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By Design: The Thinking Behind Uruguay *Crece Contigo* Planners Mull Ambitious Early Childhood Model in Chile (A)

Introduction

In the early 2000s, both Uruguay and Chile embarked on ambitious new initiatives focused on the health and well-being of pregnant women, infants, and young children. Recent research, conducted all across the world, had heightened awareness that an individual's future potential was heavily influenced by early brain development, which was in turn influenced by maternal health in pregnancy and by the quality of nourishment, healthcare, home safeguards, emotional security, and personal care given to infants and young children. Research also showed that—for lack of simple, well-understood protections during this crucial developmental window—the human potential of more than 200 million children worldwide was being squandered each year, resulting in heartbreaking losses at the personal level and expensive societal problems down the road.[1] Investments in protecting children from devastating, preventable problems in pregnancy and early childhood were, therefore, what the World Health Organization called a "best buy" in terms of social spending: interventions that virtually guaranteed a major return on investment.

It was a compelling argument that persuaded many countries to invest in early childhood programs. In 2007, Chile launched a major early childhood initiative called Chile *Crece Contigo*, or Chile Grows with You. ChCC was a sweeping, systemic approach that complemented existing maternal and child healthcare in the country's National Health System with new monitoring protocols, interventions, and a package of supplemental programs—some universal, others targeted. The program immediately drew worldwide attention and won accolades for its scope and for the thoughtfulness of its design.

At about the same time, child advocates in Canelones, an administrative region of Uruguay, were considering how they might research and design an early childhood program of their own. They were curious about Chile's approach and, like their colleagues around the world, impressed by it. At the same

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time, Uruguay was a very different country—far smaller, with different needs, different resources, different strengths, different weaknesses. The planners wanted to learn from Chile, but not necessarily to copy the Chilean plan. They wanted to design the program best suited for the needs and institutions of Uruguay. [Exhibits 1-3, Maps and Data]

Uruguay, 2005-2009: A Broad Commitment to Eradicate Poverty

A small country wedged between South American giants Argentina and Brazil, Uruguay has sometimes been called "the Switzerland of South America" for its democratic traditions and long history of progressive social policies, beginning at the start of the 20th century. The country went through a destabilizing period of economic and political turmoil in the 1970s that led to 12 years of military rule but returned to democratic governance in 1985. By century's end, the country had embraced market-based economic policies, but suffered a devastating economic crisis in the late 1990s and early 2000s that led to a rapid escalation of poverty and unemployment. In 2004, Tabaré Vázquez, a candidate of the *Frente Amplio* (Broad Front), a left-of-center coalition, won the presidency, breaking the longtime hold of the Blanco and Colorado parties in national politics.

Vázquez launched an immediate and aggressive series of anti-poverty measures. The first, from 2005 to 2007, was the *Plan de Atención Nacional a la Emergencia Social* (PANES), or National Social Emergency Plan, to be administered by the newly created Ministry of Social Development (MIDES). In a country with a poverty rate of 36.5 percent, PANES targeted the poorest-of-the-poor through cash transfers, food assistance, housing subsidies, and efforts to improve the inclusiveness of education and employment.

In 2007, Vázquez launched the *Plan de Equidad*, or Equity Plan, which included a restructured and expanded system of cash and food assistance to families and far-reaching, systemic tax and healthcare reforms. Uruguay's healthcare reform, in 2007, reorganized the healthcare system to increase overall coverage, and decrease the share of people in the public health system. Any employee or retiree could pay a monthly fee and enroll in a regulated private system, called a *mutualista*. At the same time, the administration made major new investments in the beleaguered public health system. A few years later, the effort was widely viewed as a success. About 2.5 million people signed up for the mutualistas. Another 500,000—mostly people who were poor or lived in remote areas—remained in an improved Uruguayan public health service.

A Discussion Begins in Canelones

In 2004, Uruguay's *Frente Amplio* coalition not only scored a victory in the national election, but also in the Canelones' regional and municipal election. Canelones was the country's second-largest administrative department (*departamento)* after Montevideo, the nation's capital city. Half the country's 3.4 million residents lived in either Montevideo or Canelones.

As part of a left-of-center coalition, the Canelones government was naturally sympathetic with the national drive to reduce the country's high poverty rate. But, in line with international experts in child welfare, senior leaders in the Canelones government believed it imperative that the country also move

quickly to target the health and well-being of pregnant women, infants, and young children, in particular. If Uruguay was to break the cycle of intergenerational poverty, they believed, broad anti-poverty measures were important but insufficient. The country must also prevent irreversible damage done to children during pregnancy, in infancy, and in early childhood through malnutrition, substandard health care, misguided child-rearing practices, substance abuse, violence, neglect, and emotional abuse.

While the consequential health and development problems of early childhood were well known to Uruguay's child welfare experts, they had not yet risen to prominence in Uruguayan society, generally, says Gabriela Garrido, a member of the Canelones legislature and the Director of Development and Social Cohesion.[2] "Nationally, early childhood was not an important topic. People were talking about poverty, yes, and the Emergency Plan, but not early childhood as a key element," she says. In Canelones, however, the issue had taken on more urgency. Child poverty rates were disproportionately high all across Uruguay, but even worse in Canelones. "At the time, we hadn't assessed it scientifically," says Garrido. "But you could *see* the huge child poverty, hunger, and malnutrition."

Meanwhile, the Canelones leaders knew discussions about early child development policy were also taking place, at the national level, in nearby Chile. They watched Chile closely, intrigued by the rapid evolution of thinking there.

Inspiration Nearby: Chile Crece Contigo

In Chile, discussions about the creation of an early childhood development initiative began in earnest in 2006, but they did not start in a vacuum. The discussions grew out of several years of prior research and experimentation in the Chilean central government under the center-left administration of President Ricardo Lagos.

By the end of the 20th century, Chile had developed an extensive safety net of public, private, and nonprofit programs, each with its own distinct focus and eligibility requirements. Yet the central government had no clear idea whether, or how well, they were serving the 5.6 percent of Chileans living in extreme poverty, according to Veronica Silva, then Secretary of the Social Division in the Ministry of Planning & Cooperation.[3] In 2000, the Ministry of Planning conducted a survey of these families and discovered that, in fact, most were using very few of the services to which they were entitled, either because they didn't know about them, or because they found the system confusing and difficult to navigate.

In response, Lagos and his administration created Chile *Solidario*, or Chile Solidarity, in 2002, a labor-intensive program that targeted extremely poor families. Social workers went door-to-door in poor areas, offering a two-year program of home visits that would provide a family with counseling, referrals, and assistance in navigating the Chilean social service system. In the process, the program created a number of tools—including a household-based information tracking system and a process for understanding and coordinating social service providers in each municipality—that aided social workers in their family-by-family case management. Silva believed these tools, and the case management approach, could be useful in other initiatives as well. In particular, she thought, they could be useful in

developing a major new initiative to improve early childhood development outcomes nationwide.

For a relatively prosperous, healthy country, Chile showed high rates of developmental delays for babies and young children. In the first five years of life, 23 percent of Chilean children in even the wealthiest 20 percent of the population showed some kind of serious developmental delay. For the poorest 20 percent of the country, the figure was 36 percent.[4] But figuring out the best way to address the problem would require some careful thought. To prepare the ground, the Ministry of Planning—in collaboration with the Ministries of Health and Education—conducted several pieces of "pre-investment research" in 2004-2005. This research included a cross-cultural study of child-rearing and a survey of citizen attitudes toward healthcare and family services. And rather than "sit down and think from scratch" about early childhood programming, says Silva, the Ministry of Planning decided to search for small creative programs already in existence all across the country. They sponsored a contest to honor innovative experiments in the delivery of child and family services and received more than 1,000 entries. Out of this contest came a number of ideas that would ultimately be included in Chile's early childhood initiative.

In fact, Silva believes, the interesting findings that emerged from this string of studies caught the attention of the Socialist Party's Michelle Bachelet, Chile's center-left candidate for president in 2005.[a] She was inspired to include the promise of a new early childhood initiative in her campaign platform, "*Estoy Contigo*," or "I Am with You."[b]

Bachelet won the December 2005 election and, in March 2006, the month she took office, she announced her intention to create "a system of child protection designed to equalize opportunities for the development of Chilean children from their conception to the end of the first cycle of basic education (elementary grades 1-4), regardless of their social origin, gender, the makeup of their household, or any other potential factor of inequity." (Research had identified these years as crucial for brain development in children. [Exhibit 4]) In the same decree, Bachelet appointed a prestigious, multidisciplinary, nonpartisan 14-member Presidential Advisory Council for Child Policy Reform and asked the group "to make a diagnosis of the current situation and existing deficiencies in child protection, and then to formulate and propose a set of appropriate policies and measures for the purpose of implementing a child protection system."[5]

With Silva serving as its Executive Secretary, the Council met frequently over a period of three months, conducted 46 interviews with national and international experts, sponsored listening sessions in each of the country's 13 regions, and reviewed thousands of contributions made by citizens to an open website, created for this purpose. In June 2006, the Council completed its report, which took, as its point of departure, the United Nations Convention on the Rights of the Child, ratified by Chile in 1990,

[a] Bachelet was the candidate of the Coalition of Parties for Democracy, the same center-left Coalition represented by Lagos in the 2000 election.

[b] In translation, Bachelet wrote: *The strong advances in maternal and child care, preschool and basic coverage, and nutrition, among others, suggest that this system can be built over the next four years. We will develop and we will implement new management, monitoring, and evaluation tools that will enable an integrated, relevant, and results-oriented management of components of this system.* ("Estoy Contigo: Programa de Gobierno, 2006-2010," by Michelle Bachelet, October 18, 2005, https://www.bcn.cl/obtienearchivo?id=documentos/10221.1/13433/1/2005_programa-MB.pdf, retrieved May 13, 2020.)

which emphasizes the principle of equal opportunity for all children. Consequently, the report recommended a universal program aimed at better childhood development monitoring and interventions, with additional supports for poor and vulnerable families. Bachelet sent the Council recommendations to an Inter-Ministerial Committee comprising Ministers from Planning, Education, Health, Labor, Finance, and Women's Affairs. A working group, led by Silva and made up of technical experts from each of these Ministries, turned the Council recommendations into an actionable plan (with a range of options in some areas) in October 2006. After some deliberation, the Committee recommended the name Chile Crece Contigo to signal the importance of children, families, and the collaborative spirit of the initiative (and to tip their hat to Bachelet's campaign catchphrase).

Questions of Coverage

As Chile Crece Contigo moved from design to implementation, several questions of coverage arose. One prominent feature of the initiative—a sweeping public education campaign to raise awareness, nationwide, about healthy practices during pregnancy and in caring for babies and young children—would be universal, aimed at everyone in the country. But the heart of the project envisioned by the planners was a package of new testing protocols and services to complement existing maternal and child healthcare. The central players would therefore be healthcare providers. Persuading doctors, in particular, to change their protocols would not be easy, government leaders understood. In Chile, doctors were much revered and not accustomed to receiving directives about how to do their jobs. What's more, the healthcare system in Chile included both public and private providers. The National Health Service covered about 75 percent of the population.[c] The remaining 25 percent were primarily affluent citizens who, by choice, opted for a more expensive form of private healthcare coverage. Should the new childhood initiative cover private as well as public healthcare providers? In an ideal world, yes, many agreed. But this would only work if the private providers agreed to the idea.

Thus, public leaders met with representatives of private healthcare providers to gauge their level of interest. The response to these inquiries, Silva says, was decidedly tepid. The private providers were happy to receive and distribute educational materials but were reluctant to commit to changing their own protocols. With the exception of its educational campaign, therefore, Chile decided to design a program just for the National Health Service. This would be challenging enough. "You need to convince, you need to seduce, you need to do a lot of things," Silva says. But the public system was, at least, under direct government control, and—always a plus—the new program would come with new funding. "At the end of the day, this is an *order*," she says. "The decision was to take control of those things you can control, and you can control the 75 percent of the children that were served by public health."

Another question concerned the best way to launch so big a program. To try to cover all pregnant women and children 0-9 in the National Health Service, all at once, was to court failure, Silva says. On the other hand, to launch the program in some geographic areas but not others would be inherently controversial. The Inter-Ministerial Committee proposed another option: gradual implementation, but

[c] The sprawling SNS consisted of 29 regional offices, 196 hospitals with a range of capabilities, numerous specialized outpatient clinics, and 845 primary care clinics, mostly administered by local municipal governments.

by cohort, not geography. The program could be phased in in all 345 municipalities over two years (starting with 159 that had the willingness and administrative capacity to move quickly). But in the first year, 2007, it would cover just pregnant women and children below age 1. The next year, it would expand to include children 0-2, the following year, children 0-3, and so on, until, after nine years, the initiative would cover pregnant women and children 0-9. (In fact, the initiative followed this plan for the remainder of the Bachelet administration. By the time she left office, in March 2010, ChCC covered pregnant women and children 0-4. Under the succeeding administration of Sebastián Piñera, of the right-wing National Renewal party, the program continued but the yearly expansion temporarily halted. Bachelet was re-elected president in 2013 and the annual expansion resumed when she took office in 2014.)

A third question concerned the scope of the services provided. The designers had agreed that the National Health System's maternal and child health providers would monitor a wider set of health indicators, psychosocial information, and developmental markers in pregnant women and children. They would provide education services and products helpful in child-rearing. But from the beginning, the planners also understood that, if the goal was to give every child in the system the best chance at healthy development, some families—especially those living in poverty—would need additional supports.

Research clearly showed that many of the problems associated with poverty—family stress, domestic violence, substance abuse, unsafe living conditions, poor nutrition, parental depression—had a direct and damaging effect on early childhood development. For such families, ChCC tried to do several things, borrowing loosely from the Chile Solidario case management model. Healthcare social workers or other providers would help families navigate the social protection system either by referring them to services directly, or by referring them to a newly created municipal coordinator, who would be responsible for knowing what services were available in a given municipality, and for finding out which, at any moment, were both best suited to the problem at hand and had the capacity to serve an additional family.

System Design

When the Inter-Ministerial Committee designed the ChCC initiative in more detail, they agreed that the project would be centrally managed by the Ministry of Planning (later renamed the Ministry of Social Development). Ministries of Education and Labor would also play a role. But the biggest role, of course, would be played by the National Health Service, especially in the first few years. As the age cohort expanded to include school-aged children, the Education Ministry was expected to step in and play a bigger role in tracking and monitoring child development.

Before the addition of ChCC, the National Health Service was delivering to its patients a generally well-performing, if traditional, system of maternal and child healthcare. Under ChCC, says Silva, new protocols and services were layered into each standard checkup for both pregnant women and young children. The centerpiece of this was an expanded monitoring and tracking system, called the Biopsychosocial Development Support Program (PADB). Under PADB, doctors increased the number of

health tests and developmental markers they measured, hoping to identify problems early enough to forestall damage whenever possible. In addition, clinic personnel kept track of an array of psychological and social indicators, in order to identify personal and family difficulties and risks, and to make referrals to appropriate service providers. Finally, new ChCC funding supported an existing health reform effort that had lagged, largely due to inadequate resources, to modernize birth protocols and give pregnant women more agency in the process—for instance, the option to bring a partner or friend with her, and the option to choose natural childbirth.

Entry into the ChCC system was automatic and began when a pregnant woman made her first visit to a midwife in her local primary care clinic. That initial meeting—which had previously taken about 20 minutes—now took 40 minutes. The midwife was encouraged to establish a friendly bond with the pregnant woman, offering her nutritional supplements and educational materials about the weeks ahead, healthy pregnancy practices, and childbirth options. In addition, she conducted a standardized "Abbreviated Psychosocial Evaluation" to gather a more detailed picture of the mother's social risk. Any of the following conditions/characteristics was considered a red flag:

- first check-up more than 20 weeks into the pregnancy
- fewer than 6 years of education
- younger than 18
- symptoms or report of depression
- signs or report of substance abuse
- physical or emotional abuse at home
- accidental/unwanted pregnancy
- inadequate family support

Based on the woman's income-eligibility and risk profile, the primary care team developed a plan for the remaining weeks of pregnancy, possibly including, in the case of medical risk, home visits from healthcare workers and, in the case of social risk, referrals to specific services or to the municipal coordinator who would try to find her appropriate local support services.

Once born, the baby, too, automatically entered the system with baseline data from the pregnancy and birth. The baby would then be scheduled for regular check-ups to monitor health and developmental milestones, receive vaccines, and obtain medical treatments as necessary. Through PADB, healthcare personnel also kept track of family information and, if they saw one or more of a long list of child risk factors, made referrals to the municipal coordinator:

- child with multiple visits to emergency rooms, health clinics, or the hospital;
- child with a serious underlying medical condition (e.g., cerebral palsy, genetic syndromes);
- one or both of child's parents/caregivers are teenagers;
- child's mother has less than 8th grade education;
- child of parent/caregiver with mental health disorder;
- child of parent/caregiver with substance abuse problem;
- child shows signs of neglect;
- child lives in single-parent household without good support;
- child has a sibling in the child protection system;

- child's parent/caregiver is incarcerated;
- child is in the child protection system;
- child's parents/caregivers are unemployed;
- child is living in unstable or precarious housing;
- child's family is geographically isolated;
- child is subjected to emotional, physical, or sexual abuse;
- child is exposed to watching emotional, physical, or sexual abuse.

New Services Available under ChCC

In addition to the PADB, a number of programs and services were available to families with young children in the National Health Service who wanted or needed them. These included:

- ***Newborn Support Program.*** This hugely popular ChCC program (surveys showed as high as 94 percent user satisfaction) included a package of high-quality goods delivered to every baby born in the public health system, coupled with in-hospital education from midwives about how to use the items. They included a flatpack crib with mattress and bedding, to promote safe and calm sleeping; a baby sling and nursing pillow to facilitate close contact and breastfeeding; hygiene supplies; a stimulation mat and mobile for baby; story books and an educational DVD. [See Exhibit 5. Newborn Support Program]
- ***Nobody's Perfect.*** Parents and caregivers could enroll in 6- or 8-week workshops held in primary health clinics that provided weekly two-hour training sessions, using a curriculum called Nobody's Perfect, developed by the Canadian national health system.
- ***Discovering Together.*** As a part of primary health check-ups at 4 months, 12 months, and 24 months, parents received a bag of age-appropriate games and toys designed to stimulate child development. A trained nurse distributed the goods and demonstrated how to use them to best effect.
- ***Motor/Language Workshops for Babies.*** These 90-minute workshops for parents and babies under 12 months were held in primary health clinics and were designed to encourage babies to explore and communicate.
- ***Materials to Support Hospitalized Children.*** This program provided developmentally stimulating play areas inside pediatric wards of public hospitals, so that children who required a hospital stay need not lose ground developmentally.
- ***Child Development Support.*** ChCC provided funding for the development of local parent/child services for young children diagnosed with, or at high risk for, developmental delays. These included special "stimulation" materials and guidance, which could be delivered at local clinics, community centers, mobile units, or through home visits, as best fit local needs. [Exhibit 7. Child Development Support]

Referral Services for Eligible Families

In addition to the ChCC services, many families were referred, through the PADB system, to other educational and social services in their municipality. Although most family assistance programs for low-income families did not have the capacity to serve all the people eligible for them, the ChCC planners hoped that, where services were available, the referral service would help families to find them—and in

some cases, give them preferential access. In addition, they hoped that municipal coordinators would take a proactive stance, identifying service gaps and advocating with the central government for additional funding to fill them. Common referrals included:

- ***Free childcare.*** To be eligible for publicly funded daycare or preschool, a family had to be in the bottom 60 percent of the national income distribution, and the mother or primary care giver had to be working, seeking work, or studying. Since almost all families enrolled in the National Health Service were in the bottom 60 percent of the income distribution, they were nearly all eligible for this benefit, though supply was limited in some locations.
- ***Free disability assistance.*** Families with disabled children in the bottom 60 percent of the national income distribution were eligible for free therapeutic services (e.g., occupational or speech therapy) and free equipment to address their children's disabilities (e.g., wheelchairs, hearing aids, visual aids, specialized computer programs, prosthetic devices).
- ***"Preferential access.***" Families with young children in the bottom 40 percent of the income distribution were supposed to get "preferential access" to any social protection programs for which they were eligible. The rationale was that—all else equal—it was important to serve a family with young children, in order to give the parents the best chance at providing a healthy environment for their children's development. Typical social service needs for this population included family subsidy payments, improved housing, training and job placement, legal assistance, and remedial education.

Protection for ChCC under Law

In Chile, the President could not serve more than one four-year term consecutively. Thus, unless given specific legal protection, a program closely identified with a given president—the way Chile Crece Contigo was identified with President Bachelet—could be dismantled or undermined by a future administration. Advocates for the initiative thus fought hard for the National Congress to enact a law called the Comprehensive Protection System for Early Childhood in 2009. "I almost lived in the Congress in order to do this," recalls Silva. In the end, the law was enacted by a unanimous vote. It ensured that ChCC could not be abolished, nor have its budget cut, by a future administration. Bachelet's successor, Sebatián Piñera, did initially try to change the ChCC name when he came to office (re-branding a program with a new name was a common strategy from one administration to the next in Chile), but he eventually backed away from the idea when polls indicated that the name of the program was already well-recognized by the public, and positively regarded.

Observations from ChCC Leaders

About five years after the start of the ChCC program, the National Health Service formally added the new PADB protocols into its own standards for maternal and child healthcare—a major victory in the eyes of many ChCC proponents. In any program this large, its implementation was better in some places than others, but in the main, the program was considered a success.

Perhaps the most disappointing aspect of the system was in the hoped-for improvement in social services provided to poor families with young children. These limitations were broadly seen as a problem rooted in the limited capacity of Chile's social protection system, and not in ChCC per se. Silva

believed, however, that—with more advocacy at the local level and more responsiveness in central government—the ChCC system could be used more strategically as a way to identify service gaps and lobby for the funding to fill them.

At home and abroad, Chile continued to receive accolades for its commitment to bolstering early childhood development through the ChCC program. Often asked to pass along advice and lessons learned, ChCC's creators and administrators were quick to acknowledge that, right from the start, they had enjoyed some crucial advantages:

- near-unanimous agreement among early childhood experts about the nature of the problem in Chile, and the kind of improvements needed to reduce the incidence of health and development problems in babies and young children;
- strong political support from Chilean President Michelle Bachelet, who made this program a flagship of her administration;
- the enactment, early on, of legislation that established Chile Crece Contigo as a permanent feature of government, with a standing budget line; and
- a well-established and well-respected public health system serving 75 percent of the population.

In Uruguay, Canelones Takes a Leading Role

In 2007, just as Chile Crece Contigo was moving from the planning to operations stage, the Canelones government was on the brink of taking an unusual step. It was about to take the lead on early childhood development policy in Uruguay.

As a unitary state, Uruguay's regional and municipal levels of government administered local affairs and enforced national laws and policies, but policymaking and taxing authority were almost entirely the domain of the central government. Although the Canelones departmental government and the Uruguay central government—both led by candidates from the *Frente Amplio* coalition—enjoyed warm relations, it was quite unorthodox for administrators from a regional department to drive a policy conversation. But, frustrated by the lack of attention at the national level, Canelones decided to strike out on its own—cautiously, at first—by information gathering.

With the financial and technical assistance of the United Nations Development Program, under a major UNDP anti-poverty initiative called the Millennium Development Goals, Canelones decided to undertake an elaborate door-to-door survey in urban areas of the region. The goal was to get a status report for households that included either a pregnant woman or children under age 5. Were these mothers and young children safe? Were they healthy? Were they getting the food they needed? Were they going to regular medical check-ups? Were they making use of preschool and social service programs?

The Canelones research team worked with Uruguay's National Institute of Statistics, to make sure its survey instrument was sound and representative. In addition, the team consulted with Paula Bedregal, a Chilean physician and Catholic University scholar who had served on Bachelet's Advisory Council for the

Reform of Child Policies. Bedregal provided the group with a child development monitoring instrument, "which was very valuable to us" in developing an initial survey instrument, says Marta Napol, a pediatrician on Canelones' early childhood team and, later, coordinator of the Canelones initiative.[6]

The Canelones team conducted their door-to-door survey—2,269 households—between June and September of 2007. They had braced themselves for grim news, but their findings were even worse than anticipated. "*Terrible* results," says Garrido. Among the findings:[7]

- A third of children under 5 showed signs of abnormal psycho-social development (a disproportionate share of these children were in the care of mothers with fewer than 9 years of schooling);
- 10 percent of respondents reported that they did not have enough to eat;
- 25 percent could not afford a nutritious balance of foods;
- 11 percent of babies were premature;
- 8 percent of babies had low birth weight (a disproportionate share of these babies were in families with many young children, and a disproportionate share of these large families were extremely poor);
- 20 percent of children under 5 did not go to all recommended medical check-ups;
- 13 percent of children did not go to medical services at all, with higher rates of nonattendance after the age of 2;
- 15 percent of children were obese (a disproportionate share of obese children were in the care of mothers who smoked cigarettes);
- 8 percent of children showed signs of "stunting," or impaired growth and development (stunting and childhood obesity often went hand in hand);
- Between 15 and 20 percent of mothers reported that they did not play, read, or sing with their children (and at a disproportionate rate, their children showed developmental deficits).

In addition, although healthcare, childcare, and social programs were ostensibly available, by right, to any family that qualified, many of the families reported to researchers that they made little use of such programs. In some cases, the parents were unaware that the services were available to them. In others, they were unaware of the importance of proper nutrition and regular check-ups to monitor their babies' health and development. Single mothers, in particular, were often lonely, isolated, depressed, and convinced that no government service would be useful to them. Some reported that health and social service providers were unwelcoming and unhelpful. In the areas with the highest concentration of problems—a cluster of six communities along two major highways—the researchers found alarming red flags in 70 percent of households surveyed. "It was very interesting, because we saw that families—even if they had a school or clinic close by—they didn't have access to it," says Garrido. "And it was a two-way street: they didn't go to the services—and the services didn't go get them, either."

Presented with the survey results, Canelones Governor Marcos Carámbula—a physician by training—agreed that something must be done. Under the Uruguayan system, Garrido says, that meant "we needed to find a way for the state government to impact national policies and to really change the quality of life of Canelones people."

Governor Carámbula and his administration therefore invited a group of high-level state and

national experts and administrators involved in food, health, housing, children, education, and social services to join together to discuss the survey findings. The survey had covered only families in Canelones, but no one much doubted that similar patterns existed nationwide.

At the time, the central government had its hands full with its Equity Plan and health reform initiatives and did not feel ready to launch a nationwide early childhood initiative. In the end, the parties agreed that Canelones, using a modest UNICEF grant, would undertake a small pilot program to try to improve the health and well-being of pregnant women and young children in vulnerable homes.

The next step was to design that pilot project.

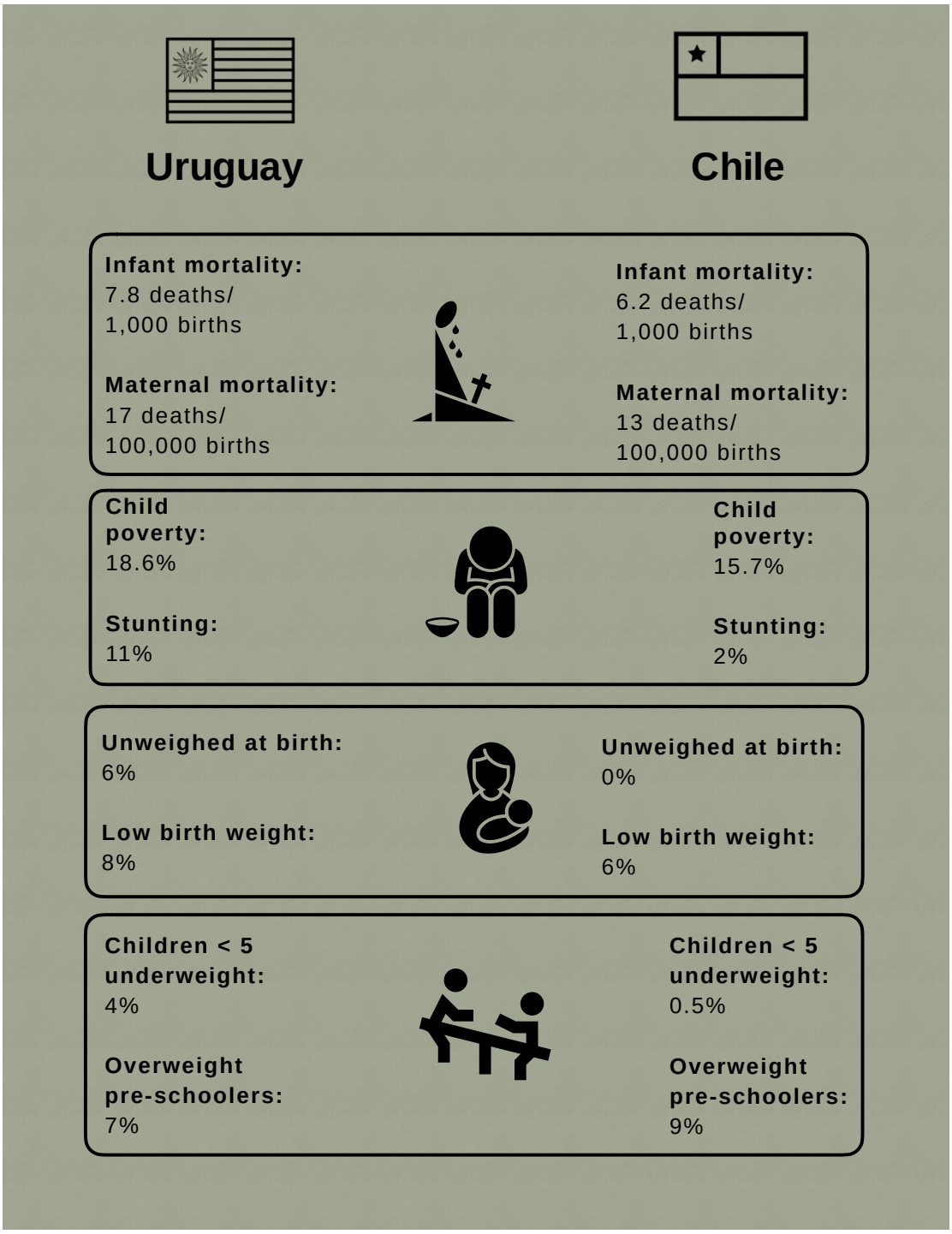
Exhibit 1. Uruguay[d]

[d] CIA World Factbook, https://www.cia.gov/library/publications/resources/the-world-factbook/attachments/maps/UY-map.gif, retrieved May 13, 2020.

Exhibit 2. Chile[e]

[e] CIA World Factbook, https://www.cia.gov/library/publications/resources/the-world-factbook/attachments/maps/CI-map.gif, retrieved May 13, 2020.

Exhibit 3. Uruguay & Chile: A Side-by-Side Comparison[f]



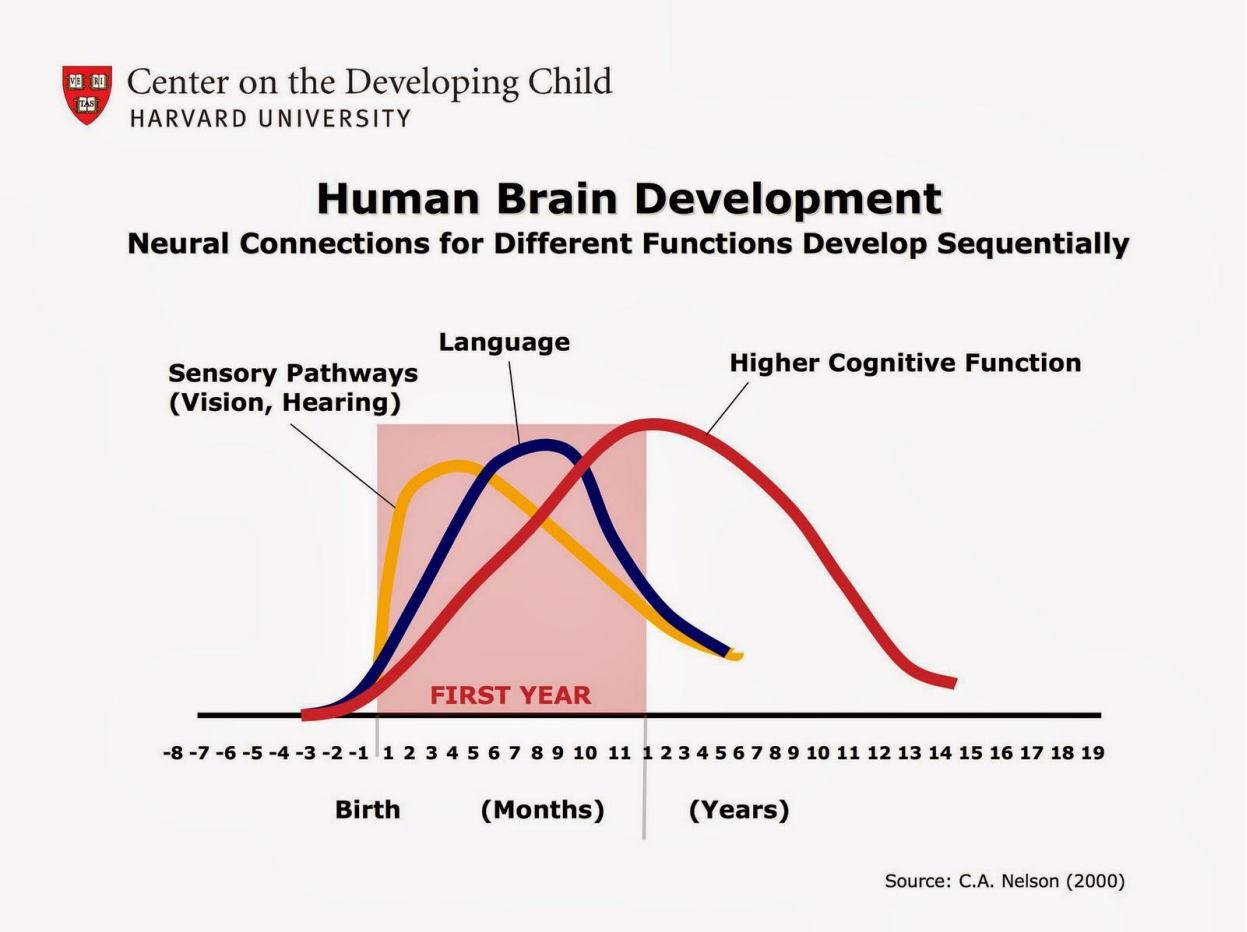
[f] Infant mortality (no dates given), maternal mortality (2017), and children < 5 underweight (2011 in Uruguay & 2014 in Chile) from the CIA World Fact Book, https://www.cia.gov/library/publications/resources/the-world-factbook/, retrieved May 13, 2020. Child poverty (2011), Stunting (2013-2018), Unweighed at birth (2010-2018), Low birthweight (2015), and Overweight pre-schoolers (2013-2018) from UNICEF, https://data.unicef.org/resources/data_explorer/unicef_f/, retrieved May 13, 2020.

Standard International Measures of Comparison

Uruguay country profile		Chile country profile
176,215 sq km	**Geographic area**	756,102 sq km
3,387,605	**Population July 2020**	18,186,770
95.5%	**Urban population July 2020**	87.7%
$22,400	**GDP per capita (PPP) 2017**	$24,600
7.6%	**Unemployment 2017**	6.7%
9.7%	**Population in poverty 2015, Uruguay 2013, Chile**	14.4%
4.9%	**Education expenditure 2017**	5.4%
9.1%	**Health expenditure 2016**	8.5%
5.05/1,000 pop	**Physician density 2017**	1.08/1,000 pop
		CIA World Factbook[g]

[g] CIA World Fact Book, https://www.cia.gov/library/publications/resources/the-world-factbook/, retrieved May 13, 2020.

Exhibit 4. Crucial Periods of Prenatal and Postnatal Brain Development[h]



In the proliferation and pruning process, simpler neural connections form first, followed by more complex circuits. The timing is genetic, but early experiences determine whether the circuits are strong or weak.

[h] Chart developed by C.A. Nelson, 2000, Harvard's Center on the Developing Child, http://developingchild.harvard.edu, retrieved May 8, 2020.

Exhibit 5. Newborn Support Program, ChCC[i]

[i] Reprinted with permission, Chile Crece Contigo.

Exhibit 6. Child Development Support, ChCC[j]

[j] Reprinted with permission, Chile Crece Contigo.

Endnotes

[1] "Early Childhood Development: A Statistical Snapshot," UNICEF, 2009, https://data.unicef.org/resources/early-childhood-development-statistical-snapshot/, retrieved May 17, 2020.

[2] All quotations from Gabriela Garrido were taken from an in-person interview with Pamela Varley in Canelones, Uruguay on November 19, 2019. Translation was provided by Lourdes Martino and Soledad Insiburo of Traducciones del Sur, http://traduccionesdelsur.uy/web/.

[3] All quotations from Veronica Silva were taken from a Zoom interview with Pamela Varley on May 12, 2020.

[4] *Informe Final II Encuesta Nacional de Calidad de Viday y Salud*, 2006, Health Planning Division, Ministry of Health, p. 125, http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/ENCAVI-2006.pdf , retrieved May 5, 2020.

[5] *Propuestas del Consejo Asesor Presidencial para la Reforma de las Políticas de Infancia*, or *Proposals of the Presidential Advisory Council for Child Policy Reform,* June 2006, https://www.siteal.iiep.unesco.org/bdnp/184/propuestas-consejo-asesor-presidencial-reforma-politicas-infancia, retrieved June 30, 2020. As translated by the online translation app, DeepL, https://www.deepl.com/en/translator, retrieved June 30, 2020.

[6] All quotations from Marta Napol were taken from an in-person interview with Pamela Varley in Canelones, Uruguay on November 19, 2019. Translation was provided by Lourdes Martino and Soledad Insiburo of Traducciones del Sur, http://traduccionesdelsur.uy/web/.

[7] *Encuesta de Crecimiento, Desarrolly y Sauld Materna en Canelones*, a joint report by UNPD, UNICEF, *Comuna Canaria* (an historical name for the state government of Canelones), and Canelones Crece Contigo, 2012, http://bibliotecaunicef.uy/doc_num.php?explnum_id=84, retrieved April 23, 2020.