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By Design: The Thinking Behind Uruguay *Crece Contigo*
Betting on the Power of Personal Connection (B)

Introduction

In 2007-2008, a small team of planners in Canelones, an administrative region of Uruguay—armed with their own determination and a small grant from UNICEF (the United Nations Children's Fund)—set about the task of designing a pilot program to try to improve the health and well-being of pregnant women and young children. If successful, they hoped the national government would expand it nationwide.

In crafting their initiative, Canelones political leaders and planning team considered multiple factors, but "internationally, what really inspired us was Chile Crece Contigo, and the strong sensitivity and conviction that the real game is played in early childhood," says Gabriela Garrido, a member of the Canelones legislature and the Director of Development and Social Cohesion for the region.[1] In addition, there were warm ties between Chilean President Michelle Bachelet and Uruguay's center-left *Frente Amplio* coalition. The Canelones leaders asked—and received—permission from Chile to name their own early childhood project "Canelones Crece Contigo," as a way to honor Chile's pioneering efforts.

But that did not mean that Canelones intended to replicate the Chile program, per se. "We knew that the reality of Canelones and Uruguay was different," Garrido says. "We needed to find our own program and identity." As impressive as Chile's program was, it grew out of a different political context, and was built atop a foundation different from that in Uruguay. [Exhibits 1-3, Maps and Data]

Diverging Paths

Chile had made a bold commitment to a universal, systemic approach to monitoring and intervention for pregnant women and young children. Such an ambitious cross-sectoral approach

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required determined leadership from the top, and significant resources, in order to win cooperation from major national ministries and agencies in charge of healthcare, education, and social programs. President Bachelet's leadership on the issue was essential in giving Chile Crece Contigo the standing to dictate changes, especially in the National Health Service. By contrast, Canelones Crece Contigo was a small pilot program run by a regional administrative department with start-up funding provided by the UN, and an uncertain future in Uruguay. It was, in short, in no position to demand protocol changes from any national ministries.

What's more, Chile's system was built on the foundation of a stable, basically well-functioning public health system. Uruguay, by contrast, had just embarked upon a major overhaul of its health system. The reform effort was still very much a work in progress. If successful, it would result in far better coverage all across Uruguay, but the new system would reduce the size of the public health system and create a network of *mutualistas:* private, decentralized hospitals with membership plans. The Ministry of Health would regulate the mutualistas and would provide financial incentives to encourage certain innovative healthcare practices but would not have direct administrative control over them.[a]

At the same time, Uruguay had its own strengths and traditions to build on. These strengths allowed the Canelones planners to chart a course that, although less comprehensive than Chile's, was quite ambitious. They understood that the families at highest risk for poor early childhood outcomes were those with health or social vulnerabilities associated with extreme poverty. Thus, Canelones decided to devise a program that went "all in" trying to help these families and their young children.

"El País de la Cercanía"

Mid 20th century Uruguayan historian Alberto Methol Ferré is credited with coining the phrase "*el país de la cercanía*" (literally, "the country of closeness") to describe a key aspect of Uruguayan identity—its small, familiar, close-knit society. In line with this closeness, Uruguay had, dating back to the early 20th century, created a broad array of home visiting programs to serve families in need. To be clear, not all of these programs had been welcomed by the recipients. Indeed, some of the early programs were later criticized as moralizing and overbearing. For example, healthcare workers were sent out as agents of hygiene improvement, "interested in modifying the unhealthy patterns of behavior of the working classes," according to one study.[2] And some programs drifted away from their original purpose. For example, by the early 2000s, a 1970s visiting nurse program for new mothers had, in many locations, morphed into a program that provided telephone reminders about baby checkups.

But in the early 21st century, the home visit approach received a revival and facelift. Such programs, under the umbrella term *cercanías,* were created with a new commitment to engage with families on their own terms. For example, in 2005, the Uruguay Education Ministry launched a program called Community Teachers (*Maestros Comunitarios*) that sent teachers to the homes of struggling students

[a] Uruguay's healthcare reform, begun in 2007, was undertaken to increase overall coverage, and decrease the share of people in the public health system. Those who could afford it received good quality, low-cost private care. The reduced burden on the public system allowed for major new investments and upgrades. 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.

with the goal of preventing them from dropping out of school and, in general, knitting stronger relationships between poor families and the public schools. (Sometimes these teachers ended up tutoring the parents alongside the students—an outcome celebrated by the program as a sign of success.)

Home Visits: In This Together

As the Canelones planners began to envision a program to improve the health and well-being of pregnant women and young children, they were naturally drawn to this revived *cercanía* model. Their research had revealed that many of the most vulnerable families were not making use of the government's existing health and social protection programs. The Canelones team wanted to help families to protect and nurture their children, and to help them access existing social services, but first and foremost, they wanted to meet the families "where they were." What was not helpful, they firmly believed, was a visit from a professional who led off by asking, "Why haven't you done *this, this, and this*? You're doing it *wrong*," says Florencia Cerruti, then an adviser to Canelones Crece Contigo.[3] To put families and providers on a more level footing, they agreed, the program would be entirely voluntary. "Families can say yes or no, and the spirit of the home visiting is to support the families—go with them as they take care of their kids," says Cerruti. The power of the Uruguayan model, echoes Garrido, is in "respecting the other person, being empathetic, being on the side and not the top, helping the family develop so that they can find a way out and improve themselves on their own."

But if the spirit of the program was clear, what, exactly, would these home visitors do? And for how long a period would they do it?

Program Goals. An obvious priority was to focus on the health of pregnant women, babies, and toddlers by way of straightforward, proven strategies. So, the group agreed that "we would promote breastfeeding, encourage vaccinations, formula (if needed) for babies, micronutrients like iron," says Marta Napol, a pediatrician on Canelones' early childhood team and, later, coordinator of the Canelones initiative.[4] These simple expedients could prevent common, serious health and developmental problems in babies and toddlers.

In addition, CCC wanted to encourage beneficial childrearing practices, to provide links for the families to other services in the area, and to work with them, in order to coordinate efforts and make these services more accessible, workable, and welcoming for vulnerable families. Early on, many of the local health and social service workers did not fully understand the constraints of these families' lives, Napol says. For example, the CCC discovered that some of their families had no idea that they were eligible to receive "food baskets" from the National Food Institute, even though the distribution of food aid was specifically aimed at the country's poorest families. (Through the efforts of CCC, Napol says, the NFI in Canelones began a practice of food delivery directly to some families in their homes, in addition to pick-up spots at restaurants, which were often located a long distance from poor neighborhoods.) Another common problem, Napol adds, concerned the scheduling protocols of local health clinics. A clinic might schedule a woman's obstetrics appointment for 7 a.m. without understanding that—given the limitations of her remote location, inadequate public transportation, and family responsibilities in

the home—it was effectively impossible for her to get there so early.

Program Duration. A further early question concerned the length of time home visitors would spend working with any given family. In this case, the intention to make a meaningful impact on a family must be balanced against the need to serve as many families as possible. In the end, they settled on a formula. If working with a pregnant woman, they would see her through the remainder of the pregnancy and the first seven months of her baby's life. If working with a family with young children, the home visitors would spend between 9 and 12 months, depending on family needs.

Professional Teams. Once the planners had decided on a mission for the home visitors, they had to think about what kind of background and training they wanted the home visitors to have. "We saw that it couldn't be implemented by just one sector of the state," says Napol. "It wasn't just a 'health care visit' or just a 'social work visit.'" So, the Canelones team came up with a fresh approach: a two-person team of professional home visitors, one with expertise in the health field (nutritionists, neuromotor specialists, midwives, nurses) and one with expertise in counseling and psychology (psychologists, social workers). "That was our trademark—what was innovative in this program," says Napol. "Before this, no one—that we know of—had thought of doing it this way." Because each team member would bring a different expertise to the table, the designers reasoned, they would be able to brainstorm together to find creative solutions to the challenges they encountered. In addition, the teams could call on the help of a supervisor to help problem-solve the toughest situations. And—as they often needed to visit homes in remote, isolated neighborhoods—traveling in pairs gave the home visitors a measure of added security.

Eligibility. The next challenge concerned how to define eligibility, and—more immediately—how to identify the first 100 families that were to receive service in the pilot. [Exhibit 4. Crucial Periods of Prenatal and Postnatal Brain Development] To receive such intensive in-home assistance, the Canelones team decided, a family must include a pregnant woman or a child under the age of 4 and must be at risk both in health and social circumstance. Examples of health risk included anemia, an underweight pregnant woman or baby, complications in a pregnancy, infection with a sexually transmitted disease, missed check-ups, substance abuse, mental illness, and lack of standard vaccinations. Examples of social risk included extreme poverty, a teenage pregnancy, a mother with substandard education (fewer than 6 years), and signs of physical or emotional abuse in the home.

To identify such families, the Canelones team invited direct referrals from local childcare and social service providers. But they did not want to limit their program to families that had already made their way into the orbit of the social protection system. They therefore also went directly to local health clinics serving the cities of Barros Blancos and Las Piedras. These clinics recorded key information for each patient on a "pink card." The CCC team began to comb painstakingly through the cards in search of eligible families with signs of risk.

In reality, however, the pink card records were often incomplete or hard to understand, Napol says. "It required a lot of work on the part of our experts to be able to translate that information from those cards into figures that would allow us to identify which children had bad nutrition rates,

which pregnant women were at risk." In addition, the CCC team discovered that health clinics were not routinely screening pregnant women and young children for anemia. "The prevalence of anemia in our country is very high—which is very risky for brain development, so it's an important factor," Napol says. In response, the CCC supplied home visiting teams with "pin prick" anemia tests to take with them on home visits, in order to screen young children for anemia. (Some clinics subsequently began to use the pin prick tests as well, Napol says. Within a few years, the Ministry of Health required health clinics nationwide to screen any child older than seven months for anemia.)

Canelones Crece Contigo Expands Statewide

After its pilot year, CCC was able to show some encouraging signs that the program had made a difference for the families it served. "There was not enough support to develop a national program at that time," says then-CCC consultant Cerruti. "But in Canelones, there was political will."

Fortuitously, the national government had created a program called Uruguay Integra, jointly funded by the European Union and the Uruguay central budget, to finance regional projects. Canelones Crece Contigo competed for, and received, a share of these funds, and was therefore able to expand Canelones Crece Contigo within the regional department between 2009 and 2011. The original home visiting program remained the centerpiece of CCC, but in the department-wide version of the program, Canelones also included some services for the entire community—primarily public education campaigns that promoted healthy eating, for instance, and green food production.

Between 2008 and 2011, Canelones Crece Contigo served an estimated 2,000 families. The program was able to show simple but marked improvements in the families it served. By linking families with the national food basket program, many reported an adequate supply of food for the first time. In addition, the number of children with ID cards—a requirement to receive any social benefits—increased. Maternal depression and the capacity of mothers to care for their children—singing to them, giving them breakfast, making sure they had vaccines—all improved, says Cerruti.

CCC was also able to help parents enroll their children in preschool, and, in the process, to persuasively demonstrate that the preschool resources in Canelones were inadequate. Access to a few hours a day of publicly funded preschool was supposed to be available to all age- and income-eligible children under law, yet "we had 7,000 children without preschool education in 2005," says Garrido. "With the data from this program, we were in a better position to negotiate with the central government. We managed to go from 22 CAIF centers to 100 in 2020." The Canelones local government helped to hasten this expansion by providing the land for some of the centers, and some of the equipment used within them.[b]

Of course, some of the biggest problems facing these families lay outside the power of Canelones Crece Contigo to solve. For example, an underlying problem for many poor families was unemployment. Between 1999 and 2002, Uruguay had fallen into a financial crisis that led to an abrupt rise in the

[b] Under the publicly funded CAIF program (*Centros de Atención a la Infancia y a la Familia* [Children and Family Care Centers]), private nonprofit organizations provided childcare to preschool aged children.

unemployment rate to more than 20 percent. That rate had since come down, and during the Vázquez administration, from 2005 to 2008, had further dropped from 12 to 8 percent.[5] But many of the families served by CCC fell into that remaining 8 percent, and the country did not have enough jobs and/or training programs to absorb them.

Another major national problem was substandard housing—essentially, shanty town slums, made up of jury-rigged, home-made shacks and shelters located on the periphery of urban areas. [Exhibit 5. Scenes from the Cerro Neighborhood in West Montevideo] Such settlements had emerged in the latter half of the 20th century but had doubled in size during the financial collapse of the 1990s, when evictions for nonpayment rose 20 percent. By 2008, an estimated 250,000 people lived in such areas, some adjacent to garbage dumps, some in flood plains, many with dirt floors and leaking roofs. Most (though not all) did have access to clean water and at least rudimentary sanitation, and most had access to electricity (though many such hook-ups were illegal). Slum upgrade projects had been undertaken under the Vázquez administration, but they were expensive and slow-going. After four years, housing conditions had improved for about 30,000 people, or 12 percent of shanty town residents.[6]

In the face of such staggering problems, Garrido acknowledges, she initially wondered whether Canelones Crece Contigo, however well-intentioned and thoughtfully implemented, would be able to make much difference in families' lives. "When I saw very painful situations of poverty and housing, I thought how will this program have an impact if it's raining through the roof and they're hungry, they're cold? How will we be able to help?" she says. But over time, Garrido was struck by how much the program could accomplish, even without—in most cases—being able to address these fundamental problems. Part of this impact, adds Cerruti, came down to the bond of trust between the primary caregiver—usually the mother—and the professional visiting team. Cerruti recalls reading the comments of the mothers, on exiting the CCC program. "A lot of them said, 'I never talk to *anyone*. This is the first time somebody has been worried about me.'"

Garrido recalls a case that made a particularly big impression on her: "We had a family in very poor housing. The house was always dirty, disorganized. The children were dirty. There was gender violence. They were unemployed." In sum, she says, "They didn't know what to do."

> The [CCC] team started working with the mum. After a few months, we saw that the mum was actually waiting, expecting the team. The floor was clean. There was a table—which was a cardboard box—with a tablecloth and dishes, waiting for the kids to have lunch. With the foods provided by the state, she cooked for the kids. The mum did enroll the children at the CAIF [public preschool] center, and she herself enrolled in a course that prepared her to serve on the cleaning staff of a hospital. And then she found a job. And she kicked out her [abusive] husband. So, the team provided that mum with tools to get ahead.

Of course, not every family experienced such a dramatic improvement. And even in successful cases, life remained a struggle for these families—but Garrido believes that the program does change the prospects for the children. "Many times, children don't see that poverty at home," Garrido says. "They suffer from the poverty, but they don't 'see' it directly. What they do perceive is the sadness. The

shouting. The bad mood. The stress. So, we tested [the proposition] that the protected and loved child, well-looked-after, even in difficult conditions, manages to grow with greater possibility. The program showed us that."

Going National: The Birth of Uruguay Crece Contigo

In 2009, José Mujica, one-time guerrilla rebel, became the *Frente Amplio's* presidential candidate, and won the election, assuming office the following year. In 2010, UNICEF Regional Director Bernt Aasen invited President Mujica and former Chilean President Michelle Bachelet to attend a high-level conference about early childhood intervention, "taking advantage of existent cooperation ties between Uruguay and Chile in this area."[7] The conference drew much attention and, at its end, Mujica pledged to review Uruguay's social policies and to find a way to bring early childhood interventions into the mainstream.

True to his word, in 2011, Mujica launched Uruguay Crece Contigo as a special project within his own presidential Office of Planning and Budget—a move that conferred prestige on the initiative and also placed it on a fast-track for implementation. He delegated the development of UCC to a team of six handpicked experts in early childhood development. Mujica's basic intention was—first and foremost—to expand the model of professional home visiting teams, designed and validated by Canelones, into a nationwide program. Next, UCC would expand the "universal" part of Canelones' program—the part most aligned with Chile's model—which provided educational materials and childrearing products to pregnant women and young children in public and private health clinics all across the country. Finally, UCC would build a "knowledge management" function into the program, sponsoring a wide range of research projects that would help UCC, and the government at large, to learn new information that allowed for continuous improvement of their early childhood policies.

The planning work began with Mujica's small team—most of whom knew one another and had worked together in the past. On the one hand, the Administration was committed to serving the whole of the country—not just its urban strongholds. But, like the Chilean planners before them, UCC feared that to ramp up the program all across the country all at once was to court failure. The UCC planners therefore decided, in the first year, to begin operations in Montevideo, home to more than a third of all Uruguayans, and in any other administrative department that met an established threshold for a set of health and social indicators including infant mortality and child poverty. Ten of Uruguay's 19 regional departments, located around the perimeter of the country, met this threshold.

To get the program up and running quickly, UCC negotiated to use office space in existing government buildings as a base for the home visiting teams and their supervisors. Many of these buildings belonged to the Ministry of Social Development (MIDES), which had the largest presence outside Montevideo of any of the country's ministries. In February 2012, UCC began recruiting candidates for the professional visiting teams and their supervisors. Like Canelones, UCC created two-person teams, comprising one health care professional and one social service professional. When the recruitment announcement was made, the program was flooded with applicants—4,000 people applied for some 100 positions. By July, the first 50 teams of home visitors had been hired

and they began to visit families. In 2013, UCC's home visiting program expanded to the less populous 9 states in the interior of the country.

In Uruguay's 2014 national election, the *Frente Amplio* again prevailed, returning Tabaré Vázquez to the presidency in 2015. He thus inherited the young—but already far-flung—UCC in his Office of Planning and Budget and faced a choice about what to do with the program going forward. Should it remain a protected program in the presidential office? Should it be integrated into one of the government ministries—either the Ministry of Health or Ministry of Social Development? Given UCC's focus on families in extreme poverty and given that many of UCC's territorial offices were already located in MIDES buildings, Vázquez ultimately decided to move the program to the Ministry of Social Development. By January of 2020, Uruguay Crece Contigo had 284 employees, altogether. [Exhibit 6, Organization, Uruguay Crece Contigo]

UCC in 2020: Three Pillars

As it moved from the departmental to national level, and as it became a full-fledged program of the MIDES ministry, UCC expanded the "universal" and "knowledge management" parts of its offerings.

Universal Program

The universal program consisted of the materials and services available to every family expecting a baby, or with children 0-4. Among the offerings:

- ***Welcome Kits for Newborns.*** Delivered in maternity hospitals since October 2013, these kits included educational information for parents about the importance of medical monitoring of babies through regular check-ups, vaccines, and treatment/intervention for any illness, infection, or developmental problem. They also stressed the importance of providing encouragement to babies and young children; to engage with them through play, reading, and music; and to set limits for them without resorting to emotional or physical abuse. The kits included a few useful items alongside downloadable music, toys, and books. [Exhibit 7. Sample Welcome Kit for Newborns]
- ***Safe Sleep Boxes.*** New parents were also provided with safe sleep information and materials intended to reduce the risk of sudden infant death syndrome (SIDS) and other sleep-related causes of death in children, such as suffocation. This included educational materials to encourage breast feeding and discourage smoking in the presence of a baby. In addition, families were encouraged to stop the practice—common in less affluent families—of arranging for a new baby to share a bed with parents or other family members. In situations where such sharing was unavoidable, parents were given a "baby box" to pile on top of the bed, allowing the baby to sleep separately, even in a shared bed. [See Exhibit 8. Safe Sleep Box] In addition, UCC provided portable baby boxes with blankets and warm clothes to families forced to evacuate their homes due to seasonal flooding and live for a time in an emergency shelter.
- ***Early Childhood Month.*** Beginning in 2018, UCC designated May as "early childhood month" in Uruguay, providing an opportunity to highlight good parenting practices. In the 2018 kickoff, UCC led or participated in 106 events nationwide, including 33 educational workshops and 24 artistic or cultural activities. Some 14 Children's Corners were officially opened that month, along with 10 breastfeeding rooms. In addition, UCC partnered with UNICEF to sponsor both a professional and

amateur photo contest, *Miradas Que Construyen* (literally, Looks that Build). The 16 winning photos showed warm family interactions (many between fathers and children) and formed an exhibit that toured the country. [See Exhibit 9, *Miradas Que Construyen,* First Prize Winner]

- ***Children's Corners & Breastfeeding Rooms.*** In cooperation with UCC's Universal Program, UCC regional coordinators actively sought to persuade public and private organizations in their territory to create indoor or outdoor "Children's Corners," or play areas with carefully selected toys, books, art supplies and interactive play structures. In addition, public and private organizations were encouraged to create breastfeeding rooms for staff and visitors to use.
- ***Educational Workshops.*** Also in cooperation with UCC's Universal Program, UCC supervisors and home visitors periodically organized or participated in local workshops and seminars to promote various aspects of healthy child-rearing.
- ***Mobile Clinic.*** A mobile clinic, staffed by a doctor, midwife, and home visitor, was deployed to remote areas of Montevideo, Canelones, San José, and Durazno, delivering both health care and health education to pregnant women (e.g., ultrasound tests, which might not be available at the local health clinic) and families with young children. These activities were coordinated with local health centers and other institutions that served UCC's families.
- ***Public Education.*** UCC promoted good parenting practices through an awareness campaign in various forms—radio, television, billboards, brochures, social media, text messages, etc.

Knowledge Management

UCC also set as a part of its mission the active pursuit of scholarly studies in various aspects of early childhood, in order to help in the continuous monitoring, evaluation, and revision of Uruguay's policies and programs for children. In particular, it conducted several studies concerning the nutritional status of young children. In addition, UCC conducted a study analyzing the food provided at CAIF centers, in order to make some suggestions for improving the nutritional quality of food offered in preschool.

But the heart of the UCC program—its central pillar—had always been, and remained, the professional home visitor program.

Professional Home Visiting Teams

Of UCC's 284 employees, the vast majority—202—were professional home visitors, who reported to 31 supervisors (each with their own geographic jurisdiction). The supervisors, in turn, reported to 13 regional coordinators. UCC had a presence in every administrative department, but three departments, with very small populations, were each served by just a single two-person team.

Each new case came to the UCC home visitor program by referral. A standard referral form was available on the MIDES website, and anyone working in Uruguay's social protection network could fill it out to submit a family for consideration; most referrals came from healthcare clinics or CAIF childcare centers. Supervisors then reviewed the referrals in their jurisdictions to see whether the families met UCC's eligibility requirements.

In small communities and rural areas, UCC was often able to provide a home visiting team to every family referred who qualified for the program. In densely settled Montevideo and Canelones, however,

demand far exceeded supply. While caseloads varied, depending on local demand, transportation issues, and the complexity of particular cases, each team, on average, worked with 30 to 40 families at a time. In Montevideo and Canelones, supervisors prioritized cases they deemed most urgent—pregnant women, children below the age of 1, emergency situations, and situations in which no other social service program was available—and placed other families on a waiting list. Supervisors reported that in urban areas, it was common to find as many families on the waiting list as those receiving service. (On the other hand, there were also more social service providers in urban areas, and UCC field staff tried to coordinate with other local providers, to make sure as many families as possible were served in some fashion.)

Not all potentially eligible families, of course, were referred to the UCC program. And some families—isolated for a variety of reasons—lived outside the orbit of the institutions most likely to refer them to UCC: healthcare clinics and childcare providers. In 2018, UCC's professional visiting teams served 4,684 households, including 1,611 pregnant women and 5,281 children below age 4.[8] Based on government data, this represented about a third of potentially eligible pregnant women and about 40 percent of potentially eligible children.[9]

The professional visiting teams in UCC—college educated, typically with expertise in psychology, social work, nutrition, midwifery, or neuromotor development—tended to be women in their 20s and 30s. [Exhibit 10. Professional Home Visiting Team in the Cerro Neighborhood in West Montevideo] In virtually every home engagement, the visiting team began by describing what the program could offer, explaining that it was entirely voluntary, and developing a work plan with family members. "It is important to note that although we approach the proposal with goals focused on the pregnant woman or child under 4 years old, a family approach is made," says Valeria Gradín, UCC Director of the Territories for Growth. Thus, the visiting team tried to work with any adult in the home with a significant role in childrearing—fathers, grandparents, aunts and uncles, etc. In addition, if, in the course of their work, home visitors identified a family member with a need for service outside the scope of the UCC program (for example, an uncle with a substance abuse problem or a sibling older than age 4 with a learning disability), the team supervisor would advocate for additional services with other local service providers. UCC teams and supervisors also tried to coordinate with other local service providers to reinforce UCC's one-on-one work with the family by building up family and neighborhood resources. For example, UCC might collaborate with other service providers to bring together families addressing similar issues, or to organize recreational outings that might reduce families' isolation.

The home visiting teams worked with each family on an agreed set of topics: non-violent childrearing practices, nutrition, child development, safe sleep habits, pregnancy and puerperium, breastfeeding, etc. In this work, they used (and adapted) UCC educational materials including small videos, pamphlets, and exercises to be practiced at home between visits. They were also able to provide a number of useful products to families, in addition to those available through the universal Welcome Kit. These included personal care items for pregnant women,[c] changing tables, mosquito netting, baby thermometers, warm

[c] This included a carrying bag, maternal nightgown and slippers, towel, toothbrush and paste, brush and hair clip, mirror, document envelope, and small hygiene and personal care items.

hooded baby suits, sun hats, winter hats, baby dishes and utensils, and simple free-standing cribs for babies up to 6 months, and also for babies and toddlers, 6 to 24 months. [Exhibit 11] Home visitors were also able to bring families a few educational toys but, in addition, they showed parents how to make creative use of everyday objects around the house to engage their children and stimulate development. The emphasis, one home visitor noted, was to help a family to make the most of what was available.

Additional assistance very much depended on particular family circumstance and the resources available in the area. The visiting teams typically helped families with government ID cards, cash transfers for food or basic family expenses, medical appointments, and childcare. In some cases—for instance, with accidental teen pregnancies—they tried to help the young mothers re-stabilize and, if possible, obtain scholarships for educational training programs. Supervisors and regional coordinators spent a great deal of time trying to secure additional services for families with other government agencies and service providers. This often meant working against bureaucratic resistance and inertia. “This is what regional coordinators and supervisors work on all the time,” says Gradín. “Networking is fundamental at all times in all interventions. UCC teams never work alone.”

Home visitors reported that perhaps the most prevalent—and frustrating—challenge for home visitors was to hear about, or witness, a woman being physically or emotionally abused by her male partner. Uruguay did have a resource for women suffering this kind of abuse. In 2016, the government had created Inmujeres, a nationwide advocacy program aimed at combating gender-based violence under the MIDES ministry. The visiting teams encouraged women to make use of this program. But such domestic abuse was endemic in some areas, and thus regarded as unexceptional by many women. Further compounding the problem, home visitors reported, was the very limited availability of outpatient therapy in the public health system. When a home visiting team believed children and adolescents to be in danger, home visitors were required to act by contacting child protection agencies. But absent a child abuse crisis, persuading women to take action against their abusers tended to be a lengthy process, at best. Even more difficult, according to some home visitors, were situations in which domestic abuse was combined with other serious challenges—for example, substance abuse or mental disability.

Home visitors also reported a host of prosaic but very real day-to-day logistical challenges. One was transportation. Many families lived in remote areas. While road access tended to be good nationwide in Uruguay, public transportation was often nonexistent or unworkable. With very little access to public cars or vans, the teams had to rely on infrequent buses and long walks to get to many families. In addition, they often did not have a “base” office close enough to their families to be useful for lunch and bathroom breaks, phone calls, and catching up on paperwork.

While the work could be hard and frustrating, team members also reported that it was compelling and often gratifying. Their supervisors reported sometimes worrying that the visiting teams became overly attached to their families, especially to the children. The mothers, too, sometimes became quite attached. (In at least one case, a mother reportedly joked that she would get pregnant again in order to keep her team.) The home visiting protocols did include a process for winding down and closing the case—reportedly important for all concerned. “Work is done with each family to visualize the achievements of

the joint work process," says Gradín and to emphasize the ongoing services and resources available to the family.

Ground Rules, Professional Home Visiting Teams

- Home Visiting Teams would be made up of one healthcare professional (e.g., nurse, midwife, nutritionist, psychomotor specialist, dentist) and one social professional (e.g., psychologist, social worker, teacher, anthropologist).
- There were two categories of families entering the program: pregnant women (the team would support her throughout her pregnancy, delivery, and the first seven months of her baby's life) and children under age 4 (the team would support the child and family for a period of 9-12 months).
- To be eligible, a family had to meet at least one of the criteria for *both* social and health risk (or, for pregnant women and children below the age of 1, for extreme social risk, even in the absence of specific health risk):
    - Qualifying health risks in pregnant women: anemia, sexually transmitted infection, unplanned pregnancy, undersized uterus, low maternal weight, below-healthy weight gain, age under 20, substance abuse, depression, domestic violence at home.
    - Qualifying health risks in children below age 4: anemia, too few health check-ups, child of a woman whose previous child died of domestic accident or unknown cause, stunting or risk of stunting, failure to meet standard developmental milestones. Additional criteria for children below age 2: low birthweight or low current weight. Additional criterion for children below age 1: premature birth.
    - Qualifying social risks for pregnant women and children below age 4: family income qualifies for a Uruguay Social Card and family allowance payments, irregular or unsafe housing, parent or child lacks official identification, family reports inadequate food in last 3 months, substance abuse at home, physical or emotional abuse at home.
- In areas where the demand for service exceeded the availability of home visitors, priority was given to pregnant women and children below age 1, situations of special urgency, situations in which no other social service provider was available, locations accessible to home visitors via public transportation.
- In addition to direct work with the families, the visiting teams also kept computerized records on each family, starting with baseline measures, answers to questionnaires, and personal observations which formed the basis of a "diagnosis" and work plan. They recorded interim measures over the months of work with the family, and then completed a final report at the end.

Results

UCC's Evaluation and Monitoring unit studied families that had been served by the Professional Home Visiting Teams between 2012 and 2018, comparing the state of play at the beginning of a home visit with the situation at the end of the intervention. The researchers identified several areas of improvement:[10]

- Families were markedly more inclined to take their children to a local CAIF center for early childhood education after the intervention. The proportion of families that "never" went to CAIF decreased from 65 percent to 38 percent. The proportion that attended CAIF daily jumped from 12 to 22 percent.
- The program also saw dramatic reductions in anemia in children aged 4 months to 4 years after the interventions—from 35 to 14 percent. The number with severe anemia similarly declined from 13 to 4 percent.
- The program also saw small decreases in the number of children who failed to meet their standard developmental milestones. Those not meeting one or more of their milestones dropped from 32 to 26 percent. Those not meeting language milestones dropped only a little, from 23 to 22 percent. But better improvements were seen in areas of motor skills, coordination, and social skills. Those not meeting motor milestones dropped from 9 to 4 percent. Those not meeting coordination milestones dropped from 11 to 7 percent. Those not meeting social milestones dropped from 11 to 8 percent.

Reflections

UCC's colleagues at Chile Crece Contigo—which had always prioritized broad and universal service—had, gradually, expanded their coverage to include children 0-9. By 2020, UCC was, by contrast, considering a narrower-but-deeper approach.

From the beginning, their goal had been to provide intensive services to those most in need—vulnerable families grappling with both medical and social risks. But, at existing staffing levels, UCC was not able to reach all such families. (Their home visiting teams were reaching about a third of high-risk pregnant women, and about 40 percent of high-risk children 0-4.) Faced with excess demand, home visiting teams in high-density areas had begun to prioritize pregnant women and children 0-1, as early childhood experts agreed that this window of time was the most crucial, developmentally. Florencia Cerruti, UCC's director of Early Childhood Policy Management, calculated that if UCC simply decided, as a matter of policy, to limit its home visiting coverage to these two groups, UCC could—at its current staffing level—come quite close to serving *all* high-risk families in the country.

Children between ages 1 and 4 in vulnerable families were, of course, still at risk, developmentally, she acknowledged. But in a world of limited resources, she thought it might be better to devise a different kind of program—perhaps less labor-intensive and expensive—for older children, in order to pour maximum resources into the country's most vulnerable, high-risk pregnant women and children younger than 1.

Meanwhile, Uruguay's November 2019 election threw the future of UCC into some question. Uruguayan voters rejected a *Frente Amplio* candidate for president in favor of Luis Lacalle of the center-right *Partido Nacional* (National Party). Lacalle campaigned on a platform of fiscal conservatism and

government austerity. What that would mean for social spending, in general—and Uruguay Crece Contigo in particular—was at first uncertain. In March 2020, however, the new government affirmed its commitment to continue UCC's work, to increase coverage to reach a greater proportion of the estimated potential demand, and to improve coordination with other MIDES home visiting programs.

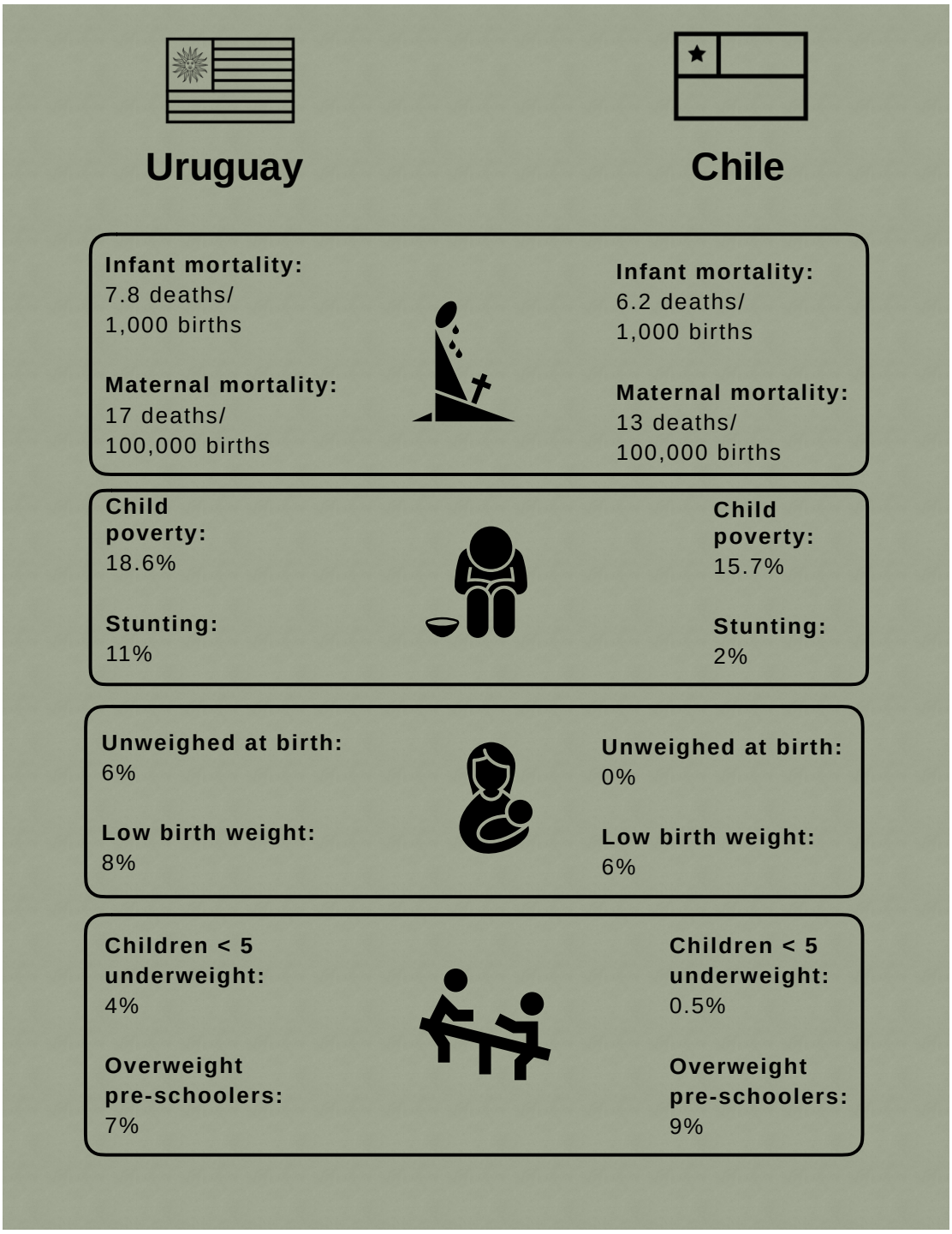
Exhibit 1. Uruguay[d]

[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]



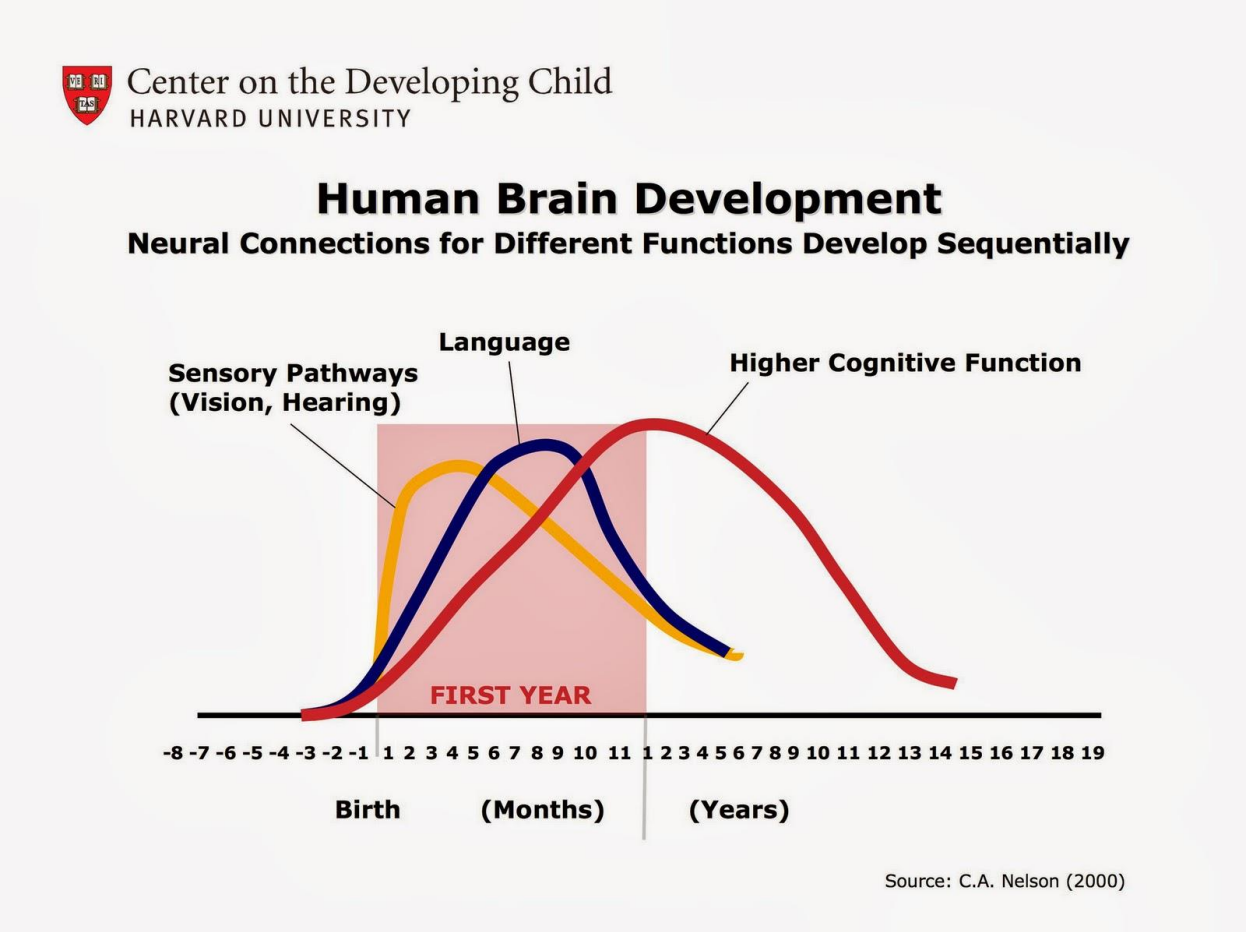
[f] Infant mortality (no dates given), maternal mortality (2017), and children < 5 underweight (2011 in Uruguay & 2014 in Chile) from the CIA World Fact Book, https://www.cia.gov/library/publications/resources/the-world-factbook/, retrieved May 13, 2020. Child poverty (2011), Stunting (2013-2018), Unweighed 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, Center on the Developing Child at Harvard University, http://developingchild.harvard.edu, retrieved May 8, 2020.

Exhibit 5. Scenes from the Cerro Neighborhood in West Montevideo[i]

[i] Photos by Pamela Varley.

Exhibit 6. Organization, Uruguay Crece Contigo

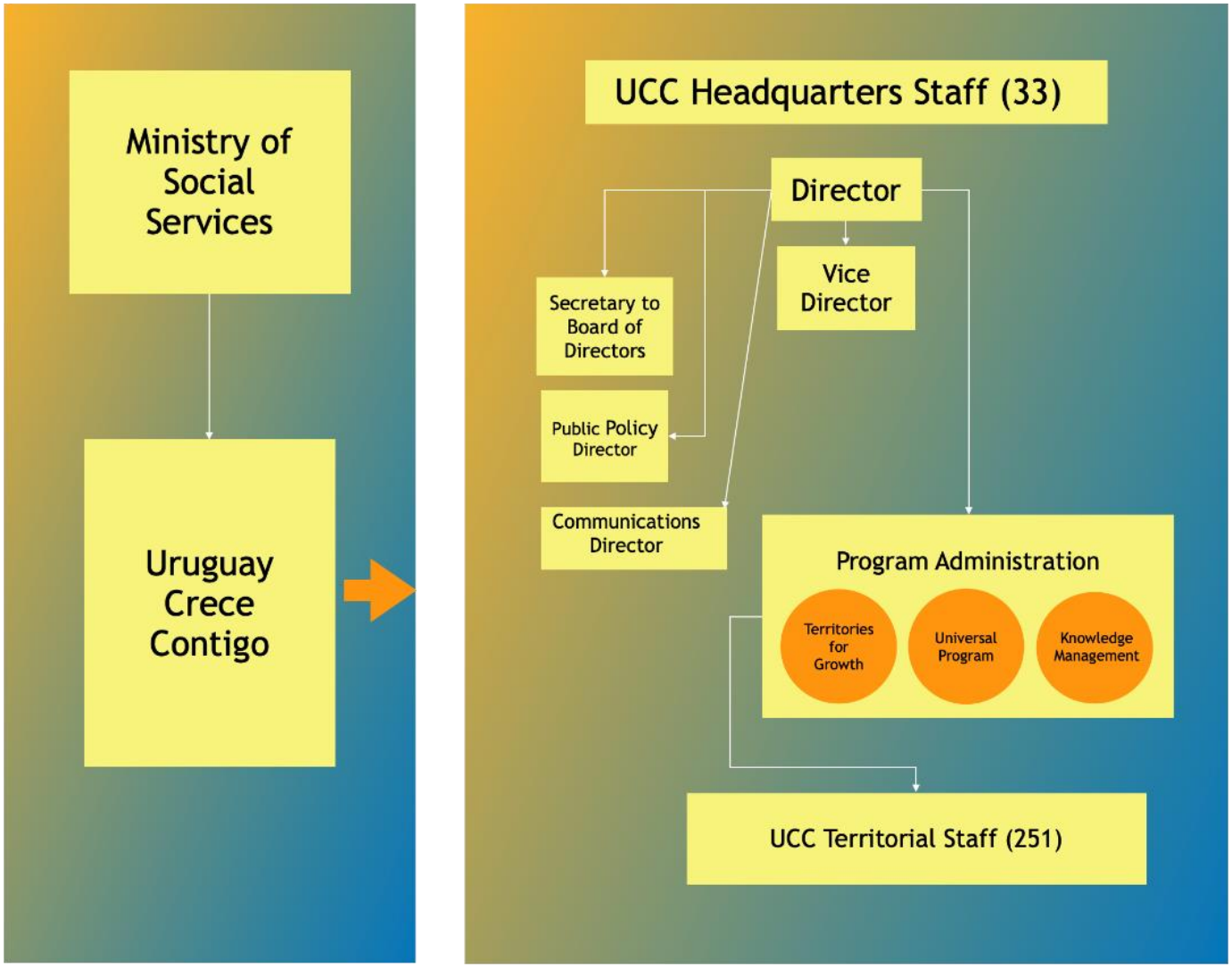


Exhibit 6. Continued…

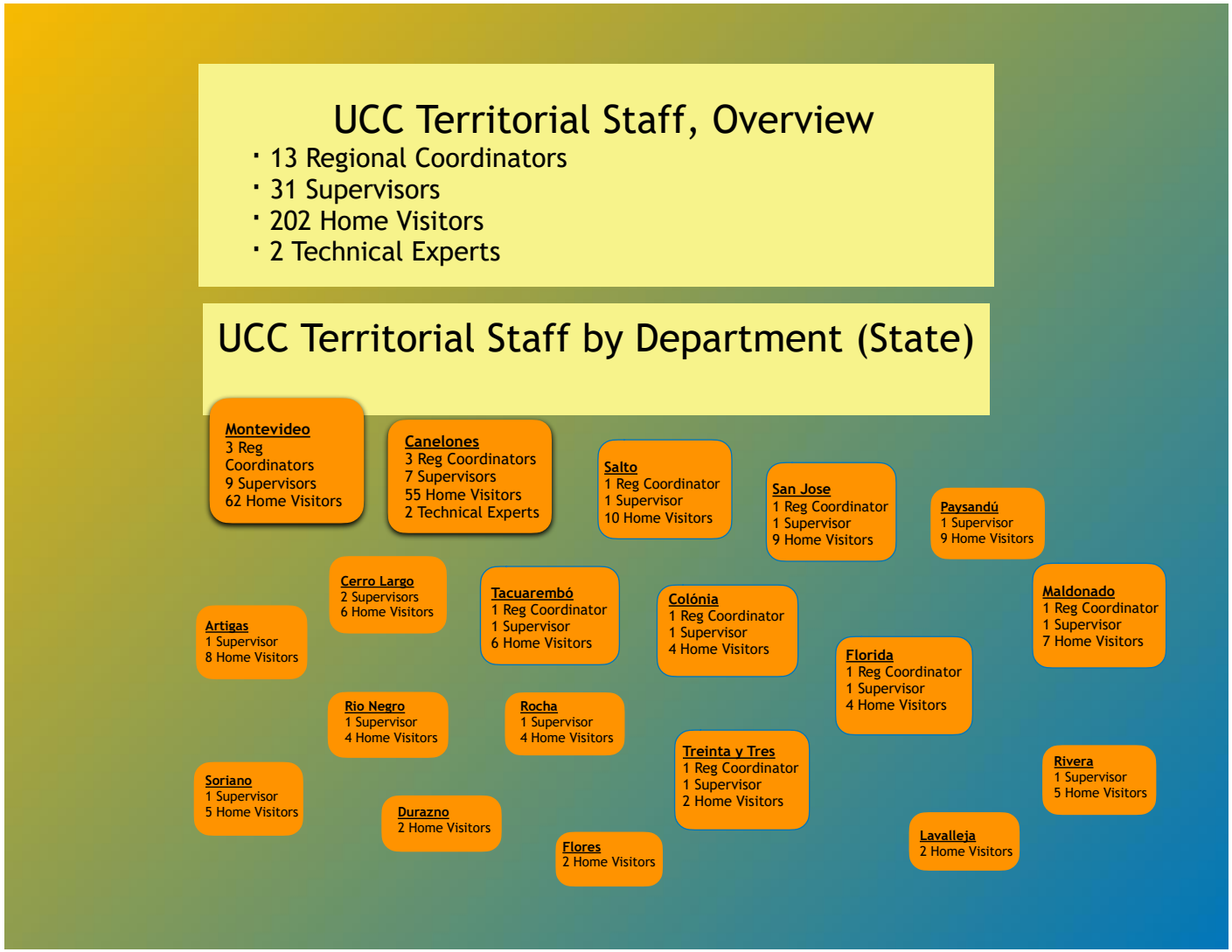


Exhibit 7. Sample Welcome Kit for Newborns, UCC[j]

Exhibit 8. Safe Sleep Box, UCC

[j] Images in Exhibits 7 & 8, courtesy Uruguay Crece Contigo.

Exhibit 9. *Miradas Que Construyen*, UCC[k]

First Prize: “Laughter” by Marcelo Damiani

[k] Reprinted by permission, Marcelo Damiani.

Exhibit 10. Home Visiting Team in the Cerro Neighborhood in West Montevideo[I]

Top, Home Visiting Team in Cerro: Valentina Macía, home visitor (nutritionist); Ana Nunes, team supervisor (nutritionist); Karelina Altieri, home visitor (psychologist); Natalia Montaño, regional coordinator (psychologist).

Bottom, Cerro Home Visitors Valentina Macía & Karelina Altieri.

[I] Photos by Pamela Varley, with approval from the team members.

Exhibit 11. Cribs for Babies & Toddlers in the Home Visitor Program[m]

Cribs like these were available for babies 0-6 months.

Cribs like these were available for young children aged 6 to 24 months.

[m] Images in Exhibit 11, courtesy Uruguay Crece Contigo.

Endnotes

[1] 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/.

[2] "*Los límites de la asistencia: análisis del programa social uruguayo 'Cercanías,'*"by Carolina González Laurino and Sandra Leopold, *Serv. Soc. Soc.* [online], 2015, n.124 [citado 2020-05-17], pp.746-771, https://www.scielo.br/scielo.php?script=sci_arttext&pid=S0101-66282015000400746&lng=es&tlng=es, retrieved May 17, 2020.

[3] Unless otherwise noted, all direct quotations were taken from in-person interviews with Pamela Varley in Uruguay between November 11, 2019 and November 15, 2019. Translation support was provided by Lourdes Martino and Soledad Insiburo of Traducciones del Sur, http://traduccionesdelsur.uy/web/.

[4] 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/.

[5] Uruguay Unemployment Rate 1991-2020, Macrotrends website, https://www.macrotrends.net/countries/URY/uruguay/unemployment-rate, retrieved May 17, 2020.

[6] "Development-Uruguay: Not Just Another Slum," by Raúl Pierri, Inter Press Service, May 25, 2009, http://www.ipsnews.net/2009/05/development-uruguay-not-just-another-slum/, retrieved May 17, 2020.

[7] UNICEF Annual Report for Uruguay, 2010, https://www.unicef.org/about/annualreport/files/Uruguay_COAR_2010.pdf, retrieved May 17, 2020.

[8] Uruguay Crece Contigo *Balance del Ejercicio* 2018, http://guiaderecursos.mides.gub.uy/innovaportal/file/41937/1/balance-de-ejercicio-ucc-2018.pdf, retrieved May 17, 2020.

[9] HKS Calculation, based on figures in the "*Informe de Monitoreo 2017-2018*," courtesy, Uruguay Crece Contigo, Ministry of Social Development, December 2019, and the Uruguay Crece Contigo *Balance del Ejercicio* 2018, http://guiaderecursos.mides.gub.uy/innovaportal/file/41937/1/balance-de-ejercicio-ucc-2018.pdf retrieved May 17, 2020.

[10] Uruguay Crece Contigo *Balance del Ejercicio* 2018, http://guiaderecursos.mides.gub.uy/innovaportal/file/41937/1/balance-de-ejercicio-ucc-2018.pdf, retrieved May 17, 2020.