health service providers, both public and private, in order to improve the quality of care for expectant mothers and infants, via integral strategies such as IIAMI–AIEPI;
- transfer skills to remote health teams via the use of ICT, specifically telemedicine.

5.2.2 Produce planning matrices that calculate the number of expectant mothers and, on this basis, plan interventions on a year-by-year basis

Bottleneck

- inadequate problem-solving capacity to adjust service provision to changes in the natural population growth rate and migratory flows observed year-on-year.

Proposed solutions:

- strengthen the Santander public health observatory as validation agent for information and data and which also analyses, reports on and issues research proposals through ‘situation rooms’ (human, technological team, resources);
- ensure prompt reporting of information on the part of all actors and improvements in the way in which information is reported, processed and delivered via administrative records;

- support and qualified involvement of the Public Prosecutor’s Office in order to validate the information at the different regional levels.

Prioritized proposed solution:

- strengthen the Santander public health observatory as validation agent for information and data and which also analyses, reports on and issues research proposals through ‘situation rooms’ (human, technological team, resources).

5.2.3 Define a strategy that creates rules and regulations and action plans

Bottleneck

- relevant authorities are unaware of their tasks and responsibilities and there is a failure to adopt centrally established standards within the municipal or regional authority.

Proposed solutions:

- train and raise awareness of standards among mayors, councils and sectors involved at municipal level;
- strengthen spaces for civic participation and control (user associations, review panels, community health participation committees (COPACOS), among others);
- establish ongoing monitoring and follow-up mechanisms to ensure regional-level compliance with standards;
- education and training in knowledge and enforceability of rights.

Proposed priority solutions:

- train and raise awareness of standards among mayors, councils and sectors involved at municipal level;
- strengthen spaces for civic participation and control (user associations, review panels, COPACOS and so on).

5.2.4 Insurance for expectant mothers not affiliated to the Social Security System for Health

Bottleneck

- lack of knowledge of the regulations on the part of those responsible (mayors) for registration with the Social Security System for Health.

Proposed solutions:

- develop educational/communicational strategies (Information, Communication and Education) to raise awareness of the regulations;
- publish the regulations in the regional and local media;
- encourage local governments to implement new regulations through positive incentives; strengthen the transfer of knowledge of the results of the participatory groups aimed at applying the regulations;
- obtain support for the mayor from academia and government in terms of his management of local insurance issues.

Proposed priority solutions:

- publish the regulations in the regional and local media.
- obtain support for the mayor from academia and government in terms of his management of local insurance issues.

Bottleneck

- little sense of joint responsibility on the part of members of the family unit and close circle of the expectant mother, particularly teenagers.

Proposed solutions:

- develop and implement educational and communication strategies for the expectant mother's close social network;
- develop and implement Information, Education and Communication social mobilization strategies;
- promote service provider compliance with the expectant mother's rights and duties.

Proposed priority solutions:

- develop and implement educational and communication strategies for the expectant mother's close social network.

SOLUTIONS TO PRIORITY BOTTLENECKS IN THE 'TEENAGE PREGNANCIES' INDICATOR

5.6.1 Design and implement communicational materials

Bottleneck

- materials and activities aimed at the different target groups are written in excessively technical language and are not child- or youth-friendly.

Proposed solutions:

- identify the target group by age, income, education and geographic location and involve them in producing materials and games aimed at young people;
- adapt successful experiences of producing communicational materials and games;
- bring together interdisciplinary teams with experience in the issues to jointly produce the models to be implemented, with the involvement of teachers, parents and teenagers.

Proposed priority solutions:

- bring together interdisciplinary teams with experience in the issues to jointly produce the models to be implemented, with the involvement of teachers, parents and teenagers.

Bottleneck

- Little interest in participating or obtaining information on the part of the target group (teenagers and youths).

Proposed solutions:

- hire appropriate staff to implement the tools to be developed;

- seek out the appropriate environment in which to implement communicational strategies and games, bearing in mind geographic location and age group, thus aiming for participant satisfaction;
- implement strategies to make the tools more enjoyable and dynamic, make appropriate use of educational methods in the actions to be developed;
- develop strategies for peer training and communication so that it is the young people themselves who transmit messages and training to other young people.

Proposed priority solutions:

- develop strategies for peer training and communication so that it is the young people themselves who transmit messages and training to other young people.

5.6.2 Identify critical points in remote rural areas where problems and a lack of knowledge have been identified in relation to behaviour, attitudes and practices in sexual and reproductive health and rights amongst children, youths and adolescents in order to intervene directly with programmes

Bottleneck

- lack of impact studies by population, geography and scope.

Proposed solutions:

- assess the level of education and training of target group families;

- train the health staff that carry out antenatal checks to analyse the psychosocial state of expectant teenagers at the first appointment, with the aim of avoiding a second pregnancy in the future;
- conduct studies or implement monitoring among the population in vulnerable areas;
- use geographic information system tools already existing in the areas as a baseline for implementing the activity;
- on the basis of municipal, regional and national plans, produce geographic information systems to hold and process relevant public health information;
- streamline the data existing within the governing bodies with regard to numbers of teenage pregnancies, and correlate this with the information systems.

Proposed priority solutions:

- train the health staff that carry out antenatal checks to analyse the psychosocial state of expectant teenagers at the first appointment, with the aim of avoiding a second pregnancy in the future;
- on the basis of municipal, regional and national plans, produce geographic information systems to hold and process relevant public health information.

Bottleneck

- high number of sexual and reproductive health projects with irrelevant content and ill-adapted to the context of youth in Santander department.

Proposed solutions:

- undertake studies in the public sectors or in health centres with a high proportion of teenage users to create a database from which critical intervention points can be identified;
- produce action plans that will have an organized impact on the focal points identified for intervention;
- find support groups and professionals with recognized expertise and knowledge in mental health to intervene with the target group;
- produce measurable and verifiable indicators of impact and outcome and achievable targets, making optimum use of existing resources;
- monitor and audit the contracting of the design and implementation of public health plans and programmes;
- coordinate the management of the departmental and municipal health departments (governing bodies) with that of the community.

Proposed priority solutions:

- coordinate the management of the departmental and municipal health departments (governing bodies) with that of the community;
- produce measurable and verifiable indicators of impact and outcome and achievable targets, making optimum use of existing resources;
- monitor and audit the contracting of the design and implementation of public health plans and programmes.

SOLUTIONS TO PRIORITY BOTTLENECKS IN THE 'MORTALITY DUE TO CERVICAL CANCER' INDICATOR

5.7.1 Raise awareness among and train health teams in the main issues relating to cervical cancer

Bottleneck

- weaknesses in identifying professional trainers with recognized expertise and knowledge in cervical cancer

Proposed solutions:

- establish a team of professionals with recognized expertise and knowledge who can serve as trainers for health administrators, defining parameters and needs in order to intervene in specific cervical cancer issues;
- implement a strategy of cross-cutting cooperation that calls on support from the institutions specializing in the treatment of cervical cancer and validates databases of professionals with recognized expertise and knowledge.

Proposed priority solution:

- establish a team of professionals with recognized expertise and knowledge who can serve as trainers for health administrators, defining parameters and needs in order to intervene in specific cervical cancer issues.

Bottleneck

- low requirements in terms of the technical specifications for the outputs provided during the training (training to be contracted by the department and aimed at the administrative and medical staff of municipal-level health institutions)

Proposed solutions:

- ensure compliance of the technical services responsible for producing the specifications and requirements for the public health training, which will subsequently be contracted out;
- approve the technical specifications to meet international standards for the training and outputs to be delivered;
- validate the specifications with a committee of experts, to include the Pan-American Health Organization (PAHO);
- Establish royalties and publication registries for the outputs provided in the training;
- Define a framework training programme on cervical cancer aimed at state employees, which includes levels and forms of care, competences and defined responsibilities.

Proposed priority solutions:

- Define a framework training programme on cervical cancer aimed at state employees, which includes levels and forms of care, competences and defined responsibilities.

5.7.2 Guarantee the full provision of cytology results, referrals for diagnosis confirmation and access to treatment, should it be required

Bottleneck

- delays between conducting tests and providing the results

Proposed solutions:

- define time-scales for delivery at different levels of care;
- purchase and use high-tech equipment that will enable cytology results to be rapidly accessed in remote (rural) areas;
- prioritize the delivery of results and medical referrals for those samples that flag up a possible risk for the patient;
- strengthen communication mechanisms between the service provider and the patient in order to ensure that delays between conducting the test and receiving the result are eliminated;
- ensure that the health service provider has the necessary equipment and resources for conducting and interpreting tests and providing results;
- strengthen the governing bodies' auditing mechanisms with regard to health service providers, so that they comply with the regulatory standards and quality controls.

Proposed priority solutions:

- purchase and use high-tech equipment that will enable cytology results to be rapidly accessed in remote (rural) areas;

- prioritise the delivery of results and medical referrals for those samples that flag up a possible risk for the patient;

- strengthen communication mechanisms between the service provider and the patient in order to ensure that delays between conducting the test and receiving the result are eliminated.

Bottleneck

- weak follow-up and monitoring by service providers in positive cases of cervical cancer encountered.

Proposed solutions:

- establish a critical path for care and monitoring of women diagnosed with cervical cancer
- implement mechanisms to ensure that there is direct contact between the service provider and patient diagnosed with cervical cancer;
- have positive results of cervical cancer delivered directly to the attending doctor;
- produce a monitoring and control matrix, ensuring that the service provider uses mechanisms such as the patient's records and history, creating early warnings in each case;
- include patients diagnosed with cervical cancer in programmes of health promotion and disease prevention and programmes of continuing care for chronic illnesses;
- prioritize the municipalities with the highest rates of cervical cancer in order to obtain improvements in quality and promptness of care and ensure follow-up via the corresponding reports;

- ensure that care is appropriate to age, sociocultural conditions and place of residence (rural/urban).

Proposed priority solutions:

- include patients diagnosed with cervical cancer in programmes of health promotion and continuing care for chronic illnesses;

- ensure that care is appropriate to age, sociocultural conditions and place of residence (rural /urban).

TABLE 5. SUMMARY OF THE ACCELERATION STRATEGY FOR MDG 5 IN SANTANDER DEPARTMENT

MDG	MDG indicator	Priority interventions	Priority bottlenecks	Indicative acceleration solutions 2010 – 2015	Potential partners
Objective 5: Improve maternal health	5.2 Percentage of women having four or more antenatal checks	5.2.1 Extramural antenatal check	Physical barriers: Difficulty in women accessing the service and transportation difficulties for the outreach teams reaching expectant mothers	5.2.1.1 Appropriate means of transport: Identify typical critical zones in order to adapt and provide medicalized forms of transport, such as motorized ambulances, that are appropriate and adapted to the geographical conditions	- Santander Planning Department - Agustin Codazzi Geographical Institute - Santander Health Department
				5.2.1.2 Community training and awareness-raising: Educational strategies in dispersed and remote communities to encourage demand, raise awareness of rights and duties and identify risk factors	- UIS
				5.2.1.3 New forms of communication: Set up a community alert and communication network for emergencies, with established protocols	- Ministry of Technologies, Information and Communication - PAHO - UNFPA
			Human resources: Insufficient and inadequately qualified human resources	5.2.1.4 Academic training: Academic strengthening of health professionals through training provided by the faculties of medicine of the department's universities, via intensive courses on technical standards	- UIS
				5.2.1.5 Technology: Transfer of skills to remote health teams through the use of ICT, specifically telemedicine	- SENA - Ministry of Technologies, Information and Communication
				5.2.1.6 Institutional strengthening: Strengthen the leadership role of the department and raise the awareness of health service providers, both public and private, in order to improve the quality of care for expectant mothers and infants, via integral strategies such as Women	- PAHO - UNDP

MDG	MDG indicator	Priority interventions	Priority bottlenecks	Indicative acceleration solutions 2010 – 2015	Potential partners
		5.2.2 Produce planning matrices that calculate the number of expectant mothers and, on this basis, plan interventions on a year-by-year basis	Information systems: Inadequate problem-solving capacity to adjust service provision to changes in the natural population growth rate and migratory flows observed year-on-year	5.2.2.1 Improve the provision of reliable data: Strengthen the Santander public health observatory as a validation agent for information and data, which also analyses, reports on and issues research proposals through 'situation rooms' (human, technological team, resources)	<ul style="list-style-type: none"> - UNDP - UIS - Higher School of Public Administration (ESAP)
		5.2.3 Define a strategy that creates rules and regulations and action plans	Human resources and follow up/monitoring: Lack of knowledge of tasks and responsibilities on the part of the relevant authorities and a failure to adopt centrally established standards at the municipal or regional authority level	5.2.3.1 Community training and awareness-raising: Strengthen spaces for civic participation and control (user associations, review panels, COPACOS and so on) 5.2.3.2 Institutional strengthening: Train and raise awareness of standards among mayors, councils and sectors involved at municipal level	<ul style="list-style-type: none"> -UNDP -UIS -ESAP
		5.2.4 Insurance for expectant mothers not affiliated to the Social Security System for Health	Human resources: Lack of knowledge of the regulations on the part of those responsible for insurance (mayors)	5.2.4.1 Communications strategy: Publication of the regulations in the mass media 5.2.4.2 Institutional strengthening: Support the mayor's management role as person responsible for local insurance	<ul style="list-style-type: none"> - Ministry of Technologies, Information and Communication. - Departmental community broadcasters - Department's commercial broadcasting companies
			Social commitment and sensitivity: Little sense of joint responsibility on the part of members of the family unit and close circle of the expectant mother, particularly teenagers	5.2.4.3 Community training and awareness-raising: Develop and implement educational and communication strategies for the expectant mother's close social network	<ul style="list-style-type: none"> -Santander Planning Departmental -UNDP -UIS -ESAP

MDG	MDG Indicator	Priority interventions	Priority bottlenecks	Indicative acceleration solutions 2010–2015	Potential partners
Objective 5: Improve maternal health	5.6 Percentage of expectant mothers aged between 15 and 19 years of age.	5.6.1 Design and implement communicational materials and games	Demographic differentiation: Materials and activities aimed at the different target groups are written in excessively technical language and are not child- or youth-friendly	5.6.1.1 Training and information: Bring together interdisciplinary teams with experience of the issues to jointly produce the models to be implemented, with the involvement of teachers, parents and teenagers, and professionals with recognized expertise and knowledge	<ul style="list-style-type: none"> - UNFPA - PAHO - Ministry for Social Protection - Parents' associations - Department of Education - Department of Health - Teachers and schools
			Participation: Little interest among the target group to participate or obtain information	5.6.1.2 Peer training: Implement strategies for peer training and communication so that it is the young people themselves who transmit messages, information and training to other youths (Design new communication models so that the information reaches teenagers clearly and achieves the intended effect of reducing teenage pregnancies)	<ul style="list-style-type: none"> - UNFPA - Institute for Interdisciplinary Programmes of Primary Health Care (PROINAPSA) - UIS - Department of Education - Department of Health
		5.6.2 Identify critical points in remote rural areas where problems and a lack of knowledge have been identified in relation to behaviour, attitudes and practices in sexual and reproductive health and rights amongst children, youths and adolescents in order to intervene directly with programmes	Information: Lack of impact studies by population, geography and scope	5.6.2.1 Strengthen antenatal checks for teenagers: Train the health staff that carry out antenatal checks to analyse the psychosocial state of expectant teenagers at the first appointment, with the aim of avoiding a second pregnancy in the future	<ul style="list-style-type: none"> - PROFAMILIA - Association of Private Clinics - UNFPA - Ministry of Health
			Targeting: High number of sexual and reproductive health projects with irrelevant content and ill-adapted to the context of youth in Santander department	5.6.2.2 Information systems: Store and process relevant public health information on geo-referenced demographic, social, economic, cultural and public indicators, a key input for decision-making	Public health observatory, Department of Health, FOSCAL Foundation, UNDP
				5.6.2.3 Definition of needs: Coordinate management and communication between the governing bodies and the community	<ul style="list-style-type: none"> - Department of Health - Health service providers and institutions - Community action group - Parent groups - Youth groups
				5.6.2.4 Monitoring and follow-up: Produce measurable and verifiable indicators of impact and outcome and achievable targets, making optimum use of existing resources	<ul style="list-style-type: none"> - Santander public health observatory - Department of Health - FOSCAL Foundation - UNDP
				5.6.2.5 Concentration of efforts: Monitor and audit in detail the (contracted out) design and implementation of public health plans and programmes related to sexual and reproductive health	<ul style="list-style-type: none"> - Santander Health Department

MDG	MDG Indicator	Priority interventions	Priority bottlenecks	Indicative acceleration solutions 2010–2015	Potential partners	
Objective 5: Improve maternal health	5.7 Death rate from cervical cancer	5.7.1 Raise awareness among and train health teams in the main issues relating to cervical cancer	Service provision: Low requirements in the technical specifications for the outputs to be provided in the training (training to be contracted by the department and aimed at the administrative and medical staff of municipal-level health institutions)	5.7.1.1 Training: Define a framework training programme on cervical cancer aimed at state employees and which includes levels and forms of care, competences and defined responsibilities	- Ministry for Social Protection - UIS	
			Human resources: Weaknesses in identifying the required profiles of professional trainers with recognized expertise and knowledge in cervical cancer	5.7.1.2 Skills transfer: Establish a team of professionals with recognized expertise and knowledge who can serve as trainers for the health officials, defining parameters and needs in order to intervene in specific cervical cancer issues	- UNDP - UNFPA - PROINAPSA - UIS - Department of Health - Private network of hospitals	
			5.7.2 Guarantee the full provision of cytology results, referrals for diagnosis confirmation and access to treatment, if required	Routes and equipment: Delays in conducting tests and providing results	5.7.2.1 Technology: Purchase and use high-tech equipment that will enable cytology results to be rapidly accessed in remote (rural) areas	- Ministry of Health - Specialist cooperation agencies
					5.7.2.2 Prompt detection and routing: Prioritize the delivery of results and medical referrals for those samples that flag a possible risk for the patient	- Department of Health - Public and private network of hospitals - Service providers
				5.7.2.1 Prompt communication: Strengthen communication mechanisms between the service provider and the patient in order to ensure that delays between conducting the test and receiving the result are eliminated	- Ministry of Health - Hospitals network - Service providers	
		5.7.2 Guarantee the full provision of cytology results, referrals for diagnosis confirmation and access to treatment, if required	Monitoring and follow-up: Weak follow-up and monitoring by service providers in positive cases of cervical cancer encountered	5.7.2.2 Service strengthening: Include patients diagnosed with cervical cancer in programmes of health promotion and continuing care for chronic illnesses	- Department of Health - Health service providers and institutions - User associations	
				5.7.2.3 Targeting: Ensure that care is appropriate to age, sociocultural conditions and place of residence (rural/urban)	- Department of Health - Health service providers and institutions - User associations	

4: ACCELERATION PLAN: BUILDING AN MDG COMPACT

TABLE 6 DEPARTMENTAL ACTION PLAN AND MONITORING AND FOLLOW-UP PLAN

MDG 5: Improve maternal health

Indicator:

5.2 Percentage of women having four or more antenatal checks

Priority interventions:	Bottleneck	Indicative acceleration solutions 2011–2015	JAN–JUNE 11	JULY–DEC 11	JAN–JUNE 12	JULY–DEC 12	JAN–JUNE 13	JULY–DEC 13	JAN–JUNE 14	JULY–DEC 14	JAN–JUNE 15	JULY–DEC 15	Possible partners
			(under negotiation)										
5.2.1 Extramural antenatal check	Physical barriers: Difficulty for women in accessing the service and transportation difficulties for the outreach teams reaching expectant mothers	5.2.1.1 Appropriate means of transport: Identify typical critical zones to adapt and provide medicalized forms of transport such as motorized ambulances, that are appropriate and adapted to the geographical conditions											- Santander Planning Department - Agustín Codazzi Geographical Institute - Santander Health Department
		5.2.1.2 Community training and awareness-raising: Educational strategies in dispersed and remote communities to encourage demand, raise awareness of rights and duties and identify risk factors											- UIS
		5.2.1.3 New forms of communication: Set up a community alert and communication network for emergencies, with established protocols											

Priority interventions:	Bottleneck	Indicative acceleration solutions 2011–2015	JAN–JUNE 11	JULY–DEC 11	JAN–JUNE 12	JULY–DEC 12	JAN–JUNE 13	JULY–DEC 13	JAN–JUNE 14	JULY–DEC 14	JAN–JUNE 15	JULY–DEC 15	Possible partners
													(under negotiation)
	Human resources: Insufficient and inadequately qualified human resources	5.2.1.4 Academic training: Academic strengthening of health professionals through training provided by the faculties of medicine of the department's universities, via intensive courses on technical standards											- UIS
		5.2.1.5 Technology: Transfer of skills to remote health teams via the use of ICT, specifically tele-medicine											SENA - Ministry of Technologies, Information and Communication
		5.2.1.6 Institutional strengthening: Strengthen the leadership role of the department and raise awareness among health service providers, both public and private, in order to improve the quality of care for expectant mothers and infants, via integral strategies such as Women and Child-friendly Institutions (IIAMI) and Integral Care of Diseases Prevalent among Newborns (AIEPI)											- PAHO - UNDP
5.2.2 Produce planning matrices that calculate the number of expectant mothers and, on this basis, plan interventions on a year-by-year basis	Information systems: Inadequate problem-solving capacity to adjust service provision to changes in the natural population growth rate and migratory flows observed year on year	5.2.2.1 Correct decisions on the basis of available and reliable information: Strengthen the Santander public health observatory as a validation agent for information and data and which also analyses, reports on and issues research proposals through 'situation rooms' (human, technological team, resources)											UNDP - UIS - ESAP
5.2.3 Define a strategy that creates rules and regulations and action plans	Human resources monitoring and follow up: Lack of knowledge of tasks and responsibilities on the part of the relevant authorities and a failure to adopt centrally established standards at the municipal or regional authority level	5.2.3.1 Community training and awareness-raising: Strengthen spaces for civic participation and control (user associations, review panels, COPACOS and so on)											- UNDP - UIS - ESAP
		5.2.3.2 Institutional strengthening: Train and raise awareness of standards among mayors, councils and sectors involved at municipal level											

Priority interventions:	Bottleneck	Indicative acceleration solutions 2011–2015	JAN–JUNE 11	JULY–DEC 11	JAN–JUNE 12	JULY–DEC 12	JAN–JUNE 13	JULY–DEC 13	JAN–JUNE 14	JULY–DEC 14	JAN–JUNE 15	JULY–DEC 15	Possible partners
													(under negotiation)
5.2.4 Insurance for expectant mothers not affiliated to the Social Security System for Health	Human resources: Lack of knowledge of the regulations on the part of those responsible (mayors) for registration with the Social Security System for Health	5.2.4.1 Communications strategy: Publication of the regulations in the mass media											<ul style="list-style-type: none"> - Ministry of Technologies, Information and Communication - Department's community and commercial network of broadcasters
		5.2.4.2 Institutional strengthening: Support the mayor's management role as person responsible for local insurance											
	5.2.4.3 Community training and awareness-raising: Develop and implement educational and communication strategies for the expectant mother's close social network												
	Social commitment and sensitivity: Little sense of joint responsibility on the part of members of the family unit and close circle of the expectant mother, particularly teenagers												

PROGRESS ON THE IMPLEMENTATION OF MAF SOLUTIONS

Based on the MAF exercise in Santander, the following actions have been implemented since August 2010:

1. Strengthening mother and child care strategies through IIAMI – IMCI programs, mother and child-friendly services and Kangaroo mothers, this latter implemented in Bucaramanga (Hospital Universitario de Santander), Socorro, Málaga and, soon, in San Gil, Velez and Barrancabermeja.
2. Technical training in cytological examination, antenatal checks and delivery care to provincial extramural professionals, provided by the Department of Obstetrics and Gynaecology (tertiary health care level).
3. Continuous training of the provincial extramural group in antenatal checks and prompt detection of risk factors.
4. Encourage higher demand for antenatal services through the extramural group.
5. The leader of the provincial team has provided technical assistance to the municipal mayors on health regulations. This has enabled Santander's public health policy to be implemented.
6. Prevention of early pregnancies through the actions of the National Program "Redes Constructoras de Paz", which works according to the following strategic principles: gender equity, human development and life planning, social construction and institutional strengthening. This program has received support from the provincial group.
7. Funds are being mobilized to implement systematic strategies of Information and Communication Technology (ICT), through the use of Personal Digital Assistants (PDAs) by the provincial team to record health information from visits to local households. This will enable a prompt analysis of the health situation in order to influence health events.
8. Legislation approved to help improve the food security and nutrition of pregnant and lactating mothers and children under 2 years of age - FAMI ICBF program in the department of Santander.
9. Coordination with UNDP to support the public health program policy guidelines for the continuity of health programs.
10. Work must be done to ensure the continuity of programs during the transition period following the upcoming local elections.



SECTION 3:

ANNEXES

Photo: Gobernación de Santander

1. METHODOLOGY

Civil servants and technical teams from Santander's authorities were involved in producing the department's health policy, along with the academic network of universities in the department, the department's public health observatory, the human rights and development observatory, public hospital users' associations, representatives of the Departmental Council for Social Policy and representatives of the Regional Planning Council.

This policy emphasizes maternal health and sexual and reproductive health as one of the main focal points of work in Santander department, and prioritizes the municipalities that are trailing the furthest behind and remote rural areas.

On the basis of this work, progress was made in the MAF methodology, involving the contributions of the following organizations and individuals:

- Officials from the Santander Health Department
- Higher School of Public Administration (ESAP)
- Industrial University of Santander (UIS)
- Departmental Public Health Observatory
- Departmental Human Rights and Development Observatory
- UNDP LMDG team in Colombia
- Consultants on the roster of national experts for the UNDP's LMDG project

The exercise was conducted at all times through working groups. In the groups, progress was initially made in analysing and reconciling the department's health figures and their respective gaps in relation to the 2015 targets for the MDGs.

A **List of interventions underway in the region** to accelerate progress towards achieving the priority MDGs was then compiled. Interventions were prioritized according to the following impact and viability criteria:

Impact:

- Impact on achieving the MDGs
- Target population includes vulnerable groups
- High return for each unit of resources invested in the intervention
- Impact of the intervention will be rapidly felt
- Evidence of impact

Viability:

- Willingness at the political level and among stakeholders to implement the intervention
- Government and partners have the capacity to plan, implement and monitor the intervention
- Funds available to finance the intervention
- No additional factors that could hinder implementation

Each criterion was evaluated according to the following scale:

- Very high impact: 1
- High impact: 0.75
- Average impact: 0.5
- Low or no impact: 0.25

For the criterion 'Are there additional factors that could hinder implementation?', the following scale was used:

- No obstacle: 1
- Some factors that could hinder implementation: 0.75
- Numerous factors that could hinder implementation: 0.50
- Factors that could completely block implementation: 0.25

In order to establish the priority bottlenecks, an analysis of causes was conducted using a methodology adapted from the Vester Matrix. This methodology assesses how the causes of each bottleneck relate to each other, thus making it easier to identify root causes, direct causes or indirect causes.

The following criteria were used in the viability analysis for those solutions proposed for bottlenecks identified as 'direct causes':

- Short-term actions can be proposed
- It is the responsibility of the municipal or departmental authorities
- There are actors willing to contribute
- The region has the financial and human resources to implement it
- It reaches a significant number of people and vulnerable groups
- It promotes equality
- It is culturally acceptable to the affected populations

The local panel of experts analysed each of the solutions, classifying the criteria as follows:

- Very high contribution: 100
- High contribution: 75
- Average contribution: 50
- Low or no contribution: 25

2. SOURCES OF INFORMATION

- National Statistics Administrative Department (DANE) 2005 Census
- Departmental Development Plan 2008-2011
- National Council for Economic and Social Policy, Republic of Colombia, National Planning Department, CONPES social documents 091, 2005
- Cundinamarca Department, UNDP. Departmental public health policy 'Health Responsibility for All'
- National Council for Economic and Social Policy, Republic of Colombia, National Planning Department, CONPES 102 2006 documents on the extreme poverty social protection network
- United Nations System in Colombia, National Planning Department, Republic of Colombia. The Millennium Development Goals. II Monitoring Report 2008
- Profamilia, ICBF, USAID, Ministry for Social Protection and UNFPA. National Demographics and Health Survey 2005

3. LIST OF MUNICIPALITIES IN THE DEPARTMENT

Bucaramanga	Galán	San Andrés	San Joaquín	Vetas
Floridablanca	Gámbita	San Jose de Miranda	Valle de San José	Albania
Girón	Hato	San Miguel	Villanueva	Aguada
Lebrija	Socorro	Aratoca	Barrancabermeja	Barbosa
Los Santos	Oiba	Barichara	Betulia	Bolívar
Piedecuesta	Palmar	Cabrera	El Carmen	Chipatá
Rionegro	Palmas del Socorro	Charalá	Puerto Wilches	El Peñón
Santa Bárbara	Simacota	Cepitá	Sabana de Torres	Florián
Cimitarra	Suaita	Coromoro	San Vicente	Guavatá
Landázuri	Capitanejo	Curití	Zapatoca	Güepsa
Puerto Parra	Carcasí	Encino	California	Jesús María
Santa Helena del Opón	Cerrito	Jordán	Charta	La Belleza
Chima	Concepción	Mogotes	El Playón	La Paz
Confines	Enciso	Ocamonte	Matanza	Puente Nacional
Contratación	Guaca	Onzaga	Suratá	San Benito
El Guacamayo	Macaravita	Páramo	Tona	Sucre
Guadalupe	Málaga	Pinchote	San Gil	Vélez
Guapotá	Molagavita			

en Santander
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GOBERNACIÓN DE SANTANDER



Colombia